

**INFRASTRUCTURE AND MANPOWER- STRATEGIC CONSTITUENTS
IN THE DEVELOPMENT OF THE HEALTH SERVICES IN INDIA: A
STUDY OF UTTAR PRADESH IN FOCUS**

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ABSTRACT

India has adopted a number of policies to tackle the problems of health despite of that the health status of Indian is still a cause for grave concern especially that of rural population. Among all the major Indian states, Uttar Pradesh has very low health status. It has one of the highest maternal mortality ratios in the country and one of the highest infant mortality rates. Whereas, insufficient health care staff, inadequate basic laboratory and emergency services and improper referral services leads to poor quality of health care services in UP. The present study seeks to use an inclusive study of secondary data to investigate the quality of primary health care in UP and ascertain important barriers that impede quality service achievement. The data provided by the Ministry of Health and Family Welfare (MoHFW) will be taken into account for the key analysis of the Infrastructure and manpower as constituents that play a major role. And the concluding part will provide with the analysis of the data and suggest improvement of the existing situation of the inferior health outcomes, a developed infrastructure with a proper and adequate facilities and manpower is necessary to improve the condition.

Keywords: Infrastructure, Manpower, Health Care Services, Uttar Pradesh, Development.

INTRODUCTION

‘Health... is a fundamental human right and the attainment of the highest possible level of health is most important worldwide social goal.’ -Alma Ata Declaration, 1978.

The Alma Ata United National conference's mission statement, health for all by 2000, has come and gone, but we continue to suffer from poor health status and weak public healthcare system. Indian public health owes its framework to the Bhore committee's (Headed by Joseph Bhore in

1943) lofty recommendations made in the pre-independence years. The committee suggested an elaborate hospital and health centre network and free care for all.

India has adopted a number of policies to tackle the problems of health despite of that the health status of Indian is still a cause for grave concern especially that of rural population. India has registered significant progress in improving life expectancy at birth, reducing Malaria, as well as reducing infant and maternal mortality over the last few decades. In spite of the progress made, a high proportion of the population, especially in rural areas, continues to suffer and die from preventable diseases, pregnancy and child birth related complications as well as malnutrition. In addition to old unresolved problems, the health system in the country is facing emerging threats and challenges.

As per the population census 2011, Uttar Pradesh with its 19.98 crores strong population having a share of 77.73% of rural population, is the most populous state in the country of 121.01 crores population. Thus, the economics of Uttar Pradesh and its development have a vital impact on the overall development of India. Despite rich potential in human capital resource Uttar Pradesh, which was once positioned to be the pace-setter for India's economic and social development now shows far less promises. However, as far as its health condition is concerned its far behind in comparison to other states of India's. The Total Fertility Rate of the state is 3.5 (as compared to 2.4 for the country). The Infant Mortality Rate is 57 and Maternal Mortality Ratio is 359 at the National level it is 44 and 212 respectively, (SRS 2007-2009) which are higher than the National average. The Sex Ratio in the State is 908 (as compared to 940 for the country). Among all the major Indian states, Uttar Pradesh has very low health status. It has one of the highest maternal mortality ratios in the country and one of the highest infant mortality rates.

STATEMENT OF THE PROBLEM

The UP government is facing the variety of challenges in delivering health care especially to rural areas. The roots of rural primary health care service delivery problems can be attributed directly to the conditions which commonly prevail within the rural areas. These conditions work as a risk factor in various health related problems. In this situation of susceptibility, people need good quality of primary health care services with better preventive and primitive measures. Whereas, insufficient health care staff, inadequate basic laboratory and emergency services and improper referral services leads to poor quality of health care services in UP.

The Indian government in recent years has taken robust steps to promote universal health care through National Rural Health Mission (NRHM) Phase-1 (2005-2012) and Phase-2 (2012-2017) to carry out statutory architectural correction in the primary health care delivery system. The goal of this mission is to improve the availability of and access to quality health care for the

people of rural areas. The mission introduced a health care called Accredited Social Health Activist (ASHA) to bridge the gap between people and health centres to enhance the utilisation of health care services.

REVIEW OF LITERATURE

Studies in the early 1990s (Shi 1992, 1994) showed that those U.S. states with higher ratios of primary care physicians to population had better health outcomes, including lower rates of all causes of mortality: mortality from heart disease, cancer, or stroke; infant mortality; low birth weight; and poor self-reported health, even after controlling for sociodemographic measures (percentages of elderly, urban, and minority; education; income; unemployment; pollution) and lifestyle factors (seatbelt use, obesity, and smoking).

In a vast country like India, efficient implementation of policies depends on the infrastructure created over the years. One of the important approaches or components to achieve Universal health care to rural population is through infrastructure. The ultimate objective of a health-care delivery system is to ensure that the rich and poor are treated equally, poverty does not become disability and wealth is not an advantage towards accessibility of health care. Thus, apart from increased budget the involvement of people in the form of Village Health and Sanitation Committees, District Health Societies, Rogi Kalyan Samities, etc. the emphasis is on enhancement of basic health infrastructure with satisfactory supply of human resource, material, drugs, equipment's, transport system, etc. (2016, Qadri and Khan). One of the core strategies for providing accessible healthcare to the population is to strengthen the sub-centres (SCs), primary health centres (PHCs) and community health centres (CHCs) – units where healthcare is actually delivered. (2011, Zakir Husain).

