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Assessment of knowledge level of rural people of Uttarakhand regarding UHC (Universal health care) services

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Abstract
Access to quality healthcare is a fundamental need of a country's citizens and lays the foundation for sustainable and equitable economic development. Over a last few decades, India has made significant progress on the primary healthcare front. A large section of the population still lacks access to these services. The study mainly focuses to assess the knowledge level of the respondents towards Universal Health Coverage. The study was conducted in 5 villages (Anandpur, Indarpur, Chukti, Narayanpur, Gukulnagar) of Kichha, Udham Singh Nagar District of Uttarakhand State. The pre-coded interview schedule and self-structured knowledge tool was used to gather the required information. 15 percent households from each of the selected village were included in the sample. Total 125 respondents were selected using simple random sampling without replacement. It was found that age and income level of the respondents were the significant factors that decide knowledge regarding UHC. Knowledge level of the respondents was found to be good.

Keywords: healthcare, economic development, universal health coverage, knowledge level, primary healthcare

Introduction
Universal health coverage means that everyone can get the health care they need, without having to pay a lot of money. It covers the entire spectrum of basic health services, from prevention to treatment, rehabilitation, and palliative care. Currently, at least half of the world's population does not have access to the health care they require. Every year, almost 100 million individuals are forced into extreme poverty as a result of out-of-pocket health spending. This has to be changed. Strong, people-centered primary health care should underpin universal health coverage. Health-care systems that work well are based in the communities they serve. They are concerned not only with the prevention and treatment of disease and illness, but also with the enhancement of well-being and quality of life (WHO).

India is on track to overtake China as the world's most populous country in the next decade. Despite the government's intention to increase funding, India continues to have one of the lowest levels of public health spending in the world. Ayushman Bharat was launched on April 4, 2018, to change the status quo in the healthcare delivery system, where decent healthcare has remained a luxury good for the majority of Indian citizens (Kurian O. C. 2019) [3].

Ayushman Bharat is a two-pronged initiative that aims to improve primary healthcare infrastructure on the ground by rolling out 1.5 lakh Ayushman Bharat – Health and Wellness Centres (AB-HWC) across the country by 2022, as well as providing secondary and tertiary healthcare insurance to the poorest 50 crore Indians. The Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), the insurance arm of this ambitious and innovative approach, has received the most attention. AB-PMJAY began operations on September 23, 2018, and has just completed a year of service. A consolidation of health insurance plans is already taking place throughout Indian states, with far greater risk coverage than the earlier Rashtriya Swasthya Bima Yojana (RSBY). According to reports, Karnataka has used the AB-PMJAY chance to combine seven existing health insurance programmes into one, while Kerala has consolidated three different healthcare systems. Despite the fact that the Centre has selected 50 crore beneficiaries, several states have chosen to expand the population coverage, it is obvious that the scheme would help establish a larger risk pool, bringing India closer to its goal of universal health care (Kurian O. C. 2019) [3].

More than ever, renewed and greater political will is required to prioritise health justice on the

global agenda and achieve universal health care. Greater investments in primary health care are needed to create a fairer, healthier society where everyone can access the health care they need, when they need it, without facing financial hardship (WHO).

Annual global mortality and DALYs (disability-adjusted life years) among women were roughly 15% lower than for men when death and disability were disaggregated by sex. Women, on the other hand, spend almost 20% more time living with handicap (YLDs). Alzheimer's disease and other dementias have seen the highest increase in female fatalities in the last two decades, nearly tripling. Females die from these neurological illnesses at a higher rate than males, with roughly 80% more fatalities and 70% more DALYs for women than for men. Between 2000 and 2019, global life expectancy grew by more than 6 years, rising from 66.8 years in 2000 to 73.4 years in 2019. While healthy life expectancy (HALE) grew by 8% from 58.3 in 2000 to 63.7 in 2019, this was owing to lower mortality rather than fewer years spent disabled in 2019. To put it another way, the growth in HALE (5.4 years) has lagged behind the increase in life expectancy (6.6 years) (WHO).

