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Full Length Research Paper

Limitations to health structure and health expenditure patterns in Anantnag district

Dhyan Swami Kapoor* and Chandra Khan Ray

Department of Sociology and Social Work, Aligarh Muslim University Aligarh (U.P) – 202002, India.

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Health is one of the most important endowments of life to which man has a birth right. According to World Health Organization, health is a state of complete physical, mental and social wellbeing and not merely an absence of disease or infirmity. The main responsibility of providing health care facilities to the citizen lies with the governments in welfare societies. India is a federal structure and has government both at the union level and at the state level. Jammu and Kashmir is one state of India enjoying special status in many respects. The main objective of this research paper is to understand the health structure and health expenditure patters in Anantnag district of Jammu and Kashmir. The specific objectives are: (a) to study the health infrastructure and its shortcomings; (b) to examine the health programmes; and, (c) to analyse the health expenditure patterns at the government level. Further, a comparative study of health indicators has also been carried out in this paper. This paper uses analytical method and is based on secondary sources of data such as government reports, research papers, census, surveys, and online sources. The paper finds that there is shortage of health care facilities in Anantnag district and different patterns are observable at the block level. The public investment is very low and unable to meet the health needs of people. Many of the health care centers are getting dysfunctional. Many health programmes are not giving desired results. The paper concludes by suggesting few health sector reform measures.

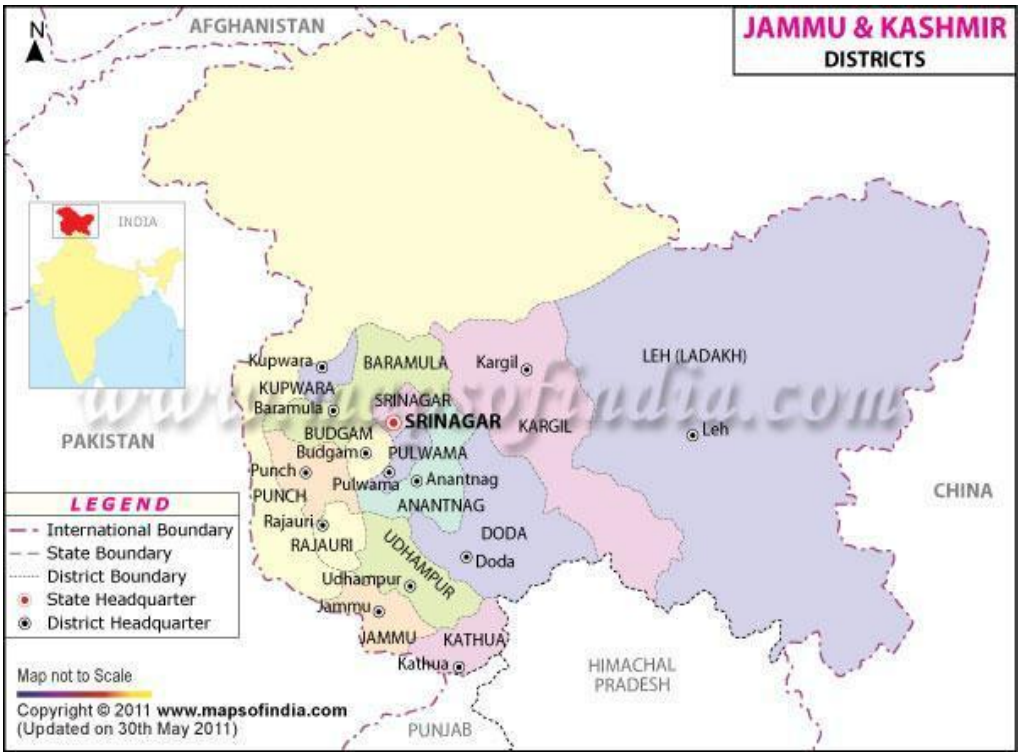
Key words: Health infrastructure, health expenditure, health indicators, health programmes.

INTRODUCTION

Health is one of the most important endowments of human life often explained as his birth right (Advani and Akram, 2007). Health is also a significant constituent of human capability that we have reason to value (Sen, 2006). Health has been regarded as a special good throughout the ages because: (i) it is a direct constituent of human well being, and (ii) it is a pre-requisite of a person‟s functioning as an agent in the society (Sudhir, 2006). Health is an integral part of development planning and finds central position in the concept of quality of life (Park, 2009). Health finds predominant place in three of the eight goals, eight of the sixteen targets and eighteen of the forty-eight indicators of the “Millennium Development Goals of the UN” (Government of Jammu and Kashmir, 2008-2009).

