RURAL HEALTH : HEALTH INFRASTRUCTURE, EQUITY AND QUALITY

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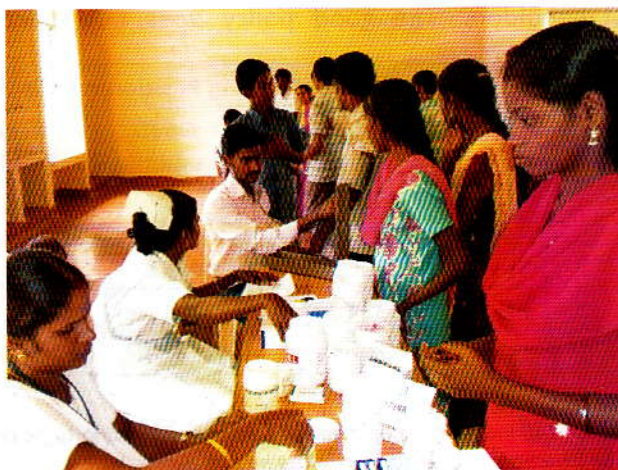
Private and other partners who wish to work with government and help in strengthening the public health care should be made accountable by community participation and social audit. The National Health Policy 2017 also lays a lot of emphasis on Universal Health Coverage. The government should focus more on quality provision of health care for all rather than quantitative coverage of all.Above all, in order to provide just and fair health care to rural population, the Government of India needs to do justice with the budgetary allocation and development of infrastructure as per need and demand.

India is the country of vast population, as per Census 2011, the total population of India is 121 crore, out of which the rural population is 83.3 crore (68.84 per cent) and urban population is 37.7 crore (31.16)[1]. It is evident that majority of population lives in rural area. Since independence, in view of the population distribution and social structure of the society, the Government of India choose to have maximum coverage and network of public health care system in order to have preventive, promotive, curative and specialized services. India opted for three tier health care system through arrangement of Sub Centres (SCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs) based on certain population norms to cater rural population. The purpose to create a network for Primary Health Care was to look at the social determinants of health and to provide the range of health care services to rural population. Therefore, the system has been developed as a three tier system with SCs, PHCs and CHCs being the three pillars of Primary Health Care System. The purpose to create such a system was to connect with the rural population and to provide different level of services as per need and regardless of their paying capacity.

In context of rural health services, the challenge of government health care system is that there are many gaps in primary health services and the health care facilities are mainly urban centric. The differences in health status in urban and rural areas are based on various factors such as: availability, accessibility and affordability of health services, literacy and educational status, poverty, employment and source of livelihood, income and family size, food intake and nutritional status, gender disparity, housing, access to clean water and sanitation facilities, information and knowledge for health programmes etc. These factors have direct impact on health status of the rural population.

All the specialized and reputed hospitals are mainly located at the state capital or the district headquarters. Whereas the rural villages where the basic health facilities are much required are neglected. The Census data 2001 and 2011shows that the number of rural villages (2279) have increased in a decade. In 2001 Census, the total number of villages were 6,38,588 and in 2011, the number had gone up to 6,40,867. On the contrary, the primary health care facilities is not showing much improvement in terms of number and services. The Government introduced various health programmes and schemes but due to many reasons, it seems there is long way for appropriate implementation of them and to get the desired



results. Recently, the government of India approved its new National Health Policy and its relevance for rural population needs to be analyzed.

National Health Policy (NHP) 2017:

The Government of India in order to provide Preventive and Promotive Health Care and Universal access to good quality health care services, has approved the new National Health Policy in March 2017. The primary aim of the NHP, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping the health systems in all its dimensions-investment in health, organization and financing of healthcare services, prevention of diseases and promotion of good health through cross sectoral action, access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health, financial protection strategies and regulation and progressive assurance for health. The policy emphasizes reorienting and strengthening the Public Health Institutions across the country, so as to provide universal access to free drugs, diagnostics and other essential healthcare.

The NHP 2017, expressed its vision for universal health coverage and creating affordable and quality health care for all. The policy assures the availability of free, comprehensive primary health care services, for all aspects of reproductive, maternal, child and adolescent health and for the most prevalent communicable, non-communicable and occupational diseases in the population. It also talked about reinforcing trust in public health care system. The Government intended to achieve various targets by involvement of all possible stakeholders. The good policy does not make any sense until it is not implemented properly. Therefore, governance and attainment of targets needs to be supplemented with appropriate funding, utilization of resources, infrastructure, quality care standards and health equity. Even NRHM (2005) had the vision of improvement in weak infrastructure, increase in public health spending 2-3 per cent of GDP, launch of Accredited Social Health Activists (ASHA), utilization of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy, (AYUSH), and decentralization of health programmes. Despite all these efforts, there are gaps and shortfalls in rural health care infrastructure at all the three levels of primary health care. Matters related to health equity and quality of care are areas of concern.