According to Sulakshana Nandi (2017) in their research highlighted that despite insurance coverage, the majority of the people still incurred OOP (out-of-pocket) expenditure. The public sector was nevertheless less costly, and catered to the more vulnerable groups. It was found that even when insured, people appear to be utilizing the public sector more. Obstetrics and gynecological conditions were significantly more probably to be hospitalized in the hospitals under public sector. There was greater probability of incurring expenditure in the private sector and the median amounts in the private sector even for the insured were higher than in the public sector. Lack of financial insurance or economic protection is important barrier in gaining and utilizing health care facilities & services and therefore higher affordability of the public sector may have led to more people utilizing it. Higher rate of using of the public sector by the people who were enrolled in the government insurance, schemes & programme values of the scheme revealed that the insurance card was used more in private than in public sector.

The Prime Minister’s Overarching Scheme for Holistic Nutrition or POSHAN Abhiyaan or National Nutrition Mission, is Government of India’s flagship programme to improve nutritional outcomes for children, pregnant women and lactating mothers. Launched by the Prime Minister on the occasion of the International Women’s Day on 8 March, 2018 from Jhunjhunu in Rajasthan, the POSHAN (Prime Minister’s Overarching Scheme for Holistic Nutrition) Abhiyaan directs the attention of the country towards the problem of malnutrition and address it in a mission-mode. Month of September 2018 was celebrated as Rashtriya POSHAN Maah. POSHAN Maah's activities focused on Social Behavioural Change and Communication (SBCC). Antenatal care, optimal breastfeeding (early and exclusively), complementary feeding, anaemia, growth monitoring, girls' education, diet, marriage at the appropriate age, hygiene and sanitation, and eating healthy - food fortification were among the major issues. During POSHAN Maah, over 12.2 crore women, 6.2 crore men, and over 13 crore children (male and female) were reached through various programmes. It's worth noting that 30.6 million people were reached in less than 30 days. The Abhiyaan has received a tremendous boost thanks to POSHAN Maah (NITI Aayog).

According to Monali Kar, *et al.* (2019) in their study found that AWWs (Aanganwadi workers) knew the term “under-nutrition” well. However most of them knew possible causes of under-nutrition and were well acquainted with the symptoms and measurements that identified under-nutrition in children. Anganwadi workers at the place of study were not having clarity about community management of malnutrition in children. They knew how and what to advice parents of children to stop under-nutrition among them. They were less familiar with all the initiatives for alleviating malnutrition in children initiated by national and state.

Majority of children believed in washing their hands while on the other hand 55% children did not use the latrine because of poverty. It was good response to the issue of hand washing, though there was very little knowledge of diarrhea spreading. With many advancements in all the fields of science, arts etc., we are still unable to provide people with clean drinking water as we can see the outcomes from children. The knowledge and practice concerning hygiene and sanitation among the children of India was not fair. This is due to lack of literacy as well as the children’s education. It is therefore highly recommended to initiate the programs to educate the people particularly the children about the hygiene and sanitation (Arvind *et al*. 2016).

A study conducted by Jayita Pal, *et al.* (2019) reported that more than half of the study population (64.7% and 50.5 %) had overall strong knowledge and practice score related to maternal-child health and family planning respectively, though they had weak knowledge in updated dosage schedule of iron folic acid tablets, sufficient attachment techniques for effective breast feeding, missed doses of OCP (oral contraceptive pills), ECP (emergency contraceptive pills), IUCD and safe period. In areas like counselling about adverse effects of addiction during pregnancy, birth preparedness and complication readiness, colostrum feeding, weaning, ECP and MTP, they performed less efficiently. The factors which hindered their performance were mainly inadequate remuneration and lack of job satisfaction.

A research on “insurance coverage under different health schemes in Uttar Pradesh, india” reported that the government funded insurance schemes like Employee State Insurance Scheme (ESIS), Rashtriya Swasthya Bima Yojna (RSBY) and Central Government Health Scheme (CGHS) and others have succeeded to provide financial protection to a very few population. Only 4.8% population are covered by any health insurance scheme in UP. People belonging to 60-69 years age group have a partially higher coverage (7.79%) than the age group of 0-15 years (3.04%), which is found statistically sure for age groups. People living in urban areas are observed to be partially less secured (4.68%) than people living in rural areas. People holding a graduate degree had a higher proportion of insurance gained (9.08%) than their less educated groups. People belonging to the richest group have the increased insurance coverage than any other socio-economic group, at 27%. Only 2.3% households of richest wealth quintile of urban areas had some arrangement of medical insurance or protection from the private insurance scheme providers, while in rural areas, across all economic groups, the extent of private insurance coverage was negligible (0.1%) (Pushpendra Singh 2016).