The health sector in India is characterized by a government/public sector that provides publicly financed and managed curative and preventive health services from primary to tertiary level throughout the country and a fee-levying private sector that plays a dominant role in the provision of individual curative care (Advani and Akram, 2007). The provision of health care by the public sector is a responsibility shared by state, central and local governments, although it is effectively a state responsibility in terms of service delivery. State and local governments incur about three-quarters and the centre about one-quarter of public spending on health. Goals and strategies for the public sector in health care are established through a consultative process involving all

*Corresponding author. E-mail:dhyan.swami328@yahoo.co.in



Map 1. Map of Jammu and Kashmir.

levels of government through the Central Council for Health and Family Welfare. The organization of public sector at the national level consists of the Union Ministry of Health and Family Welfare. The organization at State level is under the State Department of Health and Family Welfare in each state headed by a Minister. The district level structure of health services is a middle level management organisation and it is a link between the state on one side and the grass root level structures such as Primary Healthcare Centers (PHCs) as well as sub-centres (SCs) on the other side. Further, one Community Health Centre (CHC) is established for every 80,000 to 120,000 population, and this center provides the basic specialty services in general medicine, paediatrics, surgery, obstetrics and gynaecology. There is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Each PHC has one medical officer, two health assistants – one male and one female, and the health workers and supporting staff. The most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker.

STUDY AREA

For the present paper, Anantnag District in Jammu and Kashmir (J&K) is chosen as the unit of the study. Presently, there are 22 districts in the Jammu and Kashmir state. In Kashmir province, Anantnag is one of the most populated districts after Srinagar and is situated in its south and south western direction at the distance of 52 km from Srinagar. Anantnag district has eight blocks namely Bijbihera, Shangus, Mattan, Larnoo, Sallar, Achabal, Verinag, and Quazigund. Anantnag District has 129 sub-centers (SCs), 47 primary health centers (PHCs), 6 community health centers (CHCs) and one district hospital. Anantnag district is spread over an area of 2,092 km^2, with a population of 1,070,144; population density is 323 persons / km^2 (Government of Jammu and Kashmir, 2008-2009; NRHM, 2007) (Maps 1 and 2).

OBJECTIVES

The objectives of the present paper are: (a) to explain the health infrastructure, equipments, medical personal and medicines in Sub-Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) highlighting their short-comings; (b) to highlight the governmental programmes laid down for reducing the morbidity, infant mortality and maternal mortality in Anantnag District; (c) to highlight the health indicators; and, (d) to trace the health expenditure pattern in Anantnag District of Jammu and Kashmir.

METHODOLOGY

This paper is mainly based on secondary data in general and review of literature in particular. No primary data has

INDEX	DISTRICT HOSPITAL	☑	CHC/SDH	■
	PHC	+	SUB-CENTRE	∇

Map 2. Medical map of Anantnag District.

been collected as collection of primary data is beyond the purview of the work. For collection of secondary data, available literature in the form of books, reports such as National Rural Health Mission (NRHM) and Integrated Child Development Scheme (ICDS), surveys like National Sample Survey Origination (NSSO), government released information (Census, 2011) along with published articles and research papers have been contacted. The work is mainly analytical and tries to provide specific knowledge about the problem. No hypothesis has been developed as this again is beyond the purview of the work.

PERSPECTIVES, RESULTS AND DISCUSSION

Perspectives on Health

The World Development Report, 1993 argues that good health is an important part of well-being. Good health is not only a fundamental development goal in its own right, but also an essential means of promoting social-economic development and poverty reduction (Committee on Health and Development, 2003). According to World Health Organization (WHO) in 1976, "health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity". This definition emphasizes the fact that health is not merely the absence of negative traits such as illness or injury, but requires the presence of positive traits such as feelings of well-being, traits which are social and psychological as well as physical (Cockerham and Ritchey, 1997).

In recent times, the word "health" is seen from a holistic approach: Payne, Hahn, and Mauer describe health in terms of six interacting and dynamic dimensions - physical, emotional, social, intellectual, spiritual, and occupational (McKenzie et al., 2005). The functional perspective on health defines health as the ability to participate in the normal social roles (Nettleton, 1995). Different from the functionalist approach, conflict theory emphasizes on the social, economic and political forces that affect health and the health care delivery system of people in a society (Kendall, 2011). The sociologists looking at health from the conflict approach are concerned with the relation between health, illness and social organization within a society and how their meanings and definitions are influenced by the economic activity (Darulius and Kaminskas , 2007). Symbolic

Table 1. Number of health institutions by category in Jammu and Kashmir.

S/N	Category	2001-2002	2004-2005	2007-2008 (p)
1	District/ Sub-district/private hospitals	111	117	113
2	Primary health centers	361	394	380
3	Primary health sub-centers.	N.A	N.A	N.A
4	Allopathic dispensaries	258	253	243
5	Ayurvedic/Unani dispensaries.	433	437	423
6	Mobile-Medical centers	14	13	13
7	Medical aid centers	324	441	325
8	S.T.D/V.D clinics	09	08	08
9	T.B centres	11	10	10
10	F.P centers	119	119	52
11	F.P Sub-centers	1909	1809	1857
12	Leprosy sub-centers	37	28	33
13	Leprosy control units	19	25	19
14	Trachoma Units/Amichi centers/others	87	152	127
Total		3704	3806	3603

Source: Government of Jammu and Kashmir (2007-2008).

interactionists regard health and illness as social construction (Kendall, 2011). The biomedical model on health which has its basis in “germ theory of disease,” regards health as an “absence of disease”.

