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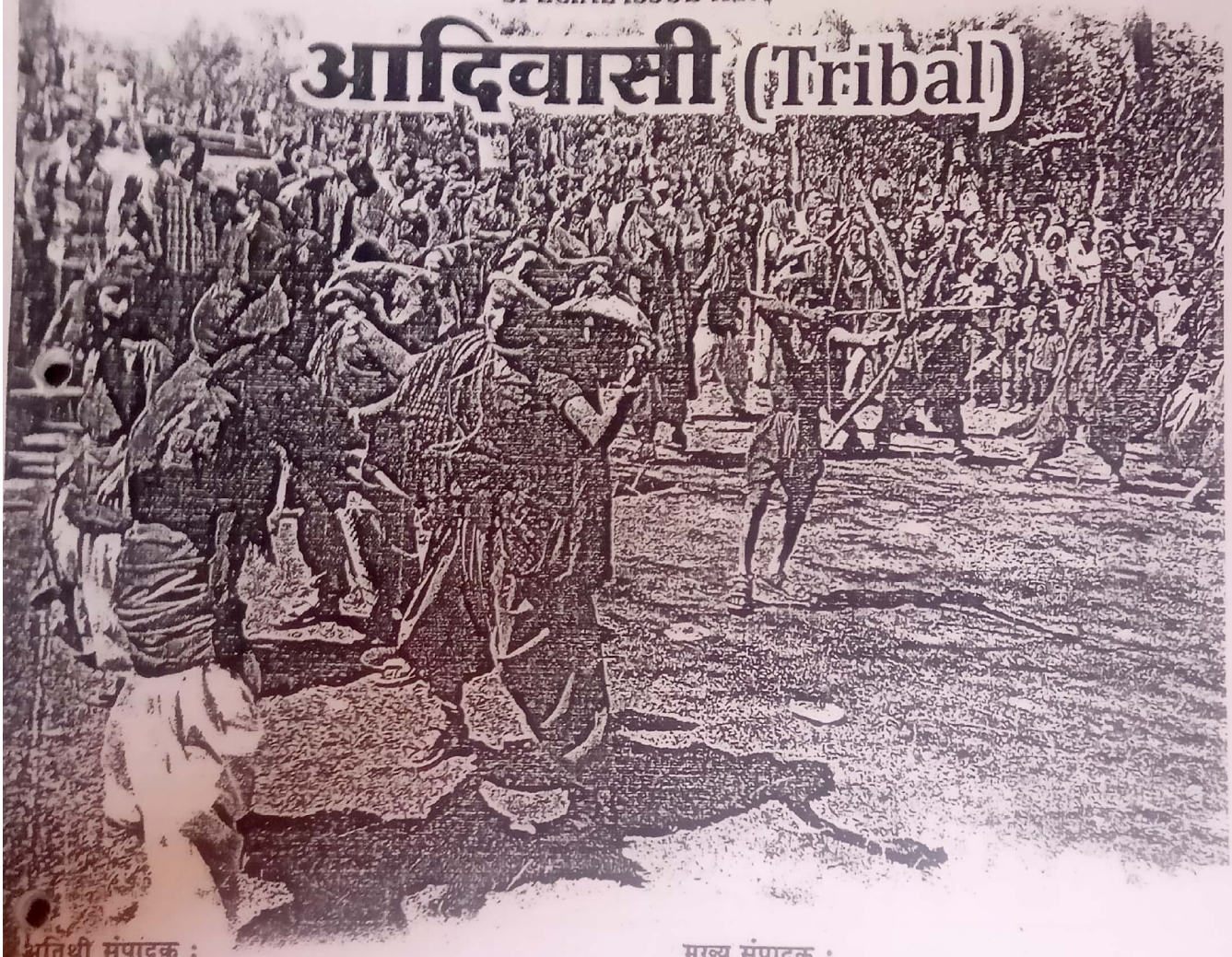

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Health Status of Tribal Population in Maharashtra

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Introduction:

Public support for health care has been historically low in India, averaging less than four percent of GDP for education and 1 percent of the GDP for health. Apart from this, there is also underutilization of funds at the national level. The replication of this is found in Maharashtra's economy. The average health expenditure as percent of GSDP in Maharashtra from 2001 to 2015-16 has been very low at 0.45 percent of GSDP.Maharashtra is a leading economy in the country, there are many shortfalls in health, nutrition, and tribal development especially when inter-district performance is taken into consideration. Apart from its performance being below the benchmark in certain indicators, there are serious issues of inter-district and social disparity in outcomes. There should be provision of primary health care for all with a special emphasis on the immunization of children and The elimination of severe malnutrition, with the halving of moderate malnutrition rates and The provision of family planning services for all willing couples.

Objective of the study:

1. To study mortality rate of tribal population.
2. To study Health Score of major tribal districts.
3. To analyze malnourishment in tribal area.
4. To study the public expenditure on health of tribal population.
5. To examine the public health expenditure on tribal Population.

Limitations of the study:

The guideline established by the Indian Government recognizes all the ethnic groups listed as scheduled tribe regardless of their level of socio-cultural assimilation with greater society. Most of the studies on tribal health have merely addressed this limitation and have rationalized their selection by confirming the inclusion of the tribe in the Indian government's schedule. Selection of tribe to study on the basis of erroneous uniform criteria increases the likelihood of misrepresentative comprehension.

