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An Assessment of Basic Health Care Facilities in Uttarakhand State

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ABSTRACT

The mountain States of Uttarakhand I known for the beauty of nature and good weather but in terms of human development especially health care these states have miles to go forward. Geographical difficulties in these states lead to the poor access to health care system. It is ironic that a state like Uttarakhand having a high Per Capita Income is lagging behind in health accessibility and health infrastructure. This paper is written to provide an idea about the scenario of health infrastructure and access to healthcare in Uttarakhand state. 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 Department, Government of Uttarakhand, Human Development Report of Uttarakhand (2018), NFHS-14 (2015-16) and National Health Accounts (2018).

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

INTRODUCTION

It is well acknowledged that development is a process of broadening the sphere of human choices and entitlements and subsequently creating systems to ensure their delivery. In fact, development, from the vantage point of people, is essentially a process of creating capabilities, so that people can participate in the growth process. Mahbub Ul Haq has articulated this as "people are analysed not mere as the beneficiaries of economic growth but as the real agent of every change in society whether economic , political , social or cultural. To establish the supremacy of people in the process of development – as the classical writer always did – is not to denigrate economic growth but to rediscover its real purpose" (Haq, 1999). The history of economic growth testifies the fact that various deprivations do not diminish in proportion to economic growth .The benefits of growth, if left to itself, trickle down very slowly, therefore to make growth process inclusive and participatory, sustained efforts are needed, to create systems to ensure various entitlements to a large number of people, whom, the market by passes (Stigliz, 2002). There are plethora of evidences that conclusively establish that public services for human development specially education and health, are crucial in the process of capability creation, developing responsive citizenry and fostering growth (Drez and Sen, 1995).

Health is one of three basic and important tenets of human development concept one of the three indicators used while calculating the human development index (HDI). The access to and availability of health care facilities is an important enabling factor and determinant of advances in human capabilities as well as human development. Health is a fundamental right of all citizens and promotion of health care, in the process of economic development has its instrumental as well as intrinsic utility. Health includes the ability to lead a socially and economically productive life. Good health – defined not mere absence of illness but well nourished status capable to lead an independent life, has its intrinsic importance as

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it is an important ingredient of human dignity (Manthan Dilipkumar Janodia, 2016). Investment in human capital leads to a healthy and educated populace which is in a better position to contribute to the growth of the economy through its employability, creativity and productivity. A healthy population is important to the economic development of a country. The provision of adequate and efficient health care system is a major challenge to all governments especially developing countries. The government has two main roles in health deliver services; first, preventing or correcting failures in the health sector markets, and second, ensuring equity in provisioning of health care services. Both components of public policy on health are equally important but the former because of its preventive nature is unique. As prevention reduces the cost of illness significantly, as cost of illness consists cost of treatment as well as opportunist foregone to earn during the period of morbidity. The opportunity cost of illness happens to be much in of vulnerable section of society – employed in informal sector without any protective social security cover and depending on daily income. Therefore, Government participation in health care system must ensure that the health needs of the poor are met, as in preventive health there are serious market failure .In the curative health care system, the incentive to invest on the cure of the diseases inflicting poor most, is not very attractive to private sector. For example like diseases stemming from nutritional deficiencies, poor sanitation including water borne diseases, inflicting most to the poor section of society. The failure of public policy on health especially in case of preventive measures like proving safe drinking water to citizen has developed many private solutions – which in most cases beyond the affordability of poor. The serious worrisome aspect of neglect of health care system is – the ill health has impact across generation. Poor health of present generation carries forwards its impact on its off spring, in multiple ways. Like lost income due prolong and recurring morbidity reduces income – thereby parents can ill afford to invest on the education, skill formation and health of children. Disease reduces life expectancy and economic productivity adversely affecting the number and quality of the working hands in the family as well in national economy. This may, in turn, result in the lowering of national income thereby fuelling the spiral of ill health and poverty. This creates a vicious circle of one generating passing its incapacitating situation to next generation and thereby perpetuating poverty typically referred a poverty trap (Banerjee and Duflo, 2011).