Health is a state subject in Indian Constitution, though the Centre plays an important role as a regulator, advisor and resource provider. The government is obligated to provide health care to every citizen of India without any discrimination on the basis of creed, colour, race, sex and the place of residence. WHO regarded health as a fundamental human right (http://www.definitionofwellness.com/dictionary/health.html). This means that government must generate conditions in which everyone can be as healthy as possible. Such conditions range from ensuring availability of health services, healthy and safe working conditions, adequate housing and nutritious food (The Right to Health, 2007). Thus taking into consideration the importance of health, it becomes one of the primary responsibilities of the state to provide health care services to all its citizens. India, despite being a signatory to the Alma Ata Declaration of 1978, which promised „Health for All" by 2000, is far from realizing this objective (Sarojini et al., 2006).

Health infrastructure in Anantnag District

Infrastructure refers to the basic support system in the form of ownership and physical conditions of the building and the basic facilities available within the building for the smooth functioning of the healthcare establishments. Some of the facilities included are supply of water, electricity, separate toilet with running water, furniture, number of beds for indoor patients, standby facility in the form of the generator, operation theatre, labor room, laboratory facility for testing blood urine, telephone, functional vehicle, investigative facility (ECG, X-ray, USG and Cardiac monitor, etc) (Facility Report, 2007).

The overall health scenario of the Jammu and Kashmir State is crying for proper planning and management in the health sector. The number of health institutions of the state is substantially decreasing year by year (Table 1). The decreasing number of health institutions is evident from the numbers of district/sub-district and other healthcare institutions. The total decrease in number of institutions from 2004-2005 to 2007-2008 is 203 institutions. From Table 1, it is clear that with moving years and increasing population, the number of health care institutions is decreasing. This decrease in number of health care institutions has increased the patient load upon the already loaded government healthcare institutions in the state and indicates the inadequate health infrastructure for the people of the state (Government of Jammu and Kashmir, 2007-2008).

Recently, the facility survey report of the state, conducted by the Ministry of Health and Family Welfare (MOHFW) clearly highlights the inadequacies of the public health infrastructure especially in rural areas of Anantnag district. This survey is the major reflection of the underdevelopment of the public healthcare system: even the district hospitals which are otherwise well capable have a major problem with adequacy of critical supplies needed to run the hospital. The rural health facilities across the board are ill provided.

The health infrastructure of Anantnag district consists of 6 district/sub-district/private hospitals, 14 Allopathic and primary dispensaries, 30 *Unani*, 8 *Ayurvedia* dispensaries, 47 primary health centers, 11 medical aid

Table 2. Number of medical personnel in health department.

S/N	Category	2001-2002	2005-2006	2007-2008 (p)
1	Doctors	4532	5239	5294
2	Nurses	2571	2804	2804
3	Compounders	2892	2976	2876
4	Vaids/Hakims	242	267	264
5	Dawasaazs	386	389	479
6	Sanitary inspectors	166	153	159
7	Health inspectors	219	249	225
8	Basic health workers	635	650	612
9	Lady health visitors	219	228	218
10	Auxiliary nurses/dias	2999	3134	3036
11	Health educators	319	345	311
12	Others	10051	11020	11007
Total		25231	27454	27286

Source: Government of Jammu and Kashmir (2007-2008).

and T.B/mobile units, 113 family planning centers and sub centers, 6 leprosy sub centers and leprosy control units (Government of Jammu and Kashmir, 2007-2008). According to the Facility Report of 2007, out of 129 sub-centers (SCs) in Anantnag district, 93% (120/129) sub-centres (SCs) and 49% Primary Health Centres (PHCs) are run in rented buildings. As much as the sub-centre buildings are concerned, 86% are in poor condition. Out of the total SCs and PHCs, only 6% SCs and 47% PHCs are getting water supply through tap, bore well, hand pump, tube well and well. Ninety nine percent SCs and 36% PHCs are functioning without electricity facility and laboratories are available only in 38% PHCs. The availability of labor room to achieve National Rural Health Mission"s (NRHM) goal of maximum institutional delivery is an important requirement for SCs and PHCs. Unfortunately, most of the SCs are without this facility and only 21% PHCs have this critical facility. To attend emergency cases, it is necessary to have staff quarters in the campus. Neither SCs nor CHCs have quarters. Only 23% PHCs are having this residential facility for the staff. Moreover not a single CHC has a blood storage unit and only 67% X-ray and Ultra sound gadgets are available at CHCs of Anantnag district (Facility Report, 2007).

Medical equipments in Anantnag District

Out of 56 recommended items/equipments for sub-centres (SCs), the average of only 95% equipments were available at the centers. At the CHCs, the availability of standard surgical equipments (set-2nd) is only 38%, standard surgical set-3rd is19%, set-4th is 19%, set-5th is 5% and set-6th is 20%, normal delivery set is 32%, equipment for an aesthetic is 11%, equipment for neo-natal recovery is 12%, kit for blood transfusion is 21% and the rest of the equipments is 4-9% (Facility Report, 2007). As a result of this inadequacy at public health facilities, it has been estimated earlier that only 20% of the population seeks out-patient services and less than 45% seek indoor-patient treatment from public hospitals. A large portion of population seeks medical care services from private sector, despite the fact that most of these patients do not have the means to make out-of-pocket payments for private health services.

