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HELTH CARE INFRASTRUCTURE IN KARNATAKA: PROBLEMS AND PROSPECTS – A STUDY

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ABSTRACT

Every one wishes to be away from disease, disability and premature death. Substantial evidence Is now available regarding the fact that good health is an important contributor to economic growth in any nation. In this background Policy makers and researchers have recognized the importance of Ments in health and health infrastructures. Public spending on health and in incomes among the poor, seem to be the major determinants of infrastructures, which would contribute to the better health status of the community. Such an outcome also depends on equitable sharing of provision of health services coupled with life-enhancing activities such as nutrition and therefore, the role of government is very important in order to achieve health in a country like India. As per the Constitution of India, the provision care by the public sector is a responsibility shared by state, central and governments; although it is primarily a state responsibility in terms of service one of the first steps for improving the health status of a nation is to Basic health care facilities to all citizens. India is a signatory to the Aim of Health for all' by year 2000. In an effort to improve rural health infrastructure, the Government of India has embarked on a plan to provide primary health care through a three-tier system comprising sub-centre's, Primary Health Centre's (PHCs), and Community Health policy is to establish, by 2,000, one sub-centre for every 5,000 population, one PHC for every 30.000 population, and one CHC for every 1, 00,000 population in the rural plains. In hilly and tribal areas the plan is to provide one sub-centre per 3,000 populations and one PHC per 20,000 population. Although these norms are applicable to the country as a whole, regional variations in availability of health services in rural areas are evident because different states are at various stages of implementation of the schemes. In Karnataka, relics of an earlier system unique to the state, know as Primary Health Units (PHUs) exist along with PHCs. PHUs are being currently upgraded to PHCs (South India Human Development Report, 2001.

***Key words:* Healthcare, PHCs, CHCs, Infrastructure, Physicians.**

INTRODUCTION:

Health is the most important socio-economic aspect of every individual life also necessary for all productive activities in the society. Ensuring proper health care is one of the most important objectives of development. Health is both an instrument and product of development is, therefore, a major factor in the development process. Health care services may be defined as all those personal and community health services including medical care and related activities directed towards the protection and promotion of the health of the community, Health care services viz, public hospitals and primary health care institutions which in turn include the entire PHC network of community health centre's Primary health centers and subsidiary health centre's and

sub centers, dispensaries maintained by government etc, Primary health care services, which consists of various interventions such as child and survival and development, special nutrition programmes and family planning. The health of the community is strongly influenced by the quality and availability of health care services to them; Medical care is a subject of health care services system the term medical care which ranger from domiciliary care to resident hospitals care refers to those personal services that are provided directly by physician's instructions.

Health is one of the vital indicators reflecting the quality of human life. It is a basic need along with food, Shelter and education and is a precondition for productivity and growth. That there is a positive correlation between the health status of people and the economic development of the country is a well established fact. It is also one of the key variables that determine "growth with a human face" even as health economic has emerged as an important area of research (Hans, 1997). Health is the most important socio-economic aspect of every individual life also necessary for all productive activities in the society. Ensuring proper health care is one of the most important objectives of development. Health is both an instrument and product of development is, therefore, a major factor in the development process. Health status in any society is determined by a number of socio economic factors such as education, nutrition, population growth, income and environment etc. Good health is an essential requirement for the enjoyment of every aspect of life. The importance of health in process of economic and social development and in improving quality of life of the citizen has well recognized. The World Health Organization (WHO) has defined health in the following way "health is a state of complete physical mental and social well-being and not merely the absence of disease or infirmity". Health is an important aspect of human well-being. Ensuring health for all has been the main goal of the central as well as state governments in India.

PRIMARY HEALTH CENTRES (PHCS):

The primary health care infrastructure in rural areas has been developed as a three-tier system. The norms for establishing Sub centre's, PHCs and CHCs. PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care to the PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP) Basic Minimum Services Programme (BMS).

As per minimum requirement, a PHC is to be maintained by a Medical Officer supported by 14 paramedical and other staf. Under NRHM, there is a provision for two additional Staff Nurses at PHCs on contact basis. It acts as a referral unit for 6 Sub Centre's. It has 4-6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services.

