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# STATE OF HEALTH IN ODISHA: A MAJOR HURDLES FOR INCLUSIVE GROWTH

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## ABSTRACT

*The health status of its population reflects the socio economic development of a state .The relationship between health and poverty is complex and multifaceted. Poverty in its various dimensions could be a manifestation as well as a determinant of an individual health. The national rural health mission (NRHM) has brought back the primacy of primary health care in India. The health sector reform started in eighties in Odisha has created an enabling environment towards necessary institutional and polices changes for improved health care services in the state. The program implementation plan (PIP) for Odisha health sector plan (OHSP) 2005-10 already on place provides a unique opportunity for the government of Odisha to align its own , the government of India's and development Partner's resources to meet the state's priority in public health provision. The objective of this paper is to make a detailed analysis of state of health in Odisha which is a key component of inclusive growth. An attempt is also made to find out the past health initiative in the state. The study is based upon both primary data and secondary data. The method of collecting data gives more emphasis on household studies and sample surveys. The study has deliberately chosen the years 1987, 1992, 1997, 2002 and 2007 to analysis the outcome of different health policies, plans and programs. The main findings are Utilization of health infrastructure by the needy as less than adequate. There is an evident gap between planning and implementation of various plans. The mechanisms of operational aspect of planning need to be strengthened.*

## KEYWORDS

State of Health, Inclusive growth, Poverty, Inequity and marginalization

## INTRODUCTION

Health is not only a critical input but also a desirable outcome of human development Health Status of its population reflects the socio, economic development of a state. Health status is shaped by a verify of factory level of income and standard of living, housing, sanitation, water supply, education, employment, health consciousness and personal hygiene, and the coverage, availability, accessibility acceptability ad affordability of health services. The poor health status of state is a product of inadequate nutrition, lack of protected water supply, and over crowded in sanitary working conditions. These conditions are conducive to deficiency diseases, airborne diseases, focally related and water borne diseases/which dominate the morbidity and mortality pattern in less development regions. In brief, these diseases arise from a set of conditions.

The relationship between health and property is complex and multifaceted poverty in its various determinant of an individual's health. In its most basic form – as a state of food deprivation and national inadequacy – poverty has a direct bearing on the morbidity and longevity of people. The other aspects of deprivation such as lack of access to critical amenities including safe water, sanitation, non-polluting domestic fuels, connectivity of life support services and most importantly to education and general awareness, contribute to reinforcing ill health and morbidity, even leading to higher mortality levels.

The state of Odisha can rightly be described as a hapless Cinderella of modern India, the trials and tribulation of Odisha are unique and no other state in the Indian Union is as adversely placed in the context of development as this state. It has been pointed time and again that Odisha represents a paradox – a land well endowed by nature with wide spread poverty among people. The poverty of Odisha is both a cause and result of under development in the economic and social spheres compared to the national averages. The relatively low level of economic development of the state can partially explain the high levels of poverty.

Again this is state whose demographic composition reveals the predominance of scheduled Tribes (STs) and Scheduled caste (S(s). The state has one of the highest Sts among the major states averaging over 22.13% as per 2001 census. In Odisha, the most vulnerable social; groups are women, STs and SCs while the most vulnerable occupation groups are landless & marginal farmers, artisans and marine fighter folk.

The root cause of poor health status in the state of Odisha is poverty (both income and human poverty) and social deprivation, low literacy (especially female literacy), and structural inequalities in terms of class, caste and sex. Thus most of the disease burden in the state is directly or indirectly attributed to poverty. The present study makes a detailed analysis of state of health in Odisha which is a key component of inclusive growth. The entire study is based upon both primary data and secondary data.

This paper proceeds as follows First, in Section 2 we make analysis of state of health in Odisha, In section 3, we find out the past health initiative in the state. Section 4 analyses the key issues and concerns. Main findings and suggestions are provided in section 5. Section 6 presents the conclusions.

## STATUS OF HEALTH

To have an overview of health status of Odisha there is a need to analyze fertility mortality indicators and Morbidity pattern. Needless to say Odisha has the poorest health indicators in the country with very high levels of Mortality, Morbidity and malnutrition, Fortunately, fertility levels for the state is relatively low compared to states like Uttar Pradesh (UP), Bihar, Madhyapradesh (MP) and Rajastan.