Janani Shishu Suraksha Karyakram

- The scheme entitles all pregnant women delivering in public health institutions to absolutely free and no expense delivery including caesarean section.
- 3.50 crore women received free drugs, 2.92 crore free diagnostics, 2.34 crore free referral transport, 1.9 crore (48 per cent) free drop back service.

Free Diagnostics Services Initiative:

- Aim: To reduce out of pocket expenditure on diagnostics and improve quality of care. States given support to provide essential diagnostics free in public health facilities.
- Operational guidelines released and approval of Rs 1023.62 crores given to 25 States/UTs.

Table -1: Building Position for SCs, PHCs and CHCs (As on 31st March, 2016)

S. No.	All India/ Total	Total Number of units functioning	Govt. Buildings	Rented Buildings	Rent Free Panchayat / Vol. Society Buildings	Buildings Under Construction	Buildings required to be constructed
1	SCs	155069	104861	32924	17282	11019	39528
2	PHC	25354	23191	583	1503	1631	1011
3	CHCs	5510	5383	5	122	390	31

(Source: RHS, 2016)

Note : (All India figure of required number of building to be constructed = Total functioning - (Government Buildings + Under construction) (ignoring States/Uts having excess.)

Rural Health Care Infrastructure:

Since Independence, the Government of India choose to have maximum coverage and network of public health care system in order to have Preventive, Promotive, Curative and Specialized services. The most important and first contact point for immediate health care is SCs, it is also important as it is connecting the rural population with Primary Health Care programmes and schemes. The PHCs works as referral point for specialized services and CHCs suppose to serve as specialized health care centre.

The Country's majority of population lives in rural areas and at present, the biggest challenge is shortfall of public health care infrastructure in rural area. The status of health infrastructure as per 2011(Census) population in India (Table -1), shows that there is a shortfall of buildings 20 per cent for SCs, 22 per cent of PHCs and 30 per cent CHCs.

Another important area of concern is the availability of manpower/ health staff. For public health service, the manpower in rural areas, as per the data shows that against the required number 1,55,069 of health workers (Female)/ANM at sub centres, there are 24,194 vacant positions and there is a shortfall of 4679 positions. Even at PHCs level, Female Health Assistance, 1013 number of positions are vacant and there is a shortfall of 11,299 positions.

National Mobile Medical Unit Services

- Objective: Take healthcare to the doorstep of the public in the rural and under served areas.
- 1122 MMUs are operational across 335 districts.

For the Doctors, 8774 positions are vacant at the PHCs which is the primary unit for health care need. The CHCs which were established with the aim to provide referral and specialist services for the rural population are also having the gaps in terms of required manpower. The data shows that at CHCs, there is shortfall in various positions. For the Surgeons, 1811positions are vacant, another important position is of Obstetricians & Gynecologists in which, 1859 positions are vacant. For the Physicians 1989, Pediatricians 1758 and for Radiographers 1955 positions are vacant[2].

Quality of Health Care:

The Quality of care depends on the various factors such as transportation, availability of doctors, water supply, electricity, diagnostic facility and availability and distribution of drugs. To assess the standards of public health services, the government developed Indian Public Health Standards (IPHS). The Ministry of Health and

Table-2: Health status of Urban and Rural Population as per NFHS-3 and 4

Population and Household Profile	Urban (%)	Rural (%)	Total NFHS-4 (%)	Total NFHS-3 (%)
Infant mortality rate (IMR)	29	46	41	57
Under-five mortality rate (U5MR)	34	56	50	74
Mothers who had full antenatal care	31.1	16.7	21.0	11.6
Mothers who received postnatal care from a doctor/nurse/ LHV/ANM/midwife/other health personnel within 2 days of delivery	71.7	58.5	62.4	34.6
Children under 5 years who are underweight (weight-for-age)	29.1	38.3	35.7	42.5
Women who have comprehensive knowledge of HIV/AIDS	28.1	16.9	20.9	17.3
98 Men who have comprehensive knowledge of HIV/AIDS	37.4	29.3	32.3	33.0
Children under 5 years who are underweight (weight-for-age)	29.1	38.3	35.7	42.5

(Source: NFHS-4)

(Note : The table presents selected health indicators and status of population)

Mental Health Policy 2017

- A rights based statutory framework for mental health in India and strengthens
- Equality and equity in provision of Mental healthcare services.
- Strengthems the institutional mechanisms for improving access to quality and appropriate mental healthcare services.

