Rajasthan's Public Health Facilities an Inter District: Analysis and Evaluation

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Abstract

The study shows that the quality of public service is extremely low and that unqualified private providers account for the bulk of health care provision. The low quality of public facilities has also had an adverse influence on the people's health. In an environment where people's expectations of health care providers seem to be generally low, the state has to take up the task of being the provider or regulator.

Introduction

This has seen a global human wellbeing change that has driven people to live fuller, happier and more prosperous lives. Good health is a major determinant of economic development and a part of the population's well-being. For human happiness and well-being, better health is central. It adds greatly to economic growth, when a healthier community lasts longer, is more efficient and saves more.

Concept of Health Infrastructure

In fitness, the word physical infrastructure has a much wider definition. Which encompasses not only health clinics, dispensaries, or hospitals, but also well-trained, service-oriented workers. Therefore the purpose of a health care system is to supply persons with health services, thus enhancing their health status. Demographic measures such as the rate of child mortality, the rate of death and the rate of birth primarily depend on the provision of health facilities. A well-developed, equitable and affordable health system relies on the health and well-being of the citizens of the community. In order to understand health care policies and welfare mechanisms in a nation, health infrastructure is necessary. Public health infrastructure offers the opportunity to avoid infections, improve health and plan for and respond to both acute threats and chronic health problems for populations, states and the country. The base for planning, implementation and delivery is infrastructure. Public health care system deserves the highest priority in any country, particularly in developing world. WHO (2000) has emphasized that the primary goal of a 5 health system should be to provide better health in a responsible manner and with fair public expenditure. Development of health infrastructure ensures a country of healthy manpower for production of goods and services. It is the responsibility of the government to ensure the right to healthy living to its citizens.

Past Formation of Health Infrastructure in India:

Public health services in the colonial era were based on health treatment for British people who were residing in India. The era saw research institutes, public health regulations, and sanitation departments, but at this time just 3% of Indian households had toilets. Annual health reports were issued and emphasised the prevention of outbreaks of infectious diseases. Death rates from infectious diseases such as cholera had fell to a low by the end of the colonial period, Other illnesses were also rampant, too. The spread of communicable diseases is under greater control in modern-day India and now non-communicable diseases, mainly including cardiovascular diseases, are big killers. In the 1946 Bhore Committee Report, which recommended the introduction of a health care scheme that was supported at least in part by the Indian government, health care reform was prioritised. India's first National Health Policy (NHP) was developed in 1983 with the aim of developing a system of primary care facilities and a referral system. The revised NHP in 2002 concentrated on strengthening the system's practicality and scale, as well as bringing private and public hospitals into the health sphere. The new policy focus in India is an effort to ensure that every person should have sufficient access to curative care in the form of universal health coverage. Recognizing social determinants of health as a significant determinant of community health and the need to provide a public health structure within the current health care system are similarly valid. This call for a distinction between the 'public health' system and the 'public health care system when the latter uses the public to indicate the government's primary function and not simply as a community as seen in public health. Support for public health has been geared at helping the middle and upper classes, as it seeks to build more opportunities for health workers, develop academic institutions and enhance training. For the poorer groups who do not reap the advantages of this aid, this causes differential access to health services. Currently, governments pay for about 75 percent of the national health system, but poor state funding neglects India's public health system.

Health infrastructure in India

India will be the most populated country by 2030, with a population of 1.2 billion increasing at the rate of 1.1 percent (Census 2011), with as many as 1.4 billion or more inhabitants. As seen by numerous health indices, India has made significant progress over the years in the field of health. Life expectancy at birth has improved, child mortality and crude death rates have declined dramatically, illnesses such as small pox, polio and guinea worm have been eliminated and leprosy has been almost eliminated. The nation aims to achieve Universal Health Care. The Public Health System of India is a three-tier system of primary, secondary and tertiary tiers of health care aimed at improving and providing health care services to people and the population as a whole.