- **FERTILITY**

The sample Registration system (SRS) has been providing data for estimating fertility measures, and is considered to be the most accurate and reliable. The fertility indicators used for analysis here are crude Birth Rate (CBR) General fertility Rate (GFR), Age specific Rate (ASFR), Gross Reproduction Rate (GRR), and Total fertility Rate (TFR).

Crude Birth Rate (CBR)

The crude Birth Rate (CBR) is the most commonly used measure of fertility. CBR is defined as the number of like births per 1000 population in a given year.

General Fertility Rate ( GFR)

Is yet another measure of fertility expressed as the number of live births per thousand women in the reproductive age group 15-49 years in a given year. As per the latest SRS data of 2007 the GFR for all India is 89.5 and the corresponding figure for Odisha is 79.7; which is relatively lower.

Age specific fertility rate (ASFR) is calculated for specific age groups to see the differences in fertility behaviour at different age.

Gross Reproduction Rate (GRR) measures the average number of female children a women is expected to give birth to during her entire reproductive span conforming to ASFR for a given year if there is no mortality.

Total fertility Rate (TRR) indicates the average number of children expected to be born to a women during her entire reproductive span. Assuming that ASFR continues to be the same and there is no Mortality.

**TABLE 2.1: COMPARES ALL THE FERTILITY LEVELS DATA FOR ODISHA AND INDIA IN 2007**

| Country/State | CBR | | | GFR | | | ASFR (20-24) | | | GRR | | | TFR | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Rural | Urban | Total | Rural | Urban | Total | Rural | Urban | Total | Rural | Urban | Total | Rural | Urban | Total |
| Odisha | 22.4 | 16.1 | 21.5 | 83.9 | 56.1 | 79.7 | 180.9 | 123.8 | 172.9 | - | - | 1.2 | 2.5 | 1.7 | 2.4 |
| India | 24.7 | 18.6 | 23.1 | 98.6 | 67.3 | 89.5 | 235.5 | 161.7 | 213.9 | - | - | 1.3 | 3.0 | 2.0 | 2.7 |

Though the southern states are ahead in fertility transition, substantial fertility decline has been marked in Odisha despite gender inequality, Socio-economic backwardness and relatively higher infant mortality rate. The rural urban fertility differential shows that in Odisha, the Urban fertility declined too much and if attained below replacement level fertility resulting further decline in fertility.

In Odisha the urban fertility reached near replacement level, but the fertility in rural areas still above replacement level. As majority of the population still lives in rural set up, the prospects of population stabilization in near future depends on the success of the efforts in rural areas.

- **MORTALITY**

Among the components of population change, Mortality has historically played an important role in determining the growth of population. Reduction in overall Mortality is an important objective of planning since the first five year plan. The National population policy 2000 (NPP 2000) National Health Policy 2002 (NHP 2002), RCH-2 (2005) and National Rural Health Mission (NRHM; 2005) have reinforced the need of reduction in mortality particularly material and input (including neonatal) mortality.

Life expectancy; is the number of years of a person would live, calculated on the basis of current death rates at any given point of time. It gives the survival rate rather than the health status of the population life expectancy figures for Odisha and Indian from 1990 to 2000 that as of Mid 2000, life expectancy of birth for Odisha is 58.5 compared to 62.5 for India.

**CRUDE DEATH RATE**

CDR is defined as the number of deaths per 1000 population in a given year. It is the most commonly used indicator of Mortality. Odisha has high level of Mortality and CDR is relatively high compared to the national figure.

**INFANT MORTALITY RATE (IMR)**

IMR is considered to be are of the most sensitive indicators of health and development and defined as number of Infant (under age one) deaths per thousand live births in a given year. As per SRS, 2007 IMR is 71 per 1000 live births in Odisha compared to the national figure of 55 per 1000 live births. Odisha is having the 2nd highest IMR. Among the states in the country. The cause of infant deaths has been premature/low birth weight, acute respiratory tract infection and diarrhea. A majority of infant deaths are preventable by simple interventions provided through the healthcare delivery system. The desired impact has not been felt since the health of a child is dependent on the level of nutrition, infection load in the community, and economic and environmental factors of neo-natal mortality and post neo-natal mortality.