Public health infrastructure provides communities, states, and the nation the capacity to prevent disease, promote health and prepare for and respond to both acute threats and chronic challenges to health. Public health infrastructure can best be described by what it is and what it does. It includes three components which are a capable and qualified workforce, up to date data and information systems, agencies capable of assessing and responding to public health needs. On the other hand access to health care is the timely use of health services to achieve the best health outcomes. It consists of four components (Healthy People, 2020) which are coverage, services, timeliness and workforce. Coverage deals with facilitating entry in to the health care system. Services are about having a usual source of care is associated with adults receiving recommended screening and prevention services. Timeliness is about the ability to provide health care when the need is recognised. Workforce is about capable, qualified, culturally competent providers. Mountain states in India are known for the beauty of nature and good weather but in terms of public health care and public education these states have miles to go forward. Geographical difficulties in these states lead to the poor access to health care system. It is ironic that a state like Uttarakhand having a fine Per Capita Income is lagging behind in health. Talking of access to health care we cannot forget health infrastructure because both are somewhat interrelated. Recent data shows little improvement and even deterioration in the reach of primary, preventive and promotive health care services. For example the proportion of fully immunized children (12-23 months) has come down from 60 per cent in 2005-06 to 57.6 per cent in 2015-16. These details can be so different if we take data geographically. Health disparity in the state is a major issue which leads to this low level of access to health care. Otherwise a state having an All India Institute of Medical (AIIMS) at Rishkesh would show this level of data. But the focus of the paper is not on health disparity it is on access and infrastructure in health care.

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

Health infrastructure is an important indicator to understand a state's welfare and health care policies. It gives us an idea about government's priorities with regard to the health care facilities. Infrastructure is the basic support for the delivery of public health activities. Five components of health infrastructure can be broadly classified as: skilled workforce; integrated electronic information systems; public health organisations, resources and research (Kumar and Gupta, 2012). Discussing health infrastructure not only implies the outcomes of health policy of a particular state but also implies the material capacity of the area of public health delivery mechanisms. The number of health personnel's, public health centres, community health centres, hospital beds, specialist doctors, and of course the quality of health delivery system determines the health outcomes. Without these a nation cannot achieve a decent human development index.

In 2018 the growth rate of India was 6.8% which was a decent rate. However in terms of health infrastructure this country is lagging behind. Economic development does not imply the development of a health care system. In 2019 the Human Development Index Rank of India was 129 among 189 countries. On the other hand china having a growth rate little less than India which is 6.6% have managed to achieve a rank of 85 among 189 countries in the same year, far better off than India. According to World Health Organisation, life expectancy at birth of India is 68.8 years in the year 2016 which is lesser than the global average of 72 years. Going further the under-five mortality rate in India was 34.3 in the year 2019. This indicates the growth of economy in India is not contributing enough to the development in health sector. For India health infrastructure is so important because of the amount of people below poverty line are so big and only if government provides quality health care we can improve the health status of the people. Not everyone is able to spend sufficient amount of money in private hospitals. The nation is facing a lot of problems in the health infrastructure scenario which are insufficiency of hospital beds, dismal number of health care centres, insufficient number of blood banks, urgent need of more medical colleges, concentration of healthcare in metro cities, non-availability of urgently needed vaccines. Only if these problems are sought out, the nation can face pandemics like COVID 19 and more to come in the future if any.

Health Infrastructure in Uttarakhand :

As a Himalayan state Uttarakhand has lot of prospects in terms of nature and weather but in terms of health infrastructure it is lagging behind. Geographically the state has many challenges which make the scenario even worse. Because of the geographical difficulty health personnel's are little hesitant to work in the state. The state is facing the problem of lack of adequate health institutions like sub centres, primary health centres, community health centres, sub district hospitals and district hospitals. Lack of good infrastructure in health care tempts the people to migrate to different cities in uttarakhand and outside. This leads to abandoning of villages in the state; we can see villages with 0 populations in the state which will not help us improve the existing scenario. This part of the paper tries to analyse the existing health infrastructure scenario in the state. As regards to health institutions in Uttarakhand, the table below shows us the total facilities and active facilities regarding the public health care system (Table 1).

Table 1 : Number of Health Institution in Uttarakhand

Health Institutions	Total Facilities	Active Facilities
Sub centres	1918	1881
Primary health centres	297	282
Community health centres	65	61
Sub district hospitals	27	27
District hospitals	21	20
Total	2328	2271

Source: Uttarakhand Health and Family Welfare Society (www.ukhfws.org)

The number of healthcare institutions in a state is very important because it gives us a major idea about the health infrastructure capacity of the area. The main health care institutions are sub-centre, primary health centres, community health centres, sub district hospitals and district hospitals. Uttarakhand has a total population of 1.01 crores and a total area of 53,483 km square. But the total of all these facilities are only 2328 in the state and among them 2271 are active.