Health infrastructure in Rajasthan

Physically, Rajasthan, the largest state of the Indian Union, is located in the northwest region of the country and has a population of 56 million (or 5 percent of the country. The population density per sq. is 165 people. The Km. The state's decadal growth rate is 28.41 percent (against 21.54 percent for the nation), and the state's population continues to rise at a rate much higher than the national rate.

Six zones covering 33 districts, 237 blocks and 41,353 villages are divided into Rajasthan. The state is largely rural and 80 per cent of the population depends on subsistence agriculture. Rajasthan Public Health System Baseline

Public Health Facilities

There are 7 medical colleges, 34 district hospitals, 12 sub district hospitals, 5 satellite hospitals, 376 CHCs, 199 dispensaries, 11487 SCs, according to the 4th Common Review Mission of the National Rural Health Mission Rajasthan (2011). Gaps remain in the state's health system. Tribal regions lack the necessary numbers of PHCs, 8 although both the required numbers of CHCs and PHCs are absent from desert and general areas.

Human resources

As there has been a significant increase in human resources for health within the NRHM phase, as per the 4th Common Review Mission of the National Rural Health Mission Rajasthan(2011), especially in the recruitment of Certified Social and Health Activists (ASHAs), the state continues to report a significant gap between needed and posted health officials at all levels Nearly all managerial ranks have vacancies, but the most important vacancies are noted for junior and senior specialists (851 vacancies), senior medical officers (225 vacancies), medical officers (763 vacancies), and rural medical officers (424 posts vacant). Additionally, 15 vacancies for the deputy chief medical officer remain unfilled throughout the province. The condition illustrates that as is required under the NRHM, the state is still unable to perform its position in delivering affordable health care to most citizens. Similarly, as at 1.1.2011, substantial shortages exist for nurses (2,186), ANMs (1,731), laboratory technicians (457) and other personnel (2,880).

Health Infrastructure disparities:

Disparities in Health sector can be determined through proper allocation of available resources and utilization as well as demand for health care needs. 9 Equitable health care is possible through proper resource allocation and access to health care is determined by health needs. Rajasthan, despite being an economically developing state of India, is suffering from the problem of disparities in public health infrastructure. Under the DISTRICT LEVEL HOUSEHOLD AND FACILITY SURVEY (2012-13), a total 989 SHCs were surveyed from 32 districts in Rajasthan depicting the following findings about inter-district disparities –

- Out of the 989 Sub-Health Centres average population covered by a SHC is 4005. The highest average population covered (6642) among the surveyed SHCs is in Dausa district and the lowest (2552) in Jaisalmer district and it is slightly lower as per prescribed in the government norms.
- Eighty One percent of SHCs have their own government building. Apart from Kota which has only 52.3 percent of the SHCs owning government buildings, all other districts has more than 60 percent of their SHCs working from government buildings etc.

- Bikaner, Jaisalmer, Jalore, Pali and Kota have more than 80 percent SHCs with ANM in position. 26.8 percent of the SHCs in the state are having additional ANMs in positon. It is highest in Banswara district having additional ANM while Churu does not having additional ANMs.

Such a grim situation of inter-district disparities in public healthcare infrastructure may be attributed to many underlying factors, which includes inadequate budgetary provisions, administrative mismanagement, shortage of human resource, infrastructural inefficiency and the complacency unwillingness of the government among all.

Review Literature:

- Newar and Sharma (2017) examined regional disparities at district level in the state of Rajasthan, at two points of time 1991-92 to 2010-11. For this purpose six indicators have been selected from agriculture sector and respective composite indices have been prepared and then districts are ranked on the basis of their composite index. The paper suggested that in agriculture sector in Rajasthan more concentrated efforts are needed so that regional disparities at district level captures a declining trend instead of the rising trend at present (though marginally).For this, there is a need to propose a comprehensive plan as per agro-climatic zones of the state taking each district as a major unit.