Medical personnel in Anantnag District

The recent state of availability of medical personnel in health department of Jammu and Kashmir is reflected in Table 2. From Table 2, it can be said that on the one hand the number of doctors has increased from 4532 (2001-2002) to 5294 (2007-2008), nurses from 2571 (2001-2002) to 2804 (2007-2008), *dawasazs* from 386 (2001-2002) to 479 (2007-2008), auxiliary nurses/*dias*/midwives increased from 2999 (2001-2002) to 3037 (2007-2008). Health inspectors also increased in number from 219 (2001-2002) to 225 (2007-2008). On the other hand, during the same period, there is a decrease in the number of compounders from 2892 (2001-2002) to 2876 (2007-2008), basic health workers from 635 (2001-2002) to 612 (2007-2008), lady health visitors from 219 to 218 (2001-2008), and the number of health educators decreases from 319 (2001-2002) to 311 (2007-2008). The total number of medical personnel decreased from 27454 in 2004-2005 to 27286 in 2007-2008. The findings suggest how the manpower availability of the state as well as districts is going from bad to worse (Government of Jammu and Kashmir, 2007-2008).

Despite the increasing number of doctors, nurses, *dawasazs* (those who provide medicines for treatment) and health inspectors, the shortage of medical personnel

Table 3. Bed strength in Anantnag district.

Government /Private health institutions in District Anantnag	218*
Average population covered per institution in the district	57563
Bed strength in a district	375
Bed strength per thousand population in a district	1 bed for 2853 persons

Source: NRHM (2007) and Government of Jammu and Kashmir (2007-2008).

and manpower of districts in the state has not been met. It can be observed from the data of Anantnag district that 111 posts of nurses, 27 posts of medical officers (MO), 4 posts of pediatricians, 5 posts of obstetricians/gynecologists and 148 posts of auxiliary nurse midwife (ANM) are vacant (NRHM, 2007). The total requirement of staff at 47 PHCs in Anantnag district is 841 where only 402 staff are in position: it reflects the shortage of more than 52% staff (Facility Report, 2007). All these vacancies in SCs, PHCs and CHCs make these healthcare institutions/centers virtually non-functional. The medical personnel and health institutions are playing the important role in preventing community members from becoming sick or ill. Their role is necessary for keeping individuals in a healthy state so that they can play their normal social roles in society and can contribute to the well functioning of the society. Since sick persons are unable to play their assigned roles in society (Kendall, 2011; Henry, 2011; Coe, 1971), there is an urgent need to recruit professionals or to fulfil these vacancies as soon as possible. It will help in making the sick individuals healthy by providing good healthcare services to them. Besides the shortage in manpower and in equipments, there is also shortage in supplies of medicines, that is, the supply of kit-A for SCs was found unsatisfactory (0%), Kit-B (1%) and availability of contraceptives was only 2%. About 21% medicines were reported available out of the total medicines recommended for PHCs. Availability of antifilarials (6%), dermatological medicine (9%), vitamins and minerals (11%), antidotes (22%), anti-infective medicine (10%), anti-bacterial (8%), and only 23% of essential drugs are noticed in CHCs (Facility Report, 2007).

Bed strength in Anantnag District

India has only 0.7 beds per thousand population as against the world average of 2.6 and has only about 100 beds per 100,000 population against the World Health Organization (WHO) norms of 300 beds per 100,000 (Ramain and Dileep, 2005). The total bed strength in government hospitals and other health institutions in Jammu and Kashmir are 13744 (Government of Jammu and Kashmir, 2008-2009) and the total bed strength in the government health institutions of Anantnag district is only 375. Out of 375 beds, 20 beds are in Achabal block, 40 in Mattan block, 40 in Saller, 20 in Quazigund, 33 in Larnoo and Bijbehra block has the highest bed strength of 50 as compared to the other blocks of the district and the lowest bed strength is in Shangus and Verinag blocks (17 each) (NRHM, 2007). From the data, it can be said that urban areas (towns) of Anantnag district have better number of beds (including private beds) at a ratio of one bed per three hundred persons but the rural areas (villages) have eight times lesser hospital beds as per required norms (one bed per five hundred persons). So there is a discrimination based on spatial distribution in hospital infrastructure in the Anantnag district depriving the rural population"s access to curative care services.

The average population covered per institution is 57,563 and the availability of hospital beds in the Anantnag is approximately 1 bed for 2,853 persons. Thus, the average load per bed is very high in Anantnag as compared to the average of the state which is 1 bed per 1063 persons (Table 3). Moreover the bed population ratio of Anantnag district is poorer when compared to Srinagar and Kopwara districts and it is estimated that to reach a modest bed to population ratio of two beds per thousand persons, there is the need of more than fifteen hundred additional hospital beds which would collectively require a huge investment over the next ten years.

The role of public hospitals in providing out-patient care services (36,103/month) is quite high than the in-patient care services (12,000) in a district. At the block level, it can be said that the average of out-patient treated per month is highest in Matton block (9,885/month) while the lowest number of out-patients treated per month is in Bijbehara block. This is due to the fact that Bijbehra block is nearest to the District hospital of Anantnag and also because of good transportation facility and easily availability of health care services and that is why people prefer to treat themselves in the district hospital of Anantnag. Similarly, the highest number of in-patients is treated in Larnoo block (639/month) and the lowest number of in-patients is treated in Shangus block (NRHM, 2007).