In the public sector, a sub-health centre (sub-centre)

is the most peripheral and first point between the primary healthcare system and the community. The data shows there are 1918 total sub-centres in the state and 1881 active facilities. Primary Health Centre, sometimes referred to as public health centres, is state owned rural health care facilities in India. There are 297 total PHCs in the state and among them 282 are active centres. A healthcare centre, health centre, or community health centre is one of a network of clinics staffed by a group of general practitioners and nurses providing healthcare services to people in a certain area. Uttarakhand has a total of 65 CHCs and among them 61 are active centres. Sub-district/sub-divisional hospitals are below the district and above the block level hospitals under the state in India. There are 27 total SDHs and all of them are active. A district hospital typically is the major healthcare facility in its region, with many beds for intensive care and additional beds for patients who need long-term care. There are 21 district hospitals in the state and among them 20 are active and one centre is not active.

In the context of availability of health personnel, facilities and coverage under health insurance it seems that there is huge lack of health personal, basic facilities and lack of awareness of health related insurance scheme such as Aausman Bharat. 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 are called health personnel. But here we are talking about health personnel in the government sector, facilities and coverage of insurance. The two tables (Table 2 and 3) below will give a good understanding of the condition of the state in this regard.

The data which was taken from Human Development Report, Government of Uttarakhand gives us an idea about health personnel/facility per lakh population and coverage of insurance. In 2016 there were 13.91 doctors for one lakh population in the state which is not so bad but not so good. There were 38.57 paramedical doctors for one lakh population. Another important detail is hospital bed which is very important for CHCs and above level hospitals. The number of hospital bed for one lakh population was 1032 in this year and that of PHCs were 2.58 which is so disturbing to see. Coming to maternity and child care centres there were 18.97 units available for one lakh population in the state. All other health care centres under the state constitute 3.44 for one lakh population. The last parts of the table are about insurance coverage in the state. In the rural areas the number of persons covered under health insurance was 24.28 in one lakh population. But in urban area the figure is higher that is 33.53. The total number of persons under health insurance coverage in the state was 57.82.

The Table 2 is about the current availability health personnel in Uttarakhand. There are 147 sanctioned allopathic doctors at PHC in the state but only 65 of them are in position currently and 82 vacant posts are there. In the case surgeons in CHCs the situation is even more terrible; there are only 6 in position as compared to 83 sanctioned posts which gives us 77 vacant posts. The vacant posts as a share of sanctioned posts in case of OBG at CHCs are 91.00% and that of physician at CHCs is 93.67. The case of paediatrician at CHCs is little better because there are 14 in position as compared to the sanctioned posts of 80. There are 289 vacant posts for specialists at CHCs and only 32 are in position. This data clearly shows the core problem of public health infrastructure in the state as there most of the cadres

Table 2 : Availability of Health Personnel/Facility per One Lakh Population and Coverage under Health Insurance (in lakhs)

Health Personnel	2016
Number of doctors per lakh population (hills and plains)	13.91
Number of paramedical per lakh population (hills and plains)	38.57
Number of hospital beds per lakh population (hills and plains)	1032
Number of PHCs per lakh population (hills and plains)	2.58
Number of maternity and child care centres per lakh population (hills and plains)	18.97
Number of other health centres per lakh population (hills and plains)	3.44
Number of persons covered under health insurance (rural)	24.28
Number of persons covered under health insurance (urban)	33.53
Number of persons covered under health insurance (total)	57.82

Source: Human Development Report, Uttarakhand, 2018

Table 3 : Current Availability of Health Personnel in Uttarakhand, 2018

Cadre	Sanctioned	In position	Vacant	Vacant posts 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: Human Development Report, Uttarakhand, 2018

are having 90% posts which are vacant.

There are many reasons for this; one is of course the geographical barrier. The qualified health care professionals are not ready to live their life in the hilly areas as the facilities like roads, schools; hospitals and public infrastructure are not up to the mark. And they won't be having a polished city life style in the hilly villages and small towns in the state. Another one is low population of the state which is very important because in a democratic country population are vote banks. This takes us to another issue which is migration. People are migrating from the state to cities for the same reasons which are not going to help in the betterment of the current situation. In order to stop migration which are mainly pull migration the government need to provide more facilities overall.

