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HEALTH PROFILE OF KARNATAKA: ON OVER VIEW

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INTRODUCTION

According to the Karnataka Human Development Report, 2005, "the health scenario of Karnataka today is a combination of achievements and challenges". While Karnataka has achieved consistent improvement in the life expectancy at birth since 1971 (from 50.6 years in 1971 to 66.1 in 2001) and key health indicators like IMR and MMR are lower in the state than the national averages, the state lags behind the other south Indian states. Further, persistent regional imbalance in health indicators has been a troubling reminder of the inequities in access and provision of health care services within the state. However, Karnataka is one of the forerunners in the country in bringing reforms in the health sector. Furthermore, Karnataka's health sector is endowed by multiple initiatives like KHSDRP, UNICEF's Projects, 12th Finance Commission grants and other schemes which provide the financial resources for implementing public health related activities in the state. The Karnataka State Integrated Health Policy 2004 states that the mission of the Karnataka

Government's Department of Health and Family Welfare is to provide quality health care which is equitable, locally responsive, participatory, accountable and transparent.

National Rural Health Mission was first implemented in Karnataka in 2005 (although the full fledged activities began in full swing in 2007-08), along with the other states and union territories. In Karnataka, the implementation plan for NRHM has been developed by integrating different strategies suggested by the state health policy as well as core strategies of NRHM. The district health action plans from all the districts of the state are integrated to form the state Program Implementation Plan (PIP) with a focus on the backward districts and high focused districts. The program implementation plan mainly gives an overview of the present health status, situational analysis of the infrastructural facilities of the state and the plan of implementation for the current year. It highlights the strategies and activities to be undertaken by different components of the program in detail so as to meet the goals and objectives of the program. As evident in the next sections, the mission has been able to improve the health status

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of the state in terms of the health indicators such as decreased MMR, IMR, increased number of institutional deliveries etc.

Important Health Indicators of Karnataka

Table 1 presents the comparison of important health indicators at the national and state levels. While Karnataka has made progress in the these three health critical indicators, other than TFR, Karnataka still lags behind other southern states in the status of IMR and MMR (as discussed in pp 24) and more importantly, large gaps exist between the target and current status of IMR and MMR.

Table 3.2: Important RCH Indicators - NRHM targets and status

Health Indicators	Target (under NRHM	India		Karnataka	
		2005	2001	2005	2011
IMR	30	58	47*	50	38*
MMR	100	254	212**	213	178**
TFR	2.1	2.9	2.6**	2.1	2.08**

*Sources: NRHM Mission Document, 2005, SRS Bulletins, *SRS 2011, ** SRS 2008*

Karnataka's Health Expenditure & Infrastructure

The state's own finances form a major component of public health expenditures in Karnataka. NRHM's share in the overall health expenditure of the state ranges between 22 percentage to 25 percentage. Table 2, presents the comparative picture of the status of infrastructure and key grassroots personnel in India and Karnataka for the years 2005 and 2011. It helps analyze the trend in rural health infrastructure and human resources through the period of implementation of NRHM. The figures reported by the state on its HR status (specifically ANMs and Staff Nurses) show excess staffing of ANMs and staff nurses. However, if Indian Public Health Standards (IPHS) based staffing recommendations are considered (as prescribed in the core strategies of NRHM, pp 11), there is a shortage of ANMs and staff nurses (3 staff nurses for 24X7 PHCs as suggested by IPHS), that is not reported in the requirement of human resources. Further, while improvement of infrastructure has been impressive, improvements in staffing has been marginal.

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Table 3.3: Comparison of health infrastructure and human resources

Infrastructure and Human Resources	India				Karnataka			
	2005		2011		2005		2011	
	Required	In position	Required	In position	Required	In position	Required	In position
Sub-Centres		146026		148124		8143		8870
PHCs		23236		23887		1681		2310
CHCs		3346		4809		254		180*
ANMs	169262	133194	172011	207868	9824	8544	11180	11433
Doctors at PHCs	23236	20308	23887	26329	1681	2041	2310	2089
Staff Nurses at PHCs and CHCs	46658	28930	57550	65344	3459	3100	3570	4722

Source: Rural Health Statistics – Comparative Statements, 2011

**The number of CHCs has been reduced due to upgradation of CHCs to Taluk Hospitals in all taluk headquarters.*

The Karnataka State Integrated Health Policy, 2004

The Karnataka state health policy (Government of Karnataka 2004) followed the formulation of the national health policy. It attempts to meet the expectations of the National Health Policy as well as reform the health sector in the state by recognizing the changes in the policy environment and the unique state specific requirements in the health. The Karnataka State Health Policy was based on the specific needs of the state and was an attempt to recognize and reconcile the large regional disparities that exist in the state's health sector. Further, it was the first of its kind in the state and drew a majority of its recommendations based on the report by the Task Force on Health and Family Welfare submitted to the state government in 2001.