HHs (households) belonging to highly socio-economically groups, from urban area, with better HH environment and most educated members have less probability of facing impoverishment due illness than their counterparts. The

problem of higher healthcare burden is faced by not only poor HHs but also the higher income groups. It is showed from the analysis that the probability of facing catastrophic expenditure and impoverishment raised almost equally because of both outpatient and inpatient expenses (Amit Kumar Sahoo, 2014).
RGJAY (Rajiv Gandhi Jeevandayee Aarogya Yojana) scheme in Maharashtra has some serious shortcomings with continued OOP expenditure, inter district travelling to avail health care and poor accountability and overall lack of adequate monitoring & controlling mechanisms. Out of the 473 empanelled hospitals, 83.7% are in the private sector. There were no aarogyamitras at PHCs anymore. In the public hospital where we had done our study, the kiosk was located outside of the main building making it very difficult for patients to locate it. There were also no banners or posters or other informative material related to the scheme inside the hospital that could help not just inform patients about the existence of such a scheme, but also provide other key information such as the position of the kiosk (Suchitra Wagle, 2017).
According to Fabian Ling Ngai Tung, *et al.* (2016) [9] in their research on "Nurses' Knowledge of Universal Health Coverage for inclusive and sustainable elderly care services" concluded that that slightly more than half of the respondents (52.5%) were unaware of the implementation of UHC (Universal Health Coverage) in Hong Kong. Two hundred and eighty-eight (88.3%) respondents correctly answered that there was no mandatory health insurance coverage in Hong Kong. Nurses found relative to the sustainable development of UHC for elderly healthcare services or facilities. The respondent's knowledge of UHC for elderly healthcare services was fairly satisfactory. Nurses with increased academic qualifications, such as the master's degree and higher, perceived a significantly increased level of importance in helping to develop/strengthen policies to enhance the quality of nursing education.
Access to quality healthcare is a fundamental need of a country's citizens and lays the foundation for sustainable and equitable economic development. Over a last few decades, India has made significant progress on the primary healthcare front. A large section of the population still lacks access to these services.
It is believed that proper awareness generation to improve preventive and prompt utilization of health services and compliance in one hand and strengthening the health system operating in the outreach areas will improve the health and quality of life of the tribal in the days to come.

Material and Methods

Descriptive research design was chosen in the study. Total 125 samples were included in the study through simple random sampling method and 15 percent households from each village were included in the total sample size. Knowledge tool was standardized for assessing the knowledge of the respondents regarding Universal Healthcare Services.
The present study was carried out in Udham Singh Nagar district of Uttarakhand state. Purposive sampling technique and Random sampling was used to select the study area and samples. Purposive sampling method was used to select the area of the present study and simple random sampling was adopted to select the sample in the present study.
A sample size is a definite plan for obtaining a sample from a given population keeping in view the nature of the study, type of the sampling techniques used, size of population etc. For descriptive data, total sample size of 125 respondents selected.
Descriptive data was collected for the selected samples through interview method. The data was collected in the month of May 2020 and June 2020. Prior to this pilot study was conducted.
The study was conducted in 5 villages of Udham Singh Nagar district of Uttarakhand state. Data were entered in Microsoft Excel 2010. The data were evaluated using suitable statistical methods i.e. frequency, percentage, Chi-square test and $P<0.05$ was considered statistically significant.

Result and Discussion

Knowledge of women beneficiaries on UHC (Universal Health Coverage) Related Services

Table 1: Frequency & percentage distribution of respondents according to the knowledge on Universal Health Coverage

(N=125)

S. no.	Statements	YES (1)		NO (0)	
		Frequency	Percentage	Frequency	Percentage
1.	I know about village health plan	37	29.6	88	70.4
2.	I am aware about the Village Health & Sanitation Samiti at my village	40	32	85	68
3.	I know the role and functions of ASHA workers	116	92.8	9	7.2
4.	Anganwadi has a health day in every month for immunization	111	88.8	14	11.2
5.	Generic medicines are available for common sickness at sub centre	81	64.8	44	35.2
6.	Is there any mandatory health insurance scheme in your village.	1	0.8	124	99.2
7.	Government schemes cover the primary health care services	80	64	45	36
8.	Government schemes cover secondary health care services	95	76	30	24
9.	Government schemes cover tertiary health care services	97	77.6	28	22.4
10.	Our children suffered with acute respiratory infection	29	23.2	96	76.8
11.	Sub centre is near to my house	110	88	15	12
12.	PHC is reachable from my house	34	27.2	91	72.8
13.	I have Ayushman card	90	72	35	28
14.	I have immunization card	125	100	0	0