OBJECTIVES AND DATABASE

The present study seeks to use an inclusive study of secondary data to investigate the quality of primary health care in UP and ascertain important barriers that impede quality service achievement. Objectives are fulfilled with help of data which has been collected from secondary sources, viz. research paper, reports and government of India website (MOHFW).

STRATEGIC CONSTITUENTS

1. Infrastructure:

NUMBER OF SUB-CENTRES, PHCs & CHCs DURING FIVE YEAR PLAN							
Uttar Pradesh	Sixth Plan	Seventh Plan	Eight Plan	Ninth Plan	Tenth Plan	Eleventh Plan	Twelfth Plan (As on 31 st March, 2016)
	1981-85	1985-90	1992-97	1997-2002	2002-2007	2007-2012	2012-2017
Sub Centres	15653	20153	20153	20153	20521	20521	20521
PHCs	1169	3000	3761	3808	3660	3692	3497
CHCs	74	177	262	310	386	515	773

There is a reduction in the number of Centres functioning at the end of 10th Plan as compared to those functioning at the end of Ninth Plan due to the division of State.

Source: Bulletin on Rural Health Statistics in India 2016, MOHFW/GOI.

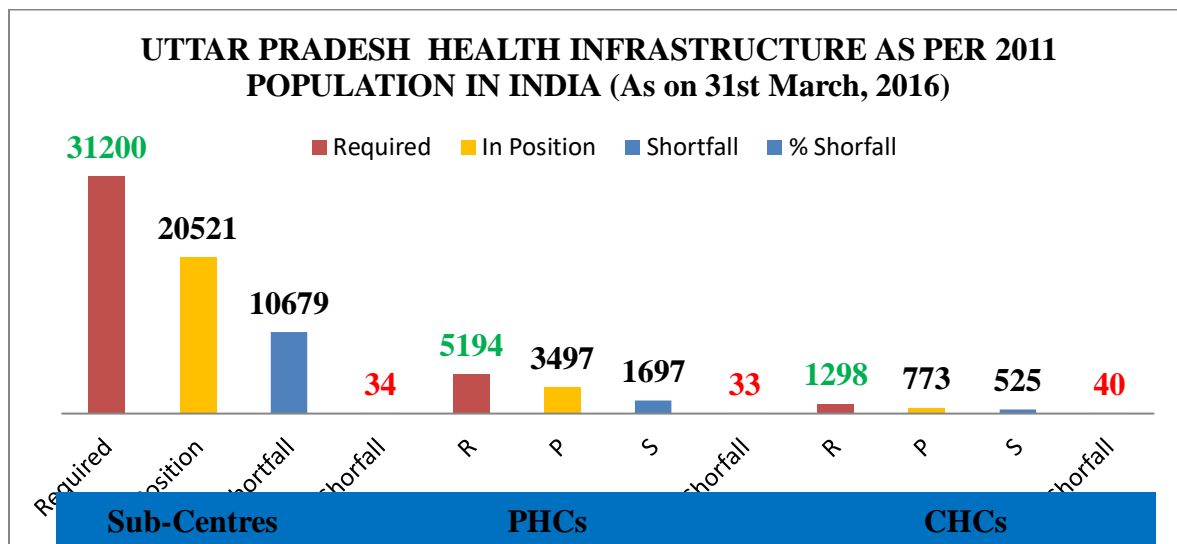
The change in the development of the infrastructure in the Sub-centres realised a change of 31% from 6th FYP to 12th FYP. And the PHCs realised a change of ... from 6th FYP to 12th FYP. Also the CHCs realised a change of ... from 6th FYP to 12th FYP.

SHORTFALL IN HEALTH INFRASTRUCTURE AS PER 2011 POPULATION IN INDIA (As on 31st March, 2016)														
States	Total Population in Rural Areas	Tribal Population in Rural Areas	Sub Centres				PHCs				CHCs			
			R	P	S	% Shortfall	R	P	S	% Shortfall	R	P	S	% Shortfall
Bihar	92341436	1270851	18637	9729	8908	48	3099	1802	1297	42	774	148	626	81
Chhattisgarh	19607961	7231082	4885	5186	*	*	774	790	*	*	193	155	38	20
Jharkhand	25055073	7868150	6060	3953	2107	35	966	327	639	66	241	188	53	22
Madhya Pradesh	52557404	14276874	12415	9192	3223	26	1989	1171	818	41	497	334	163	33
Odisha	34970562	8994967	8193	6688	1505	18	1315	1305	10	1	328	377	*	*
Rajasthan	51500352	8693123	11459	14408	*	*	1861	2080	*	*	465	571	*	*
Uttarakhand	7036954	264819	1442	1847	*	*	238	257	*	*	59	59	0	0
Uttar Pradesh	155317278	1031076	31200	20521	10679	34	5194	3497	1697	33	1298	773	525	40
All India/ Total	833748852	93819162	179240	155069	35110	20	29337	25354	6572	22	7322	5510	2220	30

Notes: The requirement is calculated using the prescribed norms on the basis of rural population from Census, 2011. All India shortfall is derived by adding state-wise figures of shortfall ignoring the existing surplus in some of the states.