Comparative study of health indicators

In the WHO guidelines for health programme evaluation, health indicators are defined as variables which help to measure changes in health. In Jammu and Kashmir, the health indicators are required not merely to measure the health status of a community but also to compare the

Table 4. Health indicators – comparative analysis.

Location	Crude Birth Rate	Crude Death Rate	Infant Mortality Rate	Sex Ratio	TFR	Child Sex Ratio	Maternal Mortality /1000 (T= total, R= rural, U=urban)
All India	23.5	7.5	50	940 (2011)	2.9	927 (2001), 914 (2011)	N.A
Jammu and Kashmir	18.9	5.5	45	883 (2011)	2.4	941 (2001), 859 (2011)	T=123, R=99, U=24
Anantnag	31.60	6.1	48	N.A	2.8	930 (2007)	T=09, R=08, U=01
Srinagar	27.00	08	45	861	2.7	946 (2007)	T=04, R=04, U=0

Source: Government of Jammu and Kashmir (2007-2008) and Report of the Task Force on Development on Jammu and Kashmir (2006).

health status of district and state with that of other districts and states; for assessment of healthcare needs; for allocation of healthcare resources; and for monitoring and evaluation of health services, activities and programs. The child sex ratio (CSR) of Jammu and Kashmir is 859 in 2011. The CSR in Jammu and Kashmir has shown a sharp decline (-82 variations between CSRs of 2001 to 2011) as compared to all the states of the country (Bose, 2011).

The health indicators of Anantnag district present adverse picture (Table 4) with birth rate of 31.60, death rate of 6.1 and infant mortality rate of 48 per thousand. It is quite unfavourable when compared with Jammu and Kashmir figures of crude birth rate (18.9), crude death rate (5.5), IMR 45/1000 respectively. Further, infant mortality rate is defined as the number of children who die before reaching their first birthday in a given year, expressed per 1000 live births (OECD, 2010). The infant mortality of Anantnag district is 48 per thousand; this is more than the infant mortality of Srinagar (45/1000) and that of the state (45/1000). Crude birth rate is the ratio of the total registered live births during a year to the total population in that year multiplied by 1,000. The crude birth rate of Anantnag district is highest (31.60) as compared to Srinagar (27.00) and the state (18.9). Besides this, it can be noted from the data (Table 4) that maternal deaths in Anantnag district (9) are double when compared to Srinagar district (4). The rural areas in both districts experience more maternal deaths as compared to urban areas. This is because of availability of adequate healthcare facilities in urban areas and lack of healthcare facilities in rural areas. This shows the inequalities in the distribution of healthcare services and infrastructure between and within rural and urban areas as well as between respective districts.

EXPENDITURE PATTERN OF GOVERNMENT ON HEALTH IN ANANTNAG DISTRICT

Health expenditure is defined as the sum of expenditure on all core health care functions, that is, total health care services, medical goods dispensed to out-patients, prevention and public health services, health administration and health insurance – plus capital formation in the health care provider industry (OECD, 2010).

One of the more obvious indicators of the inadequacy of public health in India is the very small amount of health spending relative to GDP. In developed countries, government health spending is around 5% of GDP or more (Norway - 6.9% of GDP, USA - 6.2% of GDP, etc). Even in Asian developed countries excluding India, the average health spending is around 3% of GDP (Government of Health Expenditure in India: A Benchmark Study, 2006). India, which is currently seen as an economic powerhouse and one of the success stories of global economic growth in the past decade, has government health expenditure amounting to less than 1% of GDP (Mukhta, 2011-2012). Further, this ratio is not only low internationally but is even lower as compared to our own past experience. This low spending on health and the dominance of private sources of financing make India unique (Sodani, 2007). Thus proportion of public spending on health by India is significantly low, not because India is poorer than these other countries, but principally due to the very low percent of public spending that Indian governments devote to health. This reflects the very low priority that governments in India have accorded to the health sector (High Level Expert Group, 2011).

According to the report of “National Commission on Macroeconomics and Health (2005)”, the households undertook nearly three-fourths (77.3%) of all the health spending in Jammu and Kashmir. Public spending was only 20.7% and all other sources accounted for less than 2.0% (Mukhta, 2011-2012). The exceptionally high burden placed upon households in Jammu and Kashmir context reflects the inadequate quantity and quality of public health service delivery and the people are being forced to spend out-of-pocket for buying private healthcare. The health expenditure in Anantnag district can be observed

Table 5. Year wise government health budget summary in Anantnag District (in Lakhs).