- **MATERNAL MORTALITY RATIO (MMR)**

MMR is also a very sensitive indicator of overall Socio-economic development, Social status of women and adequacy or inadequacy of healthcare system; is defined as the annual number of maternal deaths (during pregnancy, child birth and puerperal period) per 1,00,000 live births. The latest MMR by RG, 2004-06 figures published in 2009 are 303 per 1 lakh live births in Odisha compared to 254 for national level. It is also important to point out that for each women who dies as many as 30 other women develop chromic and debilitating conditions, which seriously affect the quality of life. Women in Odisha need support in obtaining access to essential obstetric care.

- **MORBIDITY**

**It**is a very important indicators of the health status and quality of life. We laid our hands on some of the reports of the survey of causes of Death (CSD). In order to get an overview of the prevailing disease pattern in the 1980's and 1990's we have made use of data on survey of causes of death (Rural) published by Registrar General's office the percentage distribution of deaths according to major cause groups for these years is furnished below.

**Table No. 2.2**

| Major Cause Groups | 1982 | 1987 | 1992 |
|---|---|---|---|
| Disease of circulatory system (anaemia, congestive heart failure/diseases heart attacks /schematic heart disease, others) | 4.8 | 11.2 | 23.3 |
| Coughs )diseases of the respiratory system, viz Asthma and bronchitis, TB if lungs, pneumonia, whooping coughs, other) | 11.3 | 8.1 | 13.4 |
| Senility | 29.4 | 39.7 | 18.2 |
| Digestive Disorders (Gastro enteritis, acute abdomen, dysentery peptic ulcer, food poisoning, cholera and others) | 8.6 | 8.2 | 8.3 |
| Causes peculiar to infancy (prematurity, respiratory infections of new born, cord infection, congenital malformation, birth injuries and others) | 20.5 | 12.1 | 0.6 |
| Other clear symptoms (cancer, measles, jaundice, cirrhosis of lever/chronic liver disease, diabetes, tetanus and other) | 7.3 | 7.8 | 6.9 |
| Disorders of central nervous system (paralysis or cerebral apoplexy, meningitis, convulsions and others | 3.9 | 3.6 | 8.3 |
| Accidents and injuries (Vehicular, suicide, drowning, burns snake bites, fall, homicide and others) | 4.5 | 4.1 | 5.5 |
| Fevers (Typhoid, malaria, influenza and others) | 8.4 | 4.2 | 4.4 |
| Child birth and pregnancy ( abortion, toxemia, anaemia bleeding of pregnancy, purperem, puerperal sepsis and others) | 0.9 | 1.0 | 1.6 |

The above table is more or less self explanatory. The health care system is centrally controlled by the Government of Odisha giving more thrust on primary health care at community level. However, secondary and tertiary health care services do exist to support the system as next referral units to fulfill the total Health needs of the community.

- **EQUITY AND ACCESS**

In Odisha marginalized groups comprise around 36% of the population. Almost 81% of ST/SC groups landless labourers. National sample survey data shows that the percentage of disadvantaged groups not accessing healthcare for location reason is higher in poor performing states. There is a shortage of PHC (Primary health centers) particularly in tribal areas. The cost of health care has grown enormously. On an average they spend 12% of their annual income on healthcare opposed to only 2% spends by reach. However the richest 20% enjoy three times the share of public subsidiary for health compared to the poorest quintile (NCAER 2000). Hospitalized ST/SC people spend more than half their total annual expenditure to buy health care, while 45% borrow money or sell asserts to cover expenses and 35% fall below the poverty line (India raising the sights WB 2001). The number of disadvantage poor, who did not seek treatment because of financial reasons increased from 15% to 24% in rural areas and doubled from 10% to 21% in urban slums in the decade 1986-96. The market share (i.e. utilization of services by the community) of PHCs is less than 8% down from 21% in 1986(NSSO 52 round). The process of globalization is a destabilizing factor. Increases in prices of drugs, advanced medical technology and medical services after 2004 under TRIPS(Trade Related Intellectual Property Rights) and GATS (General Agreement on Trade in Services) and has widen healthcare disparities between the rich and the poor. The health service delivery system is plagued with certain inherent weakness, among which those in need of priority corrective action are: effectiveness, efficiency, decentralization, and integration. In remote/ tribal areas the healthcare delivery barely reaches the population. Infrastructure still remain poor and outreach care is virtually absent (however lots of improvements have been made with the implementation of NRHM in recent times)