There are 23,673 PHCs functioning as on March 2010 in the country. Community Health Centre's (CHCs) 1,4, CHCs are being established and maintained by the State Government under MNP / BMS programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provided facilities for obstetric care and specialist consultations As on March, 2010, there are 4,535 CHCs function in the country. The details of the norms for each level of rural health infrastructure and current status an existing facility (district hospital, sub-divisional hospital, community health centre etc.) can be declared a fully operational First

Referral Unit (FRU) only if it is equipped to provided round the clock services for Emergency Obstetric and New Born Care, in addition to all emergencies that any hospital is required to provide. It should be noted that there are three critical determinants of a facility being declared as a FRU: i) Emergency Obstetric Care including surgical interventions like Caesarean Sections: ii) New-born Care; and iii) Blood storage Facility on a 24 hour basis. Iv) Sub-Centre's (SCs).

COMMUNITY HEALTH CENTRE'S (CHCS):

CHCs are being established and maintained by the State Government under MNP/ BMS programme. It is maintained by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in door beds with one OT, X-ray. Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provided facilities for obstetric care and specialist consultations. As on March, 2008, there are 4,276 CHCs functioning in the country. Sub-Centre's (SCs) .The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM) / Female Health Worker and one Male Health Worker (for details of staffing pattern, and for recommended staffing structure under Indian Public Health Standards (PHS) Under NRHM, there is a provision for one additional Second ANM on contract basis. One lady Health Visitor (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centre's are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Sub-Centre's are provided with basic drugs for minor ailments need for taking care of essential health needs of men, women and children. The Ministry of Health & Family Welfare is providing Central assistance to all the Sub-Centre's in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Worker is borne by the State Governments for NRHM under the Swap Scheme, the Government of India has taken over an additional 39,554 Sub Centre's from State Government / Union Territories since April, 2002 in lieu of 5,434 Rural Family Welfare Centre's transferred to the State Governments / Union Territories. There are 1, 47,069 Sub Centre's functioning in the country as on March 2010. Number of Sub Centre's existing as on March 2010 increased from 1, 46,026 in 2005 to 1, 47,069 in 2010. There is significant increase in the number of Sub Centre's in the States of Chhattisgarh, Haryana, Jammu & Kashmir, Maharashtra, Orissa, Punjab, Rajasthan, Tamil Nadu, Tripura and Utterakhand. As on March, 2010, there are 1, 47,069 Sub Centre's, 23,673 Primary Health Centre's (PHCs) and 4, 535 Community Health Centre's (CHCs) functioning in the country. As an March 2015, there are 1, 48,767 sub centers 22,992 PHCs and 4,735 CHCs function in the country.

Number of sub-centre's, PHCS and CHCS Functioning in India

Sl.No.	State/UT	2005			2010			2015		
		Sub centre	PHCs	CHCs	Sub centre	PHCs	CHCS	Sub centre	PHCs	CHCS
1	Andra Pradesh	12522	1570	164	12522	1570	167	12755	1678	180
2	Arunachal Pradesh	379	85	31	288	97	48	302	101	50
3	Assam	5109	610	100	4604	856	108	4708	876	115
4	Bihar	10337	1648	101	9696	1863	70	9718	1901	78
5	Chhattisgarh	3818	517	110	4776	716	143	4879	735	155
6	Goa	172	19	5	172	19	5	192	21	07
7	Gujarat	7274	1070	272	7274	1096	290	7378	1102	301
8	Haryana	2433	408	72	2484	441	107	2590	461	115
9	Himachal Pradesh	2068	439	66	2071	449	73	2095	460	81
10	Jammu & Kashmir	1879	334	70	1907	375	77	1920	390	87
11	Jharkhand	4402	561	47	3958	330	188	4102	340	192
12	Karnataka	8143	1681	254	8143	2193	325	8159	2210	350
13	Kerala	5094	911	106	4575	813	233	4581	825	245
14	Madhyapradesh	8874	1192	229	8869	1155	333	8899	1176	345
15	Maharashtra	10453	1780	382	10580	1818	365	10690	1835	380
16	Manipur	420	72	16	420	73	16	431	78	18
17	Meghalaya	401	101	24	405	109	29	420	111	31
18	Mizoram	366	57	9	370	57	9	378	60	11
19	Nagaland	374	87	21	396	126	21	402	132	24
20	Orrissa	5927	1282	231	6688	1279	231	6764	1291	235
21	Punjab	2858	484	116	2950	446	129	2965	456	132
22	Rajasthan	10512	1713	326	11487	1504	368	11565	1518	372
23	Sikkim	147	21	4	147	24	0	158	29	01
24	Tamilnadu	8682	1380	35	8706	1283	256	8810	1298	265
25	Tripura	539	73	10	627	79	11	635	82	13
26	Utterakhand	1576	225	44	1765	239	55	1785	241	57
27	Uttar Pradesh	20521	3660	386	20521	3692	515	20725	3701	518
28	West Bengal	10356	1173	95	10358	909	348	10415	913	355
29	Andaman Nicobar Islands	107	20	4	114	19	4	120	21	5
30	Chandigarh	13	0	1	16	0	2	21	2	3
31	Dadra &Nagar Haveli	38	6	1	50	6	1	56	6	2
32	Daman & Diu	21	3	1	26	3	2	29	3	3
33	Delhi	41	8	0	41	8	0	48	10	1
34	Lakshadweep	14	4	3	14	4	3	17	5	4
35	Pondicherry	76	39	4	53	24	3	61	26	4
	All India	146026	23236	3348	147069	23673	4335	1,48,767	22,992	4,735