Component	2008-2009	2009-2010	2010-2011	2011-2012	Total
A1 - Strengthening of District Health Management Unit	14.16	7.48	8.032	4.889	34.561
A2 - District Programme management Unit	139.93	142.503	157.3942	173.5373	613.3645
A3 - Maternal Health	353.826	294.3256	303.0822	301.7704	1253.004
A4 - Newborn and Child Health	33.06	10.4	2.8	2.8	49.06
A5 - Family Planning	139.38	89.694	98.6634	108.5297	436.2671
A6 - Adolescent Health	13.43	9.773	10.2003	11.22033	44.62363
B1 - ASHA Accredited Social Health Activist	249.6	253.76	243.936	268.3296	1015.626
B2 - Provision of united funds at sub centers	42.56	38.97	88.508	88.57	258.608
B3 - Provision of united funds at CHCs	73.15	37.246	42.4516	42.5676	195.4152
B4 - Provision of united funds at PHCs	33.57	9.45	14.175	14.2245	71.4195
B5 - Mobile Medical Units	64.71	40.96	40.96	40.96	187.59
B6 - Upgrading CHCs to IPHS	535.92	479.56	39.42	39.41	1094.31
B7 - Upgrading PHCs to 24 h service	1813.51	1948.372	536.172	536.172	4824.226
B8 - Upgrading SCs	1882.832	1843.769	38.5209	42.37299	3807.495
C1 - Cold Chain Maintenance	100.3	36.55	21.6	21.6	180.05
C2 - IEC and Social Mobilization	104.11	96.396	101.0756	106.4432	408.0248
C3 - Alternate Vaccine Delivery Mechanism	59.54	65.494	72.0434	79.24774	276.3251
C4 - Supervisory Support and Vaccine Transportation	1.25	1.25	2.065	2.065	6.63
C5 - Data Monitoring and Logistics	112.038	41.0168	40.82098	45.18308	239.0589
D1 - RNTCP	67.3884	66.08524	72.71086	79.97895	286.1635
D2 - Leprosy	9.76	9.76	9.76	9.76	39.04
D3 - NMC Programme	24.72	13.92	13.92	13.92	66.48
D4 - Other Vector Borne Diseases	3.86	3.36	3.36	3.36	13.94
D5 - Controll of Blindness	32.245	12.6695	11.33645	10.4699	66.72085
D6 - Integrated Disease Surveillance Programme	20.5	11	11	11	53.5
D7 - Iodine Deficiency Disorders	32.9	2.9	2.9	2.9	41.6
D8 - Inter Sectoral Convergence	66.736	69.0096	71.51056	74.26162	281.5178
D9 - Community Health Action	28.8	15.74	16.814	17.9954	79.3494
D10 - (PPP)	91.65	62.5	44	44	242.15
D11 - Gender and Equity	26.36	27.896	30.6856	33.75376	118.6954
D12 - Capacity Building	68.74	62.02	74.76	74.76	280.28
D13 - Human Resource Plan	1052.653	1052.653	1709.944	1713.784	5529.033
D14 - Procurement and Logistics	140.83	15.38	13.609	13.976	183.45
D15 - Demand Generation-IEC	100.8	110.8798	121.9683	134.1648	467.8129
D16 - School Health	38	38	38	38	152
D17 - Financing Health Care	57.1	57.56	61.581	67.702	243.943
D18 - Bio medical waste management	14.444	15.8884	17.482	19.228	67.0424
Total	8121.214	7330.181	4548.137	4600.64	24600.17

Source: NRHM (2007).

from its spending on various health programmes (Table 5).

Reproductive and child health (RCH)

Reproductive and child health (RCH) is one of the priority programmes including maternal health, child health, adolescent health and family planning. RCH is meant for prevention and management of unwanted pregnancies, promotion of safe motherhood and child survival, nutritional supplements for the poor, treatment of reproductive tract infections and sexually transmitted diseases, reproductive health survey for adolescents, sex education, contraceptives, safe delivery and reduction of morbidity and mortality. In order to increase the institutional deliveries, which are major concerns, focus has been fixed on upgrading the PHCs to functioning 24×7 and also enhancing the skills of the medical personnel. A sum of Rs.9065.76 lakhs has been planned for activities under the RCH-II in which government is refocusing on primary and rural healthcare services (NRHM, 2007).

"Human resource" component has been given the first priority under the RCH programme. Out of the total sum planned for RCH, 5529.03 lakhs have been planned for the component of "human resource" during the year 2008-2009 to 2011-2012 for fulfilling the vacant positions of 111 nurses, 82 health assistants and 78 clerks and other positions in a district. The main objective of spending on this component is the recruitment of the required staff and filling the vacant positions for providing better healthcare deliveries where it has been seen that out of 841 staff

positions only 402 staff are in position in 47 PHCs of Anantnag district which reflects shortage of more than 52% (Facility Report, 2007).

Maternal healthcare package of antenatal care is the main programme of NRHM to strengthen RCH care. The second priority under RCH programme is given to the component of “maternal health” for which 1253.00 lakhs has been planned for the time period of 2008-2012 and its main objectives are: (a) to reduce maternal deaths in a district from existing 300 per lakh to 100 per lakh; (b) to bring down the prevalence of anaemia to 30%; (c) to strengthen obstetric care in order to increase institutional deliveries up to 100% up to 2012; (d) also to have blood bank available at every 24 h per seven days and obstetric care at PHC/CHC level. These objectives could be achieved by providing complete awareness to ANC, provision of iron folic tablets, calcium, vitamin-A at the sub-centers in adequate quantities, providing facilities for institutional delivery at sub centers and transportation for pregnant ladies (OECD, 2010). Besides, the allocation of funds for the components of human resource and maternal health, 436.27 lakhs for “family welfare” and 49.06 lakhs have been provided for “child health” for the period of 2008 to 2012 with the objective to reduce infant mortality rate (28/1000), live birth (48/1000) and also to increase immunization coverage and to enhance couple protection rate to 100% (NRHM, 2007).

