Health Care System in Rural India: Recent Trends

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Abstract
Health has been always remained an indicator of social development of every nation. India has been striving its best to ensure health of its every citizen. But despite eminent efforts, Outreach of primary health care in our rural areas is a concern. The whole health care system is divided into three levels which are: Primary Health Care, Secondary Health Care and Tertiary Health care. Primary health is being made accessible in rural areas through the PHC’s, CHC’s and Sub-Centres. But after 67 years of Independence, health care delivery system is not up to the mark in rural areas. Various social surveys and reports have highlighted the gaps between access and utilisation of rural health care services.

Key Words: Primary Health Care, Health care Services, Rural Health Care

1 Introduction
Health has been declared a fundamental human right. This means state has the responsibility for the health of its people. Health status of country people plays a major role in the development of nation. It is a well known fact that India next only to China, second largest country in the world. But health status of majority of people is far from the satisfactory status as compared to China and other developed countries. In India, communicable diseases are not still under control. Health has been defined as “a state of complete physical, mental and social well being and not merely an absence of disease or infirmity” (WHO 1946). Health status of population is one of the significant indicators of social and economic well being. Like in most countries, the poor and marginalized have less access to health services, whether public or private. The main barriers are physical, financial, social and informational. The predominant rural context with poor transportation facilities and lack of health infrastructures further aggravates low utilization of health care facilities and services.¹

2 Health care in India
Health care is a public right. Health care is an expression of concern for fellow human beings. The term health care embraces a multitude of services to individuals or communities by agents of the health services or professions for the purpose of promoting, maintaining, monitoring and restoring
health. It is responsibility of the state to secure the nation with basic health amenities. Health is influenced by a number of factors such as adequate food, housing, basic sanitation, healthy life style, protection against environmental hazards and communicable diseases. The ‘Health System’ is intended to deliver health services; in other words, it constitutes the management sector and involves organisational matters, e.g., planning, determining priorities, mobilizing and allocating resources, translating into services, evaluation and health education. The history of health care system in India goes back with the recommendations of Bhore Committee (1946), which suggested the integration of preventive and curative services at all administrative levels, The Committee visualised the development of primary health centres in 2 stages (a) As a short term measure, it was proposed that each primary health centre in the rural areas should cater to a population of 40,000 with a secondary health centre to serve as a supervisory, coordinating and referral institution. For each primary health centre two medical officers, four public health nurses, one nurse, four midwives, four trained dais, two sanitary inspectors, two health assistants, one pharmacist and fifteen other Class Four workers were recommended (b) a long term plan (also called the three million plan) of setting up primary health units with 75 bedded hospitals for each 10,000 to 20,000 population and secondary units with 650 bedded hospitals, again reorganised around district hospitals with 2500 beds. The Committee also made special recommendation in the area of environmental hygiene, public health engineering, housing, health education, health services for mothers and children, health services for school children, industrial health service, the population problem, medical education and research and vital statistics.

In 1977, Government of the India launched a Rural Health Scheme based on the principles of “placing people’s health in people’s hands. It is a three tier system of health care delivery in rural areas based on the recommendations of the Srivastav Committee in 1975. The most important recommendations of the Srivastav Committee were that primary health care should be provided within the community itself through specially trained workers. As a signatory to Alma Atta Declaration 1978, Government of the India is committed to achieving the goal of health for all through primary health care approach. The basic recommendations of the Srivastav Committee were accepted by the government in 1977.

The World Health Assembly (May, 1977) decided that the main social goal of the governments and WHO in the coming years should be the “attainment by all the people of the world by the year 2000 AD of a level of health that will permit them to lead a socially and economically productive life”. Here “Health for All” doesn’t mean that in the year 2000, doctors and nurses will provide medical care for everybody in the world for all the existing ailments; nor does it mean that in the year 2000 nobody will be sick or disable. But it means that there will be an even distribution of resources among the population so that people will use the available resources for better health. Health for All implies wide ranging improvements not only in the access to health services, but also social and economic development .The Keeping in view the goal of WHO “Health for All” by 2000 AD, the Government of India evolved a health policy based on primary health care approach in 1983. It stressed on the need for providing primary health care services with special emphasis on curative, preventive and promotes services. Apart from the formulation of national health policy 1983, the Government of has been envisaged a number of health programmes for the promotion of health among people. National health Policy (2002) recommended decentralization of health system by establishing new infrastructure in deficient areas. It increased the expenditure health sector up to 6% GDP of which (55% primary health sector, 35% secondary and 10% tertiary). A big
initiative towards the convergence of Primary health care services in the rural areas was taken with the resolution of the government India to launch National Rural health Mission.