The policy reviews the gains made in health indicators and improvement in infrastructure made over the past decades. It also focuses in detail on the existence of "health gaps" within the sector in the state. These gaps exist between rural and urban sectors (IMR: 70 in rural, 25 in urban areas based on SRS 2008), between different regions of the state (highlighting the districts in Hyderabad Karnataka and Belgaum division, for example, as shown in Table 3), between different communities and between genders. It mentions the "relatively low level of public confidence in public sector health services, particularly at Primary Health Centres" that affects the various health programmes implemented by the state.

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Table 3.4: Selected district-wise Health Indicators in Karnataka

District	Safe delivery	Complete immunization (%)	Composite health index (%)
Well Performing Districts			
Hassan	69.7	92.8	81.55
Shimoga	83	92.9	80.37
Kodagu	79.4	94.8	80.06
D Kannada	91.5	86	78.77
U Kannada	86.1	89.9	76.11
Udupi	91.5	86	75.97
Average Performing Districts			
Mandya	61.9	88	75.86
Mysore	69.7	92.7	75.7
Bangalore Rural	79.1	83.7	75.34
Bangalore Urban	90.6	77	75.19
Chitradurga	53.8	88.4	73.98
Tumkur	63.5	88	73.97
Dharwad	65.3	74.8	73.03
Chamarajanagar	69.7	92.7	72.18
Chikmagalur	78	83.5	72.13
Kolar	59.2	90.6	71.92
Gadag	65.3	74.8	69.72
Belgaum	68.6	64.8	68.75
Haveri	65.3	74.8	65.66
Poor Performing Districts			
Bellary	54	52.6	65.54
Davanagere	53.8	88.4	65.43
Bijapur	50.1	53.2	62.86
Bidar	52.5	50.3	60.55
Raichur	48	37.2	58.34
Gulbarga	47	25.3	58.31
Bagalkot	50.1	53.2	54.71
Koppal	48	37.2	53.09

Source: Karnataka State Integrated Health Policy, 2004.

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**Indicators devised by the National Commission on Population, 2001*

The task force recognised 12 important action items, which included creation of public health cadre, integrated approach towards health care, involvement of community and PRIs, rigorous planning and monitoring mechanisms and focussing on minimizing disparities in health outcomes and access to health infrastructure

Recognizing these issues, the policy indicates the prioritization of primary health care and addressing community health needs as the major approaches towards attaining better health indicators in the state. For this, it suggests *a synergistic approach through inter-sectoral coordination and involvement of PRIs*. In this regard, the policy agrees to provide equitable proportions of funding to primary, secondary and tertiary health care (55 percentages, 35 percentage, and 10 percentage, respectively).

Other important forward looking aspects of the policy are: the *establishment of planning and monitoring unit* for organized health planning and tracking of established process and outcome indicators, *creation of two cadres within the department, namely medical care and public health cadres* and centralized and specialized sections within the department for drug procurement, engineering, construction and infrastructure maintenance.

The strategies adopted by the state health policy reflect on the challenges faced by the department of health and family welfare. Together with high gaps in health indicators across different geographical locations and communities and the reduced share of public finances on health expenditure, the health policy dedicates considerable thinking on reforming the existing administrative setup of the health department. The working of the department prior to recognizing these needs was essentially similar to that of any other line department of the government, with centralized planning and expenditure, compartmentalized activities, vertically alligned, disease specific interventions, less devolution of funds and little community participation and hence the lack of sufficient focus on primary health. These and similar challenges are documented in the report of the Task Force on Health and Family Welfare (2001).

CONCLUSION

The State Health Policy provides a conceptual framework for future health related policy reforms in Karnataka, as well as documenting the reasons why wide-spread governance reforms are needed within the health sector. It covers the major aspects of the agenda items recommended by the state's task force on health and family welfare. It is a broad but comprehensive statement of Karnataka's intentions and objectives with respect of health. Two important aspects of the policy that stand out are: *the recognition and understanding of existing disparities in the health sector*

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(from human resources, infrastructure, process indicators to health outcome indicators) and the emphasis given to planning, standardization of health indicators and monitoring of health related issues.

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