UTILIZATION AND FINANCING OF HEALTH SERVICES IN A SUB HIMALAYAN STATE

Mitasha Singh[1], Des Raj[2], Shailja Sharma[3]

[1]Junior Resident, Department of Community Medicine, Dr. Rajendra Prasad Government Medical College, Kangra.
[2]Junior Resident, Department of Community Medicine, Dr. Rajendra Prasad Government Medical College, Kangra.
[3]Medical Officer, SIHFW, Kangra at Chheb, Himachal Pradesh.

ABSTRACT

Health services in Himachal Pradesh a sub-Himalayan state in India with majority of population residing in rural area is provided maximally by public sector under Ministry of health and family welfare (MoHFW). Although the state has a hostile weather and geographic conditions with a poor economy, the utilization of government health services is maximum. The health sector still receives 2.5% share of budget. The health indicators of the state are better than the country's indicators. The inequalities and inequities still exist across rural urban population and socioeconomic status groups. The following article discusses the existing barriers and the various strategies by government.

KEYWORDS
Health Financing, Himachal Pradesh, Inequities.

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INTRODUCTION

Himachal Pradesh (HP) one of the smaller states in north- west part of the country with a population of around 0.68 crore[1] has made significant progress in bringing down the crude birth and death rates and other mortality indicators hence increasing the standard of living. Majority (91.3%) of the population resides in rural areas and about half the area is covered under tribal belt. In HP the health services (promotive, preventive and curative) is primarily provided by Ministry of health and family welfare and the department of Indian health systems of medicine and homeopathy. Due to the large rural population and hostile geographic and weather conditions, the State is still backward and poor in terms of economy.

Health Infrastructure

The state has number of medical, public health and Ayurveda institutions with specialized institutions for treating tuberculosis, leprosy and STDs. But there is disparity existing in rural and urban distribution and geographic distribution of these health facilities. The majority of general hospitals (GH) are situated in urban areas, with no GH in rural areas of district Bilaspur and Kullu. There are no urban civil dispensaries (CD) at Chamba, Kullu, Hamirpur, Mandi and Una district. In contrast maximum eight CDs are in Shimla district. There are no STD clinic and units at rural areas of around half of the districts.[2]

Private Sector, NGOs and Voluntary Health Institutions

The private sector is growing fast in the state with private clinics, nursing homes and other diagnostic centers. But these private sectors have mainly grown up in selected urban areas of state. NGOs and other voluntary sectors are still few in number and not providing curative services in state so far.

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Corresponding Author:
Dr. Mitasha Singh,
Department of Community Medicine,
DRPGMC, Kangra,
Tanda-176001,
Himachal Pradesh.
E-mail: mitasha.17@gmail.com

Utilization of Health Services

District level health survey- 4 data of the state shows that all components of antenatal care are more likely to be received by women in urban areas (94.4%). Similar results were seen in DLHS-3 where even education and wealth index was also taken under consideration and the higher educated and women in higher wealth index utilized more of services. Delivery at private health institutions were low as compared to government sector, but those deliveries which were conducted at private institution were more in urban areas (14.7%) as compared to rural (11.6%).[3]

Fully immunized children were more in urban areas (Difference of 10.2%), however the number came down from previous year.

Government health facilities are still the most utilized ones in this state but rural and urban disparities exist. ANC utilization was more in public sectors of rural areas (90%), pregnancy (87.5%) and post-delivery complications (84.4%) were dealt maximally in public sector in rural areas. Vaginal deliveries were conducted more in rural government institutions (86.6%) as compared to urban (60%). There were no cases utilizing government facilities for ARI in urban areas and only 50% of urban population utilized these services for diarrhoea management.[3]

The unmet need for family planning has decreased from previous years but the trend of higher unmet need in urban population (13.8%) continues in DLHS-4 also as compared to rural (11.6).[3]

Morbidity and Mortality Indicators

Infant mortality rate is the most sensitive indicator of health services. According to National family health survey (NFHS) in all the rounds the IMR is seen to be declining at a very good rate in urban areas to 11 per thousand live births but in rural area it first declined but again rose in the third round to 36 per thousand live births.[4]

The reported prevalence of any acute and chronic illness was lower in urban population (1.5%, 2.3% respectively) as compared to rural population (2.3%,3.1% respectively).[3]

Anaemia was more prevalent among females and in rural population as compared to urban population and males. Adults having blood sugar higher than 140 mg/dl and 160 mg/dl was

seen in 19.7% and 10.5% of urban population respectively as compared to 16.2% and 6.7% in rural population. Also above normal blood pressure (>140/90) was reported more in urban population as compared to rural (3.5% higher).[4]

Health Expenditure

Out of pocket health expenditure per delivery in public health facility was higher in urban public facility (Rs. 4700) as compared to rural health facility (Rs. 4630), however the gap was not much wide. The health sector has received 2.5% share of the budget in the year 2015, which is the same as previous years.[4]

Inequalities

The health indicators of the state are better than the country's indicators. But there are some inequalities across geographical areas, gender, residence and wealth status. Many of these health inequalities result from a broad set of social, economic, and political conditions which influence the level and distribution of health within a population. This can be seen in HP where in term of infrastructure the politically strong areas have more number of health facilities. It is evident from the data that the utilization of preventive and curative services from government facilities is higher in rural areas than urban. There are areas which lack in much of infrastructure due to geographical constraints. The urban population has access to private health facility but still the government general hospitals with higher facilities are located in urban areas of the state only.