Source: Department of Ministry of Health and family welfare, India.

The existing public health infrastructure, though can meet prescribed norms is not evenly distributed across the State. Many institutions are not functional due to staff shortage and non-availability of drugs and consumables and essential equipment. Facility Survey of 1999 by Government of India indicates that about three-fourths of the CHCs have no adequate equipments and only one-third of the PHCs provided delivery care. As a result of such inadequate public health facilities, it has been estimated that less than 20 percent of the population, which seek OPD services, and less than 45 percent of that which seek indoor patient treatment, avail of such services in public hospitals. A large portion of population seek medical care services from private sector despite the fact that most of these patients do not have the means to make out-of packet payments for private health services (NHP 2002).

HEALTH CARE INFRASTRUCTURE IN KARNATAKA:

The state of Karnataka has total number of 293 hospitals. Out of these, 176 are government owned. There are 1,297 numbers of primary health centres, 622 primary health units / dispensaries, 7,793 sub-centre's and over 50,000 beds in the state. The Government of Karnataka has taken some of the major initiatives to improve the state of health in Karnataka.

1. Three-tier health infrastructure comprising primary health centre's, health units, community health centres and sub-centre's.
2. The government policy is to establish a primary health centre for an average of 30,000 people, a dispensary for 15,000-20,000 people and a sub-centre for 5,000 people (Economic survey of Karnataka)

Health services to reach public through a wide net work of 1679 primary health centre's, 301 community health centre's, 177 hospitals, 27 district hospitals, 553 primary health units, 8143 sub centre's and 304 maternity hospitals and 124 urban health centre's in the State. Demographic indicators show that sex ratio in Karnataka is 964, infant mortality rate is 50 and under five mortality rate is 70. Maternal mortality rate is 195 per lakh live births; Family welfare has always been a priority social sector. The strategy is directed towards voluntary adoption of family planning methods supported by maternal and child health care. 10.74 infants have been immunized. 599 primary health centres in the most backward areas provide round the clock nursing facilities in order to reduce the maternal and infant mortality rates. 68 primary health centres are being upgraded to community health centre's have been handed over to private medical colleges and NGO for complete management (Economic Survey of Karnataka 2013-14).

The other Health Institution in Karnataka, 2014-15

Health Institution	Number
Medical College	36
District Hospitals	27
Referral Hospitals	57
City Family Welfare Centre	2
Rural Dispensaries	176
Ayurvedic Hospitals	122
Ayurvedic Dispensaries	589
Unani Hospitals	13
Unani Dispensaries	51
Homeopathic Hospitals	20
Homeopathic Dispensaries	42

Source: M/O Health and F.W. GOI

Health Care Infrastructure in Karnataka: 2010 to 2015.