**PAST HEALTH INITIATIVE IN THE STATE**

Most of the programs for nearly 25 yrs after independent were either centrally sponsored or were provided by the public health system of the state govt directly. These health services were not been able to significantly improve the health of the people in the state. For numerous reason therefore considering the critical health needs of Odisha, the state govt for the first time initiated an externally added project in 1980 titled the "Odisha health and family welfare reform project (OHFWRP)". The first form of the project (1980-87) covered three coastal district (Puri,Cuttack,Ganjam) and two tribal districts(Kalahandi & Phulbani). The intervention was basically infrastructure devt, training, and strengthening of IEC. The basic objectives was to promote national policy on population and maternal and child health (MCH) in the state. In the phase II of Odisha health and family welfare reform project (1989-96) attempted to consolidate the achievements in this five districts and extended another five district Dhenkanal, Keonjhar, Mayurbhanj, Sambalpur and Sundargarh (pre dominantly SC/ST population)

**OHFWRP**

| Phase I | 1980-87 |
|---|---|
| Phase II | 1989-96 |
| Phase III | 1997-2000 |

The state government initiated reforms in several areas. Some of these are follows.

- Introduction of user charges in the government hospitals.
- Drug procurement and distribution.
- Total risk protection against five diseases (malaria, diarrhea, leprosy scabies and acute respiratory infection)
- Decentralization of health service Management.
- Personal polices.
- Management of PHCs.
- Privatization of health care services.
- Asset maintenance.
- Lunching of National Rural Health Mission (NRHM)

**1. KEY ISSUES AND CONCERNS**

To address effectively the problem of inequity and marginalization, an attempt has been made to identity critical issues. The issues are the following

- Tribal health.
- Health in the KBK region.
- Women's health.
- Health of the young people/adolescents.
- Health of the Elderly.
- Health of the urban poor.

**TRIBAL HEALTH**

Major contributors for poor health status and disease burden of the tribal people are:

- Poverty and consequent under nutrition in both Macro and Micronutrients.
- Poor environmental sanitation, poor hygiene and lack of safe drinking water.
- Lack of access to health services and health care facilities resulting in increased severity and/or duration of illness.
- Social barriers preventing access and utilization of available health care facilities.
- Vulnerability to specific diseases such as malaria, Yaws, Tuberculosis and genetic diseases like sickle cell, anemia and G-6PD deficiency.

**HEALTH STATUS OF KBK** (Undivided Kalahandi, Bolangir and koraput) region.

The undivided Kalahandi, Bolangir & Koraput (KBK) region comprising of right districts of Odisha is regarded as one of the most backward areas in the state. Then number of Medical institutions in KBK region appears to be inadequate since most of the areas in this region comprise of hilly, inaccessible areas with difficult terrain and out of from main road and majority of the population are tribal communities, SC and BPL families. On an average one sub-centre is catering to the health need of 4440 people against the norm of having sub-centre for a population of 3000 in tribal areas. The lack of adequate infrastructure and livelihood opportunities with acute poverty of this region is quite known to the entire world due to occurrence of starvation deaths among the people in Kalahandi District, Another dimension of this precarious condition is also reflected in mass migration of the people to the neighboring states in search of employment opportunities.

**Womens Health** It is being increasingly recognized that women's health issue go much beyond material morbidity and mortality to include nutrition, child bearings, contraception, abortion, reproductive health, reproductive Tract Infections (RTIs), Sexually Transmitted Diseases (STDs) including HIV/AIDS, communicable diseases, Women in Odisha are affected by many of the same health conditions as men, but women experience them differently. The prevalence of poverty and economic dependence among women, their experience of violence, negative of our society towards women and girls. Limited power many women have their sexual and reproductive lives and lack of influence in decision making are some of the social realties which have an adverse impact on their health. Lack of food and inequitable distribution of food for girls and women in the household, inadequate access no safe water, sanitation facilities, fuel supplies (Particularly in rural and urban slums) deficient housing conditions all overburden women and their families and have a negative impact /effect on their health.