The National Rural Health Mission (2005) has been launched with a view to bringing about dramatic improvement in health system and health status of the people, especially those who are residing in the rural areas of the country. The mission seeks to promote universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization. As National Rural Health Mission (NRHM) has emphasised the accessibility and affordability of primary health care services in the rural areas, Access to health care services has four dimension- availability, accessibility, affordability and acceptability. On the other hand, Health service utilisation is a concept of expressing the extent of interaction between the service and the people for whom it is intended. The government has converted the NRHM into National Health Mission into 12th plan including urban health with the gamut of its operation.

### 3 Level of Health System in India

#### 3.1. Primary Care Level:
It is the first level of contact of individuals, the family and community with the national health system, where primary health care (essential health care) is provided. As level of care, it is close to people, where most of their health problems can be dealt with and resolved. In the Indian context, primary health care is given by primary health care centres and their sub-centres through the agency of multipurpose health workers, the village health guides and trained guides. Primary care involves the widest scope of health care, including all ages of patients, patients of all socioeconomic and geographic origins, patients seeking to maintain optimal health, and patients with all manner of acute and chronic physical, mental and social health issues, including multiple chronic diseases. Consequently, a primary care practitioner must possess a wide breadth of knowledge in many areas.

#### 3.2. Secondary Care Level:
At this level, more complex problems are dealt with. In India, this kind of care is generally provided in district hospitals and community health centres which also serve as the first referral level. Secondary care is the health care services provided by medical specialists and other health professionals who generally do not have first contact with patients, for example, cardiologists, urologists, and dermatologists. It includes acute care: necessary treatment for a short period of time for a brief but serious illness, injury or other health condition, such as in a hospital emergency department. It also includes skilled attendance during childbirth, intensive care, and medical imaging services. The "secondary care" is sometimes used synonymously with "hospital care". However many secondary care providers do not necessarily work in hospitals, such as psychiatrists, clinical psychologists, occupational therapists or physiotherapists, and some primary care services are delivered within hospitals. Depending on the organization and policies of the national health system, patients may be required to see a primary care provider for a referral before they can access secondary care.

#### 3.3. Tertiary Care Level:
At this level, most specialised services and facilities are delivered by highly specialised health workers. Tertiary care is specialized consultative health care, usually for inpatients and on referral from a primary or secondary health professional, in a facility that has personnel and facilities for advanced medical investigation and treatment, such as a tertiary referral
hospital. This care provided by the regional or central level institutions like Medical College Hospitals, All India Institutes, Regional Hospitals, Specialised Hospitals and other apex institutions. In addition, the tertiary level supports and complements the actions carried out at the primary level. Examples of tertiary care services are cancer management, neurosurgery, cardiac surgery, plastic surgery, treatment for severe burns, advanced neonatology services, palliative, and other complex medical and surgical interventions.