Particulars	2010			2015		
	Required	In position	Shortfall	Required	In position	Shortfall
Sub-centre	7369	8143	-	9147	9744	-
Primary Health Centre	1211	2195		2395	2295	100
Community Health Centre	302	323		326	350	-
Multipurpose worker (Female) / ANM at Sub Centres and PHCs	10338	8028	2310	10538	10929	-
Health Worker (Male) MPW(M) at Sub Centres	8143	3762	4381	9550	5762	3788
Health Worker (Female) / LHV at PHCs	2195	1170	1025	2595	1770	825
Health Assistant (Male) at PHCs	2195	837	1358	2398	1998	400
Doctor at PHCs	2195	2814	619	3850	3790	60
Obstetricians and Gynecologists at CHCs	323	215	108	398	250	148
Physicians at CHCs	323	192	131	398	240	158
Pediatricians at CHCs	323	116	207	398	220	178
Total specialists at CHCs	1292	691	601	1507	1375	132
Radiographers	323	30	293	398	115	283
Pharmacist	2518	1983	535	2500	2475	25
Laboratory Technicians	2518	1242	1276	2500	2400	100
Nurse / Midwife	4456	1647	2089	5601	4969	632

Source: RHS Bulletin, March 2014-15, M/O Health and F.W. GOI)

The Government of Karnataka has accorded priority status to health sector over the year and has taken efforts to improve the standard of living of people thereby creating a positive influence on the health and well-being of the citizens of the state. The structural units of health sector are health infrastructure and its related health care financing, which are the key input indicators in the health delivery system. The state is following the national pattern of three-tier health infrastructure in rendering primary health care through primary health centres (PHCs), sub-centres, and community health centres its people by way of implementing various national and state health programme of public health importance through its network of various types of health and medical institutions.

TREND IN HEALTH FINANCING BY THE CENTRE AND STATE:

The financial allocation for the health sector over the past decade indicates that the public expenditures on health (through the central and State Governments) as a percentage of total government expenditure, have declined from 3.12 percent in 1992-93 to 2.99 percent in 2003-04. Similarly, the combined expenditure on health as a percentage of GDP has also marginally declined from 1.01 percent of GDP in 1992-93 public health expenditure increased from Rs 89 in 1993-94 to Rs. 214 in 2003-04, which in real terms is Rs 122 Health care is financed primarily by state Government, and state allocations on health are usually affected by any fiscal stree they encounter. Besides chronic under funding, the sector has been plagued with instances of inefficiencies at several levels result resources. All these factors combined have had an adverse impact on the public health sector's ability to provide health care services to the people.

It is estimated that in order to meet the target expenditure level, total plan expenditure will need to grow at 29.7 percent annually during the first three years of the Eleventh Five year Plan, which breaks down to 30.2 percent for the centre and 29.2 percent for the States. As a result, total health expenditure of the Centre and States respectively, will rise to 0.55 percent of GDP and 0.85 percent of GDP in 2009-10 in the last two years of the plan, total plan expenditure will need to rise at about 48 percent annually. This will result in a total health expenditure of 0.87 percent GDP by the Centre and 1.13 percent by states in 2011-12. Therefore, during the eleventh five year plan, while the Central Government makes every effort to augment resources for health, State Government will be persuaded to assign at least 7-8 percent of State expenditures towards health care. And yearly increase health expenditure 2.32 to 3.50 percent GDP by the center and states during the plan.

PROBLEMS OF PUBLIC HEALTH DELIVERY SYSTEM IN KARNATAKA:

Public health services are an essential part of country's development infrostrutive. Public health services and even implementation of public health regulations have been neglected. Public health services are pro-growth, pro-poor and self targeted towards the poor.

The Bhore Committee set up in 1946, set the foundation for the current public health care system. The committee recommended free health care funded by the state. Since health is a state subject, the state governments provide hospitals, dispensaries, PHC's sub-centers etc. But, the public health delivery mechanism has the following problems in the state.