National Rural Health Mission (NRHM)

National Rural Health Mission (NRHM) is another important programme launched by government (2005) in the district of Anantnag, which includes village health water and sanitation committee, up-gradation of health facilities as per IPHS norms, selection and training of Accredited Social Health Activist (ASHA), functioning of quality assurance committee, infrastructural development, etc. It envisions the provision of easily reached, affordable and quality healthcare to rural population, especially the vulnerable sections. From the total budget on health expenditure in Anantnag district, 12280.97 lakhs (2007-2012) have been planned for NRHM. CHCs are the first referral units where referral cases from lower level health care establishments are sent. CHCs have to take care of these referred cases besides their usual healthcare activities. Out of 12280.97 lakhs, 1094.31 lakhs (2007-2012) is allocated for “Up-gradation of CHCs” as per IPHS norms with the main objective to provide good state of healthcare to the people and fulfil the shortages in terms of drugs (only 23% of essential drugs is there in PHCs, which is unsatisfactory), manpower (only 23% clinical manpower is available) and infrastructure (only 33% separate aseptic labour rooms are available at CHCs). 4834.23 lakhs (2007-2008) have been planned for up-gradation of PHCs with its main goals to make PHCs to conduct deliveries 24×7 and also to develop infrastructure up to IPHS standard (NRHM, 2007; Facility Report, 2007). Besides this, 1015.63 lakhs have been planned for ASHAs. They are playing an important role in reducing maternal and infant mortality in a district by creating general awareness among the general public regarding various healthcare services provided in healthcare centers and also by keeping a complete watch on pregnant women. 3807.49 lakhs have been planned for the up-gradation of SCs into PHCs and equip them all for conducting deliveries with the help of auxiliary nurse midwives (ANM) and skilled birth assistants. The health assistant (female) also known as ANM has a key role to play in the implementation of RCH programme at grass root level but only 110 ANMs are looking after the work of 129 SCs in a district, which reflects the gap of 19 ANMs as per IPHS norms which need to be fulfilled. For the maintenance of CHCS, PHCS and SCs, united funds have been provided with the main objectives to make CHCs 24×7 institutions where surgeries can be conducted, to make SCs well furnished to serve the community and also to develop the infrastructure of all centers up to the IPHS standard (NRHM, 2007).

Despite the allocation of funds for the up-gradation and maintenance of CHCs, PHCs and SCs, 242.15 lakhs (2008-2009) have been planned under NRHM for public private partnership (PPP) with the main objective to involve private and public sector and different social groups on decision-making for health problems.

National Disease Control Programme (NDCP)

National Disease Control Programme (NDCP) is launched by the Jammu and Kashmir government in all districts. In Anantnag district, NDCP includes revised national tuberculosis programme (RNTCP), leprosy control programme, malaria control programme, and blind control programme, vector born diseases, integrated disease surveillance and iodine deficiency disorder. The budget planned for national disease control programme is 567.44 lakhs (2008-2012). Out of 567.44 lakhs, 286.16 lakhs have been planned for RNTCP, which aim to stop the spread of tuberculosis in the region as it is a rising concern among the rural population of Anantnag district (to achieve the detection rate of 70%, cure rate of 85%, smear (*dag*) conversion rate of 90% during the time period of 2008-2012). A total of 66.48 lakhs have been allocated for national malaria control programme with the objective to spread awareness of malaria by informing and educating the people in order to keep the region malaria free. This needs the support of social welfare department to inform the general population. Similarly, 39.04 lakhs have been allocated for leprosy with the intention to reduce the prevalence rate of leprosy; to eradicate and ensure proper monitoring and, availability of leprosy drugs; and 13.94 lakhs have been planned for other vector born diseases like dengue, filariasis, Japanese encephalitis, etc (to deal with the condition occurring due to the large influx of tourists and pilgrims

who may carry dangerous strains into the immunological setup of the host population). For the effective surveillance system, the “integrated disease surveillance programme” has been introduced in the district which includes case detection and recording, compiling the weekly reports, report transmission, analysis and interpretation, taking appropriate action, investigation and confirmation of suspected cases and outbreaks, providing feedback and giving out results and evaluation leading to improvement in the system with the main objective to prevent the use of impure water and to improve the sanitation and hygiene of the people in the district by providing safe drinking water through inter-sectoral convergence and advocate proper waste disposal (NRHM, 2007).