Literature Review:

Existing research on indigenous health in India, as in many developing countries (Abu SM et al.2004; Granich R et al.1999; Hsu HJ, 1990), is restricted to specific indigenous groups (Kate SL, 2001; Friedman MS & Somani J, 2002). The ability to meaningfully generalize the extent and nature of indigenous health patterns in India, consequently, remains limited. Using a nationally representative sample, differential distribution of socioeconomic resources accounts for indigenous health inequalities, this would emphasize the need to redress the pervasive and

For instance, Jawhar taluka in Palghar district is the worst block in the state. The miserable nutritional scenario in Palghar is indicated in the table below. Undernourishment has caused infant deaths in a short span of three months at the beginning of the current year.

Table 6: Undernutrition in Palghar (March, 2016)

	Weighed	Normal	MAM	SAM	Deaths(0-1yr)	10(1-6 yrs.)	Birth
Palghar	129825	98783	26100	4942	32	10	2025
%	-	76.09	20.10	3.81	15.80		

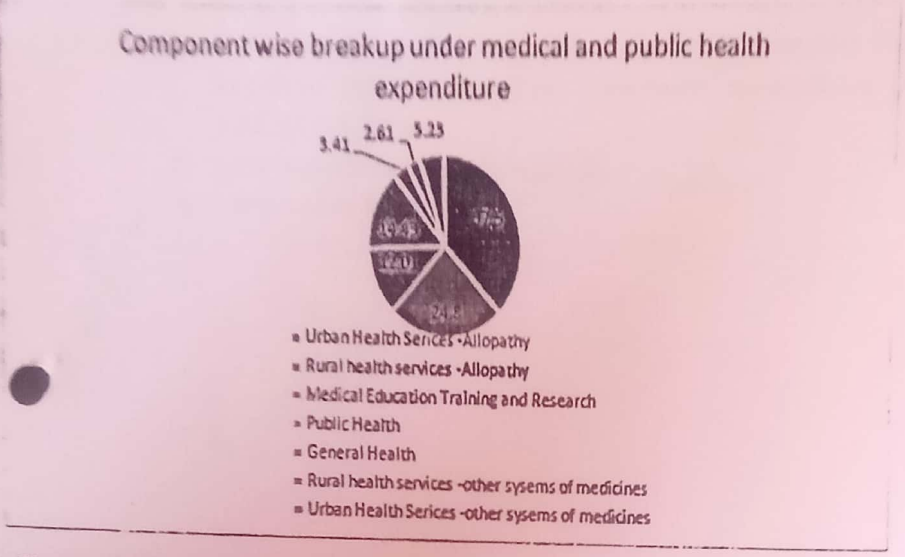
For tackling the nutritional challenge, few studies have given emphasis on Nutrition Mission for Maharashtra at least for targeted districts, however, presently there is no separate budget for programmes or schemes such as Supplementary Nutrition Programme and the funding is expected to come from existing schemes and programmes such as NRHM/NHM, Human Development Mission, Village Health and Nutrition Committee Funds, Rogi Kalyan Samiti etc. Perhaps, while evaluating the performance of these districts, it is strongly felt that as the nutritional status is closely linked to the livelihood issue, it could be tackled with better implementation of MGNREGs in the backward districts.

Looking at the socioeconomic profile of the poorly performing districts/blocks on malnourishment, it is felt that the existence of SNP and ICDS in these blocks is not adequate, it appears that the health and the nutritional status of the population in the rural and the tribal areas cannot be improved only with such interventions. The nutritional status needs to be linked closely to the issue of livelihoods. In the absence of regular livelihood for poor in rural and tribal belt, public services alone do not seem to be offering a sustainable solution for their problems.

3. Public health expenditure

Public health expenditure as a percentage of total expenditure on health in Maharashtra is 8.0 in 2015-16 and it just behind two other states namely UP (12.2 Percent) and Rajasthan (9.5 percent), though there is a decline in this percentage in past three years from 9.3 and 9.4 in 2013-14 and 2014-2015. The total public expenditure on health is divided as 94.50 percent as revenue expenditure and only 5.50 is capital expenditure. This has obviously led to deterioration in public health infrastructure further increasing the burden on people forcing them to spend more from out of pocket. If we examine the component-wise break of public expenditure, it is indicative of urban bias in the provision of public health services as more is spent on urban areas as compared to rural areas in the state as indicated in the graph below.

Graph: 3 Component wise breakup under medical and public health expenditure



4. Challenges faced by Health sector in Maharashtra:

1. Unregulated private sector with varying quality and under qualified practitioners
2. High percentage of out of pocket expenditure (80 to 85 percent) , due to decreasing public health expenditure which adversely affects the health outcomes
3. Substantial rural-urban and inter-district disparities in health outcomes mainly due to disparities in access to health care services, water and sanitation.
4. Social disparity reflects in variability in health outcome and nutritional status of SCs and STs. For example, children of STs are twice more likely be malnourished than other children.
5. Shortage of human resources in the health sector. Lower density of health workers as compared to the norm.

Conclusion:

To conclude, analysis of these three major sectors of Maharashtra's economy reveal that the budgetary provisions for Health, and Tribal have always been lower than expected. In the graph below the expenditure on Medical and public health clearly support this statement. Though the suggestion is higher public expenditure could help in reducing the disparities and help in achieving the targets, there could be other determinants that help in reducing divergence in the outcome indicators for these sectors such as the governance structure which could be largely responsible for the inefficiency of the public expenditure. The question volume of allocations is examined here, but the how the funds are spent is a matter of implementation which is equally important.

Lastly, the policy makers should give some attention to health disparity and nutritional shortfalls and on tribal backwardness for achieving better outcomes for all the sections of population in the state by tackling these issues and this review of Maharashtra expects to provide some relevant inputs in the sectors discussed in the paper.

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