Analysis of the data revealed that about 30 percent people knew about the village health plan whereas, nearly 70 percent respondents did not know.
The data clearly revealed that 32 percent respondents clearly knew about village health & sanitation samiti at their village while 68 percent respondents did not have knowledge. About 93 percent respondents knew the role and functions of ASHA (Accredited Social Health Activist) workers, while 7 percent

did not know.

About 89 percent of the respondents knew that anganwadi has a health day in every month for immunization and only few respondents (11 percent) had no knowledge about it.

Data from the table 4.3 revealed that nearly 65 percent respondents reported that generic medicines are available for common sickness at sub centre, but about 35 percent respondents reported that they did not have knowledge about it. Nearly 99 percent respondent reported that there is no mandatory health insurance scheme in your village, but only few respondents (1 percent) reported that there is mandatory health insurance scheme.

Nearly 64 percent respondent knew that government schemes cover primary health care services while 36 percent did not know about it. About 76 percent people knew that government schemes cover secondary health care services whereas, 24 percent did not know. Nearly 78 percent respondent had knowledge that government schemes cover tertiary healthcare services, but about 22 percent did not have knowledge regarding this.

It is evident from the table 4.3 that nearly 23 percent respondent reported that their children suffered with acute respiratory infection and majority of the respondents (77 percent) reported that their children did not suffer with acute respiratory infection.

About 88 percent people reported that sub centre is near to their house, but 12 percent people reported that sub centre is far away from their house. Nearly 27 percent people reported that PHC (Public Health Centre) is reachable from their house, while 73 percent people said that PHC (Public Health Centre) is not reachable from their house.

Nearly 72 percent people had Ayushman card, while 28 percent people did not possess Ayushman card. All the respondents had immunization card.

Table 2: Frequency & percentage distribution of respondents according to their knowledge

(N=125)

S.no.	Category	Frequency	Percentage
1.	Unaware	36	28.8
2.	Aware	89	71.2

The data pertaining to knowledge level of the respondents showed that nearly 71 percent respondents had knowledge about UHC (Universal Health Coverage) services and 29 percent respondents had no knowledge.

Testing of Hypothesis

$H_{01:}$ Knowledge level of the respondents is not affected by age

$H_{02:}$ There is no significant relationship between occupation and knowledge towards UHC (Universal Health Care) services

$H_{03:}$ There is no significant relationship between income and knowledge towards towards UHC (Universal Health Care) services

For applying Chi-square test, the knowledge level was classified as no knowledge and high knowledge. In order to find out dependency of knowledge level of the respondents on age (21-30 years, 31-40 years and above 40), occupation (labourer, business, cultivation, service), income (upto 10,000, 10,000-20,000, > 20,000). Chi-square test Independence of two attributes applied.

The results of Chi-square values are presented in the table 3:

Table 3: Chi-square value for age, education, occupation & income

S. No.	Variables	Degree of freedom	Tabulated value	Calculated chi-square value
1.	Age/Knowledge level towards Universal Health Care services	2	1.368	1.980*
2.	Occupation/Knowledge towards Universal Health Care services	3	7.81	3.64*
3.	Income/Knowledge level towards Universal Health Care services	2	1.386	4.06*

* Significant difference at 5 level of significance

On the basis of chi-square values it was concluded that knowledge level of the respondents is influenced by age and income but there is no relationship between occupation and knowledge of the respondents towards UHC (Universal Health Coverage).

Conclusion

On the basis of the findings of the present study it was found that majority of the respondents were in service and most of the respondents were in the age of between 30-40 years. Most of the respondents had pucca house. Majority of the respondents (47.2%) were from the age group of 40 & above. Majority of the respondents (37.6%) have income ranging from 10,000 to 20,000 rupees.

The data pertaining to knowledge level of the respondent showed that 71.2 percent respondents were aware about UHC services and 28.8 percent respondents were unaware. Knowledge level of the respondents is influenced by age and income.

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