- Bala(2016) in her study is primarily concerned with the analyzing the spread of Public Health Services across the State of Haryana and to examine the interDistrict disparities in area of health indicators. In this study data from secondary sources like statistical abstract of Haryana and Data from HMIS portal has been 12 used and composite index for estimation of District wise disparities have been used. The composite index has been computed by taking average value of all the indictors may be called as deprivation indicators. Study witnessed from the data analysis of health infrastructure over a period of time and other indicators of health that despite the steady improvements in the overall health and HMIS indicators of the Haryana State, there is wide disparities among the few of the district. These districts experience a lower quality of health services and are less likely to receive routine medical procedures and have higher rates of morbidity and mortality than non-minorities.

- Garg and Gupta (2014) attempted to examine the inter-district disparities in health infrastructure in Haryana. For this purpose, 10 indicators of heath infrastructure are selected and their COV, Ratios and Deprivation and Development Indices are worked upon. Statistical value of COV confirms the gap in the availability of health facilities in various districts of Haryana. Finally, the deprivation as well as development indices of health infrastructure reveal the discrepancies in districts with regard to health infrastructural development

- Ghosh (2013) studied Public Health Services and Health Insurance in West Bengal with Special Reference to Darjeeling District. The study used various primary and secondary data and mathematically analyzed them using Logit analysis, multiple regression model, Pearson's correlation coefficients, $\chi 2$ test. It is found that West Bengal's performance had always been

better than all-India averages with regard to most of the vital statistics and in infrastructure development. Masarguppi and

- Karne (2013) made an attempt to study the reasons of disparity in 19 states of India for three sectors- Agriculture, Industry, Service sector 13 including infrastructure. The paper has used Multi-stage Principal Component Analysis to identify the factors contributing to inter -state disparity and thus prepared Composite Index of Economic Growth in order to measure the extent of disparity. Total 9 indicators for each sector – Agriculture, Industry, Service sector including infrastructure were selected and further were divided into Indicator I and indicator II for each sector. For agriculture sector Indicator I included five indicators representing agriculture performance and Indicator II included four indicators representing land utilization. For Industrial sector Indicator I represented industrial sector performance and included 5 indicators and indicator II represented industrial sector productivity which included four indicators. For service sector indicator I represented Sector Performance and included 4 indicators and indicator II represented Infrastructural Performance and included 5 indicators. The results of the study have shown that every state needs to identify its 'Lead' sector which ensures backward and forward linkages for other sectors to grow and thus enhancing the overall growth of the state.

Research Objectives

The main aim of this study is to analyse the inter-district availability of and variability in health infrastructure in Rajasthan. The specific objectives of the study are –

1. To study the demographic, economic and health profile of Rajasthan state and compare it with that of India.
2. To describe the public health infrastructure in Rajasthan on the basis of individual indicators.
3. To study the regional disparities in public health infrastructure of Rajasthan on the basis of selected indicators.
4. To identify the factors behind the existence and growth of inter-district disparities in public health infrastructure in Rajasthan.
5. To analyse the inter-linkages between public health infrastructure and health outcome.

Methodology:

The study will be based on secondary data collected from various sources –

1. Statistical Abstract of Rajasthan
2. Basic Statistics of Rajasthan

3. Some Facts About Rajasthan published annually by the Directorate of Economics and Statistics (DES), Government of Rajasthan, Jaipur
4. District Level Household Survey (DLHS-III)
5. National Sample Survey (NSS) Reports
6. Census Reports
7. Rural Health Statistics Reports
8. Various issues of Economic Review

Conclusion:

Public health professionals work to prevent population-wide health problems through educational programs, policies, services, regulation of health systems and some health professions, and research. In contrast, clinical professionals, such as doctors and nurses, focus primarily on treating individuals after they become sick or injured. The dramatic achievements of public health in the 20th century have improved our quality of life, increased life expectancy, reduced infant and child mortality, and eliminated or reduced many communicable diseases.

A strong public health infrastructure to prepare for and respond to both acute (emergency) and chronic (ongoing) threats, protects the nation's health. To become more coordinated, efficient and effective, public health must identify and sustain "core" services; increase adherence to national public health standards; coordinate among health departments and other sectors, especially health care; stabilize funding for basic infrastructure and core services; and explore shared services. An NCSL article, A Wealth of Public Health, discusses the public health system and the state legislative role.

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