1) Insufficient medicines. 2) Unfriendly behavior of doctors.3) Referring outside for medicine.4) Poor quality of health services. 5) Gap in man power and infrastructure especially at the primary health care level. 6) Plethora of hospitals not having appropriate manpower, diagnostic services and drugs. 7) Inefficient distribution, use and management of human resources leading to lack of key personnel, un-motivated staff, absenteeism. 8) Long waiting hours; in convenient clinic hours. 9) Inefficient systems for purchasing drugs, supplies and services, which fail to ensure quality. 10) Corrupt practices and unclean surroundings. 11) Lack of privacy. 12) Non-availability of doctors for 25 hours. 13) Obsolescent and unusable equipments. 14) Dilapidated state of buildings.15) insufficient essential drugs. 16) Insufficient capacity of the facilities.

SUGGESTIONS FOR THE IMPROVEMENT OF PUBLIC HEALTH CARE INFRASTRUCTURE SYSTEM IN KARNATAKA:

- Enforcing good management and governance is absolutely essential since the implication of bad practices in the public health care system hurts persons who are poor.
- No health system can function unless; there is a minimal level of integrity, fair play and rule of law.
- Consumer forums, village health committees, Transparency Act, right to information, imparting of value system, e-governance, redressal system etc are some of the instruments that need to be employed by the government for counter-checking malpractice.
- No among of funding or administrative reforms can help till there is an overall institutional discipline enforced at all levels and pride for good work instilled.
- Introducing the concept of 'barefoot doctors' (China's model). These men and women car be given rudimentary training in treating the most common ailments affecting the villagers.
- Present system of education needs to be reviewed and there is an urgent need to re-introduce the earlier practice of short-duration, less expensive medical related courses for doctors qualified to treat simple ailments like fever, cold, diarrhea, headache etc. After all, most illness people suffer from all quite simple and do not require the service of a specialist (Mandal Commission, 2006).
- In the context of weak regulatory system, increasing demand for good quality care from middle class, there is a need to examine mechanism for improving the quality of health services.
- Filling up the sanctioned vacant posts at the earliest through recruitment of appropriately trained staff.
- Revised personnel policy to attract more health personnel to work in rural areas through financial and academic incentives.
- Hundred percent immunizations for pregnant mothers and children below five years must be targeted.
- Strengthening infrastructure facilities further for easy accessibility.
- Involving Panchayat Raj Institutions, NGOs in health matters.
- Making the people to understand the importance of pre-natal and post-natal care.
- Globalization does not mean that the government should minimize its role in the health sector. The government should take the responsibility of the poor in respect of health care for which it should raise the resources partly through a progressive tax and partly through a system of social insurance.
- Major sops are required to boost sagging health sector of the country.
- With governments several health care initiatives proving to be ineffective, the development of private health care facilities would be crucial for the development of the health sector in India.

- Incentives under the health sector would boost the industry's positioning as a major hub for medical tourism for overseas patients.
- Decentralization of health services is the most essential reform to be carried out at the organization level to improve public health services in the country.
- Utilization of subsidized / free public health services by the better off is to be discouraged to increased access to the poor.
- A bill which would make it mandatory for all the students of government medical colleges to serve in rural areas for a specific period is needed. The reasoning behind this proposal is that those who have been benefited from the government's subsidized education must give back to our rural areas.
- The state governments will have to ensure adequate level of financial autonomy to the PHCs to enable them locally purchase drugs and minor equipments, make local arrangement for referral transport.

CONCLUSION:

The existing public health infrastructure is not evenly distributed, public hospitals are located district head quarters and state capital, it restraints accessibility of the health services to the poor in rural areas whose employment and wage is low and those who are in unorganized sector they need support of health care. The existing level of government expenditure on health in India is low. Poor people borrow heavily or sell assets to cover their health expenses, and as a naturally those hospitalized are pushed into poverty after such health care expenses. To increase the PHCs and Public hospitals inclusive approach is necessary, one way is to strengthen lower level of PHCs, and Public hospitals in rural areas, encouraging NGO's to run hospitals, small hospitals within 50 number of beds and financial support should be provide to the poor in rural areas, in order to access the good health care services. In economic terms, educated healthy people build a healthy nation with a healthy growth rate. Infrastructure of a nation not only presents the human face of the economic growth process, but represent the very essence of well rounded progress. The Importance of investments in health and health infrastructure and public spending on health increase in incomes among the poor, seem to be the major determinants of health infrastructures, which would contribute to the better health status of the community. The policy makers and Government authority is to all efforts to reach the make health facilities within the reach of common man in the society.

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