R: Required; P: In Position; S: Shortfall; *: Surplus
 Source: Bulletin on Rural Health Statistics in India 2016, MOHFW/GOI.

The data taken here is of the EAG (Empowered Action Group) states and only these are taken into consideration for the study. This study find out that the health infrastructure and the health care in UP has continuously been short of these infrastructural needs. Which we have illustrated in the above figure. And this remains a major hindrance in the development and providence of the health care services. The data indicates that the state of Rajasthan is in best of the condition as in all the three types of centres, it is running in surplus. Although, the rough and worsening condition is of Bihar and Uttar Pradesh.



The required subcentres were 31200 whereas the in position it is 20521, this makes a shortfall of 10679 which makes up 34 per cent of shortfall. The case for the PHCs is that the required centres are 5194 but the in position data indicates 3497 centres making it a shortfall of 1697 which in percent makes a 33 per cent shortfall. The position of CHCs is that the required centres are 1298, whereas the in position centres are only 773, shortfall is of 525 and we can say that in percentage as 40 per cent shortfall.

The data provided by Ministry of Family and Health Welfare, Government of India indicates that in total number of Sub-centres, the government buildings are 17219, rented buildings are 3302, building required for SCs are 1270, and 2032 are under construction. PHCs required buildings are 65 whereas CHCs are running in surplus.

2. MANPOWER:

Uttar Pradesh	Required	Sanctioned	In Position	Vacant	Shortfall
	[R1]	[S]	[P]	[S-P]	[R1-P]
Health worker (Female)/ ANM at Sub Centres	20521	23695	23695	0	*
Health worker (Female)/ ANM at Sub Centres and PHCs	24018	27449	27161	288	*
Health Worker (Male) at Sub Centres	20521	9080	3152	5928	17369
Health Assistants (Female)/ LHV at PHCs	909	143	121	22	788
Health Assistants (Male)/ LHV at PHCs	3497	5757	954	4803	2543
Doctors at Primary Health Centres	3497	4509	2209	2300	1288
Total Specialists Surgeons, OB & GY, Physicians and Paediatricians	3092	2099	484	1615	2608
Laboratory Technicians at PHCs and CHCs	4270	1331	963	368	3307
Nursing Staff at PHCs and CHCs	8908	4497	4412	85	4496

Source: *Bulletin on Rural Health Statistics in India 2015, MOHFW/GOI.*

In the primary health care delivery system the grass root level health workers ANM (Auxiliary Nurse Midwife), LHV (Lady Health Visitor), and AWW (AnganWadi Workers) play an important role to provide the basic health services to the rural population of India. Infact they are the key drivers for providing the basic health facilities. But the data shows that at the SCs health workers females are in surplus whereas male workers are fall short of 17369. At the PHCs health assistants male as well as female fall short of 2543 and 788 respectively. Doctors who are responsible for the health care also fall short of 1288. Although, the required numbers are 3497, but in position are 2209. Till 31st March 2016, vacant posts for Doctors were 2300. Total specialists (Surgeons, OB & GY, Physicians and Paediatricians) shortfall is of 2608 and the post still vacant are 1615. Laboratory Technicians and Nursing Staff at PHCs and CHCs were very low, indicated by 3307 and 4496 respectively.

In UP, due to poor quality in Health care services the public hospital users are less satisfied than those in the private hospital users as they get quality treatment. Therefore, improvement in quality of primary health care services are needed to improve the current health status. Improvement in quality fills the gap between actual and achievable practice and leads to better health outcomes. (2015, Kumar, Virendre and Mishra).

Uttar Pradesh carries a large burden of India's morbidity along with the problem of high MMR and IMR. A study conducted by Gupta et al, shows that 68 per cent mothers die due to pregnancy related causes.(2006, Gupta et al.). And this is due to the poor level of infrastructure that is being provided. The situation prevailing in the state exposes the poor condition of health services provided by the UP government. In UP, the present condition is very unsatisfactory, due to the poor quality of health care services. And UP is suffering the problem of worst health outcome even among the EAG states.

CONCLUSION

Due to this shortfall the present working staff bears the burden of the shortfall and which increases the amount of work on the present staff.

The basic aim is to improve the health standard of the people and lower the disease and illness among the masses. But due to the workload they fail to achieve the required service. And due to which we do not provide the required outcome which we are expected to.

For the improvement of the existing situation of the inferior health outcomes, a developed infrastructure with a proper and adequate facilities and manpower is necessary to improve the condition. Many studies point out that due to the high workload on health care workers their approach towards work was unsatisfactory. Similarly, poor management of health care services is also a contributing factor in delivering low quality health care services in UP. There is a need of a regular monitoring and supervision to enhance the quality of primary health care services. Along with quality health care services, health services should be more pro poor, client friendly and respond to the preventable diseases timely.

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