Immunization programmes

Besides the RCH, NRHM and NDCP, the government has also launched the immunization programmes in the state. District wise budget has been planned for immunization programmes. Total budget planned for immunization programme in Anantnag district is 2252.48 lakhs for the time period of 2007-2012 (which is lesser as compared to the budget planned for RCH and NRHM but more than the budget planned for NDCP). Under the “immunization programme”, the priority is given to the component of supplies and logistics. Out of 2252.48 lakhs (2007-2012), 1381.45 lakhs has been planned for the component of supplies and logistics with the objective to provide preventive, curative services, health promotive supplements and to ensure 24 h logistics and all supplies in all health institutions, as it has been reported that there is only 21% medicines available out of the total medicines recommended for PHCs (only 6% anti-filarials, 9% dermatological medicine, 11% vitamins and minerals, 22% antidotes, 10% anti-infective medicines, 8% anti-bacterial medicines are available at PHCs in the district). Further funds under immunization programme has been planned for the other components such as 6.63 lakh for supervisory support and vaccine with the main objective to ensure proper maintenance of cold chain at various levels to ensure uninterrupted supply of the effective vaccines at all delivery points; 276.33 lakhs for “alternate vaccine delivery” with the main objective to decrease the dropout rate of children with respect to different vaccines; 408.02 lakhs for IEC and social mobilization to achieve the goal of educating and informing the people regarding the various health services and also make general masses aware of the disease from time to time (NRHM, 2007). Besides these programmes, central government scheme Integrated Child Development Scheme (ICDS) is also working at Anantnag district. From the analysis of availability of funds at the district level, it has been noticed that the availability of funds in Anantnag district increased from 44.20 lakh in 2001-2002 to 65.08 lakh during 2006-2007 with the main objective to provide food supplies for children through Angan Wadi Centers (AWCs). In Anantnag district, Quazigund block has the highest number of AWCs (280) but the highest number of children (18965/month) benefiting from ICDS is in Mattan block with the help of 232 AWCs. As far as the utilization of funds by the district is concerned, Anantnag district recorded the highest (96%: 2005-2006) followed by Kupwara (94%), while the lowest rate of utilization of funds has been recorded in Rajouri district during the years 2005-2006 (Evaluation report on ICDS, 2009).

Conclusions

The findings clearly reflect the inadequacies of the public health infrastructure especially in rural areas of Anantnag district. The inadequacy is not only related to availability of health centers at grass root level (village level) but also lack of equipment and manpower in the existing centers. On an average, only 9% equipments were available at these centers and all centers had shortage of trained para-medical staff. Thus, there is a discrimination based on spatial distribution in hospital infrastructure in the Anantnag district depriving the rural population‟s access to curative care services. Further, the facility for in-patient care is much poorer than the out-patient care. The health indicators of Anantnag district show adverse picture when compared with figures of the state in general. The exceptionally high burden of cost of treatment placed upon households in Jammu and Kashmir reflects the inadequate quantity and quality of public health service delivery and the people are being forced to spend out-of-pocket for buying private healthcare.

Thus it can be said that the healthcare delivery system in Anantnag district is not good. The already inadequate health infrastructure shows further miseries, making the people vulnerable to various diseases and other forms of deprivation. Lacking of proper management in health institutions led to the collapse of many PHCs and SCs in a district. Lack of specialists, anaesthesiologist, gynaecologists and other technical staff at CHCs, PHCs and SCs rendered the essential services ineffective and some PHCs and SCs have become non-functional in a district. The decreasing number of PHCs and SCs in Anantnag district is a testimony of that. Women‟s health has not received proper attention of policy makers as the special health facility for them is not yielding the desired results.

Mental health is mostly a neglected area. There is a ten-fold increase in psychiatric diseases due to an ongoing conflict, tremendous stressful conditions, overwhelming fear and uncertainty during last ten years; but no attention has been paid to expand such services. The PHCs do not have any specific professional for treating such situations. The emergency health services are available only in towns of Anantnag district and rural areas of Anantnag district are without such facility causing transportation of the patients to longer distances to sometimes results in

avoidable deaths. The golden hour is lost in travelling these long distances. Family welfare services are not only inadequate but there is also lack of credibility. Availability of wide range of services has not been ensured. The public health expenditure needs proper investment. Investing on health sector should cover broad areas of enhancing public amenities also. Thus the health system and structure of Anantnag district needs proper interventions to make it comprehensive, effective, accessible, affordable and equity based.

SUGGESTIONS

District health system should be strengthened by paying due attention on:

- Substantial network of health institutions.
- Large number of service providers (personnel) recruitment.
- Infrastructural development should be given a priority.
- Provision of free services or at low/negligible fee.
- Provision of free medicines as per availability of budget.
- Considerable volume of equipments being procured annually.
- Expansion of referral transport system.
- Availability of specialized services and super specialty facilities in various disciplines.
- Health indicators must be better than state as well as national average.
- Misuse of resources should be avoided and special attention should be given towards the mental health.
- Sentinel surveillance centers and public health laboratory must be made available to control emergence of infectious diseases.
- Make health management in hospitals better without which resources will continue to go down the drain.
- Emphasize more on RCH; referral system could be strictly implemented.
- A comprehensive approach that encompasses individual health care, public health, sanitation, clean drinking water, access to food, and knowledge of hygiene, and feeding practices.
- Reducing disparities in health across regions and communities by ensuring access to affordable health care.
- Good governance, transparency and accountability in the delivery of health services that can be ensured through involvement of Panchayati Raj Institutions (PRIs), community, and civil society groups, etc.

Accountability, transparency and bottom up planning will go a long way to improve the functioning of healthcare institutions in a district. Quality assurance programme should be properly implemented. In-service training programmes need greater attention to enhance the knowledge and skills of health probe. Provision of safe drinking water and proper sanitation will be there which can reduce both morbidity and mortality in Anantnag district.

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