**YOUNG PEOPLE / ADOLESCENTS 'HEALTH'**

Adolescent is a critical link between the childhood and adulthood of the person. It is now widely recognized that adolescents have particular health needs that differ in many ways from those of adults.

In Odisha, more than 0.78 crores of population belongs to age groups of 10-19 years. The adolescents are very vulnerable and at risk of unwanted pregnancies due to ignorance and lack of access to contraceptives during such as STDs, HIV/AID and RTIs are also on the rise amongst adolescents in the age group 15-19 years.

The five key interventions that could be considered to cater to adolescents / young people's health development needs are

- Providing information
- Building Skill
- Providing Counseling
- Improving youth friendly health services
- Creating sate and supporting environment .

**HEALTH OF THE ELDERLY**

Odisha has comparatively higher percentage of elderly to the total population than other status in India. There is a need of establishing a model for simple, sustainable and economic health care delivery system for elderly at community level complementing the existing health care services in the state. Since the proportion of elderly living alone is increasing day by there is a programmes in "home nursing" which will build a cadre of care givers at the community level in to meet the growing health care need of the elderly in the 21st century in the state.

**HEALTH OF THE URBAN POWER**

India's as well as Odisha;s when poor are vulnerable to many health risks as consequences of poor hygienic and sanitation. The health indicatiors of urban poor are after poorer/ worse than their rural counterparts. Urban averages for health and many other indicators, mask sharp disparities between the urban poor and those better off.

**THEMATIC ISSUES**

- Quality of care (QOC)
- Public Private Partnership (PPP)
- Health care financing
- Community Risk pooling during illness and health insurance for the poor.
- Mainstreaming AYUSH (Ayurveda, Yoga, Unani Siddha and Homeopathy)
- Corporate Social responsity
- Community Monitoring

**SUGGESTED INNOVATIVE APPROACHES**

- Involving the tribal communities in the planning process as well as in the management and process as well as in the management and implementation of various programmes.
- Involvement of NGOs and community Based organizations (CBOs)
- Promotion of tribal system of medicine, and tribal healers to be part of the health team.
- Initiate to be part of the health team.
- Initiate community midwife training.
- Strengthening Health service Delivery.
- Strengthening Health sector management system.
- Enhancing demand and utilization of services and bring equity and gender into the mainstream.

## CONCLUSION

The slow pace of health sector reforms in Odisha poses a major challenge. Also poverty, social justice and gender issues have nor been brought centre stage in health sector reforms. Linking health programmes to poverty alleviation is critical in the context of Odisha because the burden of health services falls disproportionately on the poor.

Poverty remains one of the main reasons for untreated illness, thereby resulting in a sharp increase in morbidity. This burden is compounded further in a situation of unequal gender relations on the hand and unequal social status on the other.

Now that NRHM is in place, one can take the opportunity of this programme platform. The NRHM has brought back the primacy of primary health care. It has given prominence of place to what is called communitization', In fact, it is the hallmark of NRHM. Communitization means community ownership in terms of community-based planning implementation, management and, of course, monitoring.

Communities need to known their to health care, so that they make appropriate demands on health care systems. People's demand for services can be improved as part of the provisions of the 73rd and 74th Amendments and the Right to Information Act.

Health relates to everything that goes to constitute human lifestyle and life system. Therefore, the concept of health and health care has to transcend the present narrow techno-centric understanding and unethical top-down prescriptive care system. Health is to be holistic and health care is to be for health development of all and actively participatory.

Like any right, health has to be asserted rather than given or taken. Responsibility for health policy development, management and advocacy should not be limited to health professionals. All Stakeholders and those contributing to human development and services, including the people, should participate in the process of development. Quality of life and inclusive growth cannot be improved without people's participation, involvement and initiative. Preparing the young people of the state to be healthy and productive is crucial for utilizing the available window of opportunity.

This is an opportunity to convert people into a productive asset to society to make Odisha into a developed state, a vibrant economy and society, it is our social responsibility to make health a people's agenda and take it beyond advocacy to the common concern of all in Odisha.

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