The above mentioned three levels form the entire gamut of health care system in India. Among these three levels, Primary Health Care assumes greater importance because it plays crucial role in maintenance of health standard of people living in the rural areas. Primary health care is the essential health care. It is universally accessible to all citizens and acceptable to them through their full participation and at cost that the community can afford. Primary health care is socially appropriate, universally accessible, scientifically sound first level care provided by health services and system with a suitably trained workforce comprised on multi-disciplinary teams supported by integrated referral system in a way that gives priority to those who are in need and addresses health inequalities, maximises community and individual self reliance, participation and control; and involves collaboration and partnership with other sectors to promote public health. Comprehensive primary health care includes health promotion, illness prevention, treatment and care of the sick, community development, advocacy and rehabilitation. Primary Health care approach is based on the principles of social equity, nationwide coverage, self reliance, intersectional coordination, and the people’s involvement in the planning and the implementation of health programmes in the pursuit of common health goals. The concept of primary health care involves a concerted effort to provide the rural population of the developing countries with at least the bare minimum of health services. As a signatory to Alma Atta Declaration, the government of India has pledged itself to provide primary health care. The obstacles to the implementation of primary health care in India include shortage of health manpower, entrenchment of a curative culture within the existing health system and a high concentration of health services and health personnel in urban areas. The Alma Atta Declaration has outlined eight essential components of primary health care:- Health Education concerning prevailing health problems and the methods of preventing and controlling them, Promotion of food supply and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, Immunization against major infectious diseases, Prevention and control of locally endemic disease, Appropriate treatment of common diseases and injuries and Provision of essential drugs.

4 The structure of Primary health care in India

4.1 Sub - Centre: It is the first contact point between the primary health care system and the community. Each sub centre should have at least one Auxiliary Nurse Midwife (ANM), female health worker and one male health worker. There is a provision for a sub centre over a population of 5,000 in a plain area and 3,000 in hilly/tribal/difficult area.

4.2 Primary Health Centre: Primary health Centre is the first contact between rural community and medical officer. There is a minimum requirement for a PHC is medical officer supported by 14 paramedical and other staff. There is a provision for a primary health centre over a population OF 30000 in a plain area and 20000 in a hilly area. It acts as referral unit of 6 sub centres.

4.3 Community Health centre: - Community health centres are being established under the minimum basic needs programme. A community health centre is required to be supported by four medical specialists i.e., surgeon, physician, gynaecologist, paediatrician and 21 paramedical staff.
There is a community health centre over a population of 1, 20, 000 in plain area and 80,000 in hilly area. It acts as referral unit of 4 primary health care centres. The above mentioned sub-centre, primary health centre and community health centre are hub and heart of delivery of primary health care services. Data revealed by National Health Statistics 2012 that 148366 CHCs, 24049 PHCs and 4833 are functional into whole country for delivering primary health care.

### 5 Current Challenges of Rural Health Care System in India

Parthajit Dasgupta (2013) has highlighted the facets associated with rural health care system in India. He coded a report by the United Nations which revealed that 75% of the health infrastructure in India, including doctors and specialists and other health resources, is concentrated in urban areas where only 27% of India’s population lives. The rural population of India is around 716 million people (72%) and yet there is a chronic lack of proper medical facilities for them. This is one of the reasons for the differences in urban and rural healthcare indicators.

Some of the key facts relative to the current state of the rural healthcare system in India have been highlighted in a report by the National Rural Health Mission (NHRM). They are:

- The ratio of rural population to doctors is six times lower than in urban areas
- The ratio of rural beds vis-à-vis the population is 15 times lower than in urban areas
- 66 percent of the rural population in India lacks access to preventive medicines
- 31 percent of the rural population in India has to travel over 30 km to get needed medical treatment
- 3,660 PHCs in rural India lack either an operation theatre or a lab or both
- 50 percent of the posts for obstetricians, paediatricians, and gynaecologists in PHCs or CHCs are vacant
- There is a 70.2 percent shortfall of medical specialists in CHCs
- 39 percent of PHCs are currently without a lab technician
- Infectious diseases dominate the morbidity pattern in rural areas: 40% in rural areas vis-à-vis 23.5% in urban areas.

### 6 Conclusion

Government experience difficulties in attracting and retaining doctors in rural area and it has long been recognized as a contributing factor to the relatively higher levels of morbidity and mortality in rural areas. Studies suggest that resolving the health problems of rural communities will require more than simply increasing the quality and accessibility of health services. Underutilization of existing rural hospitals and health care facilities is also a common phenomenon. Many a time rural patients bypass local rural hospitals despite the availability of comparable medical services. The general conditional logit analysis of data on patients and hospitals suggests that hospital characteristics (size, ownership, and distance) and patient characteristics (payment source, medical condition, age, and race) influence rural patients’ decisions to bypass local rural hospitals.

### 7 References