Problem of Access to Healthcare :

Access to health care facilities is important for enabling the factors and determinants of advances in human capabilities. Modern age economists will agree that safeguarding the health and wellbeing of the people is one of the main functions of a government. The health care facilities of government are needed to reach the population irrespective of caste, religion, gender, region, and language. In the case of Himalayan states the access to health care situation is little problematic because of the geographical barriers. The tropical setup in Uttarakhand is such that people living in villages and hills face difficulties in accessing basic health infrastructure facilities. The rural-urban and hills-plains disparity is real in the state in terms of access to healthcare. In the capital regions of the state it is easy for the people to reach out to the health care centres for basic and first hand treatment. But for people living in villages or hilly areas has to travel a lot for the treatments which is difficult for mainly emergency cases.

For better understanding the scenario of access to health care it is important to compare it with the neighbouring state which is also a Himalayan state, Himachal Pradesh. The table below shows major health indicators like Infant Mortality Rate, Under Five Mortality Rate, Institutional Birth, Percentages of Immunisation and Underweight.

In the year of 2015-16, 40 infants were dying per 1000 live birth in Uttarakhand; in Himachal Pradesh it is slightly better which is 34 per 1000 live birth. The Under Five Mortality rate was 47 per 1000 live birth in Uttarakhand and 38 in Himachal Pradesh. In the case of institutional births Uttarkhand has a percentage of 69 and Himachal Pradesh was 76%. Immunisation is low in the state which is 58% as compared to the rate of 70% in Himachal Pradesh. There are 27% of underweight children in the state which is 21% in the neighbouring state. The data shows lagging behind of Himalayan states but the case of Himachal Pradesh is slightly better in all indicators (Table 4).

Table 4 : Major Health Indicators, 2015-16

Indicators	Uttarakhand	Himachal Pradesh
Infant Mortality Rate	40	34
Under Five Mortality Rate	47	38
Institutional Births (%)	69	76
Immunisation (%)	58	70
Underweight (%)	27	21

Source: NFHS-4, 2015-16

Role of Government and Need for Change:

According to the Indian Constitution health care delivery is in the hands of states. But in reality states have struggled to maintain and develop health care delivery system that they are more dependent on the centre. Now the situation is changing as states account

for 75- 90 per cent of public spending on health. Since the New Economic Policy which allows more and more private sector public health is at the risk of competition. The growing private hospitals are a result of liberalisation move by the government but it is important for the current government to step-up. In a country like India not everyone can afford to go to private hospitals but still they are going. People are mainly going to these hospitals because they are not getting enough facilities and treatments in our public health sector. Considering the data given in this paper we can say that in these states the health infrastructure scenario is worse. For the betterment of public health sector, there is a need for more spending on health care. The table below shows the total health expenditure of Uttarakhand, Himachal Pradhesh and Kerala.

Uttarakhand is spending 2.6 per cent of the states GSDP, while Himachal Pradesh spends 3.0 per cent and Kerala spends 4.5 per cent. The state of Kerala is known for their development in the public health sector; still the state is spending 4.5 per cent of their GSDP for health care system. But the state of Uttarakhand, comparatively a new state is spending only 2.6 per cent. Himachal Pradesh spends 3.0 per cent of their GSDP on healthcare. In order to strengthen the public health sector the states have to invest more in the health sector (Table 5).

Table 5 : Health Expenditure as Percentage of GSDP

States	Total Health Expenditure as % of GSDP
Uttarakhand	2.6
Himachal Pradesh	3.0
Kerala	4.5

Source: National Health Accounts, 2018

Conclusion :

Public health care system in Uttarakhand is characterised by shortage of health personnel and facilities. The problem of an acute shortage of doctors in the state is real because of the geographical barriers, that qualified doctors are not willing to spend their life in rural, hilly areas of the state. Lack of a polished city life style in the state does not invite health care workers. It is clear from the data shown in this paper that there are a big number of vacant positions for skilled doctors and specialists, which is around 90% for most cadres. As vacant posts are high the workload of the remaining health personnel is high too, which is one more reason for the doctors not to come. The population in the state is mainly scattered, so there is a need for more construction of PHCs and CHCs; which takes us to the problem of access to healthcare. Health disparity is a major concern for the policy makers in the state because a scattered population. Some villages in the state looks like abandoned and most of them are not having good healthcare facilities. People in the rural and hilly areas have to travel a lot for even getting first hand treatments. Thus we can imagine the cases of emergency cases. There is a need for boost in investment for the public health care system in the state.

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