Nutritional disease like anaemia is more prevalent in rural parts as compared to non-communicable diseases (Diabetes, hypertension) which are more prevalent in urban areas. Also anaemia was more prevalent among females of all age groups. In terms of utilization of maternal and child health services, although the utilization in form of antenatal care and immunization (Preventive services) was more from the public sector but the rural population was lagging behind the urban population.

The budget allocated to rural and urban population has no difference with reference to health. But out of pocket expenditure is increasing both in rural and urban, more so in urban because of many possible reasons.

The public health system is said to be more rural centric but the utilization of those services are more among urban population in Himachal Pradesh because they are better educated and socioeconomically sound.

Inequities

The inequalities stated above do not completely represent inequity. Majority population of HP being rural, most of the infrastructure is concentrated in these areas. The deficiencies are mainly due to geographical and political barriers, which are being dealt with.

It is well known that reduction in mortality and morbidity is partly due to preventive and curative interventions by public health services. The utilization of preventive services such as childhood immunization and ANC are effective indicators for assessing the availability, accessibility and quality at the primary level of health services provisioning. The ANC and immunization coverage in HP is better than national average but intrastate variation is due to financial and human resource constraints in the public health services. The variation also occurs across various socio economic groups which have been highlighted in DLHS-3 data. The utilization decreases as we move from higher wealth quintile to lower quintile group. These preventive services concentrate more in rural areas is the reason behind increase in unmet need of family planning services.[3]

In curative services also the state is well developed at primary level with good referral facilities. There is dependence on public sector both in rural/urban and across all socioeconomic groups. The variation is present only in urban population where private sector has started blooming.

The acute and chronic morbidities were more among rural population. This apparent anomaly is probably because people living in towns have better access to public and private services compared with those in rural areas, and therefore, experience a higher financial burden when they access healthcare. The nutritional disorders were more prevalent in rural areas and lifestyle disorders in urban are self-explanatory. Anaemia remained more prevalent in females across all ages and more so in rural population.

Affordability of health services is determined by the cost of treatment, households' ability to manage these costs, and its impact on the livelihood of households. The OOP expenses in HP is seen to be more in urban population even in utilizing public facilities, largest component of which is on purchase of medicines.

Strategies

The National Health Policy of 2015 and the 12th Plan documents have expressed concern about the persistence of inequities in provisioning, use and health outcomes.[5] A high level expert group has recommended on universal health coverage in twelfth plan, through increasing public expenditure on health. This has also been stressed upon in the policy but no clear solutions are available. Only possible outcome in both are seen in form of public private partnerships.[6]

The policy recognizes the need for the holistic approach and cross sectoral convergence in addressing social determinants of health. This would also require the development and use of indicators to measure the determinants and the disease outcomes and systems to measure such indicators. Targeted investment in building health infrastructure and putting in place an adequate number and skill –mix of health human resources and supplies in under-serviced areas where the gaps are the greatest, would remain a major strategy of improving access.

The major shift suggested is to scale up the national health programme to cover the entire urban population within the next five years- and this requires adequate financing on a sustained basis to match the requirement. ASHA has been recruited in Himachal Pradesh to function as a bridge between first level health facility and the community.

This same concept shall extend to all urban areas also. Though the population per center ratio would be about half (One for every 10,000 population) the relationship between number of providers and registered families would be the same - meaning additional human resources and supplies to deliver this larger range of preventive, promotive and curative care services- so that it becomes the first port of call for every individual and family.

In urban areas operating the infrastructure in two shifts may also enable higher access- provided the human resources for primary care never falls below the population to provider ratio. In facilities, which have much higher case-loads, the human resources deployed must be proportionately higher to ensure quality of care. These recommendations can only be fulfilled on basis of human resources, which is still lacking, more due to attrition, corruption and political reasons.

In response to the high out-of-pocket expenditure on health services and the increasing burden on the poor and socially marginalised, the government has initiated an insurance scheme, Rashtriya Swasthya Bima Yojana (RSBY). Twelfth plan has recommended that RSBY should be transferred to Ministry of Health and Family welfare, so that it becomes the core of Universal health coverage.

A need for thinking beyond maternal and child health is focused in the 12th plan to improve the health services for women and girls. But no strong strategy has been suggested. This issue strongly needs to be looked into by identifying other social determinants and then forming a strategy.

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