Features of the Act:

- Provision of advance directive.
- Nominated representative
- Special clause for women and children related to admission, treatment, sanitation and personal hygiene
- Restriction on use of Electro Convulsive Therapy and Psychosurgery.

Family Welfare (2016) data shows that at SCs level, there are 1,55,069 functional units and out of that, 2155 are as per IPHS norms. In case of PHCs, there are 25354 functional units and out of it, only 5280 are as per IPHS norms, similarly there are deficiencies in CHCs , there are 5510 CHCs and out of it, 1470 are as per IPHS norms. In case of water and electricity supply at SCs, there are 28.5 per cent without regular water supply and 25.6 per cent are without proper electricity supply and 10.5 per cent are without all-weather motorable approach road. Similarly at PHCs, 4.6 per cent are functioning without electricity and 6.6 per cent are without regular water supply and 5.9 per cent are without all-weather motorable approach road. Moreover, at present, the treatment standards and attitude of health care staff are not measurable in absence of any uniform treatment standards and accountability of system.

In such a situation of shortfall in infrastructure, particularly minimum facilities and manpower, low level of budgetary allocation, the goals set by NHP 2017 to achieve by 2020 and 2025 seems to be tough and there is a need of specific plans and targets to fill these gaps in a time bound manner.

Health Equity and Rural-Urban Divide:

In rural India, health infrastructural facilities are still inadequate. All the above mentioned deficiencies and gaps resulted into vulnerable health state of rural population. The NFHS-4 data clearly reflects the urban and rural divide in terms of health outcome. As of now, NFHS -4 shows a better picture in comparison to NFHS-3 (Table- 2) but that needs to be critically analyzed in terms of equal distribution of resources and services in urban and rural areas and among all social categories. NFHS -4 data shows that, Infant Mortality Rate is 29 for urban areas and 46 for rural areas. Under five mortality rate is 29 for urban areas and 46 for rural areas.

Mothers who had full antenatal care were 31.1 per cent for urban areas and only 17 per cent in rural areas. Mothers who received postnatal care were 72 per cent in urban and 58 per cent in rural areas. Children under 5 years who are underweight 29 per cent in urban and 38 per cent in rural areas, men and women who have comprehensive knowledge of HIV/AIDS is 37 per cent in urban and 29 per cent in rural and 28 per cent in urban and 17 per cent in rural area respectively. Households using improved sanitation facility is 70.3 per cent in urban areas in comparison to 36.7 per cent in rural areas. A very important factor for good health is clean fuel for cooking, data shows Households using it is 80.6 per cent in urban areas and only 24 per cent in rural areas.

The Way forward:

To provide maximum coverage to the rural population with basic health care infrastructure, the government needs to fill up the gaps in Health care provisions that are existing at present. Due to the shortfall in infrastructure, the rural population faces many challenges and they have to travel to long distances to get the basic health care facility. In case of health care needs, the distance, and lack of transport facility is a major challenge for rural population, which creates difficulty in accessing the basic health care facility. In addition to that, they may face loss of their daily wage and work . Government needs to create specific strategies in time bound manner to create basic health care infrastructure for the rural population as per the requirement.

For the rural population, health care requirements are different than the urban due to various social economic reasons. Rural population is mainly engaged in agriculture labour activity and

NHM Free Drugs Services Initiative

- Funding available under the NHM leveraged to support and reward states that agreed to launch free drugs initiative by increasing their own state budget for this purpose.
- Detailed Operational guidelines released to the states. So far, all the states have notified free drug policy.
- Model IT Application Drugs and Vaccination Systems developed by C-DAC and shared with states.17 states are implementing DVDMS application.

Systems put in Place:

- Facility wise Essential Drug List.
- Robus procurement system.
- IT backed logistics and supply chain management.
- Proper warehousing and necessary drug regulatory and quality assurance mechanisms
- Standard treatment guidelines.
- Prescription Audit and Grievance Redressal Systems to ensure provision of quality free essential drugs.

there are many challenges of agriculture sector. The environmental conditions and unfavorable financial situation leads to mental stress and depression in farmers and daily wage labourers working in the field. The rising numbers of farmers suicides and migration is an indication of the need of immediate intervention through state and central government and protect the sources of livelihood in rural areas. As of now, the majority of mental health centers and practioners are available in urban areas whereas, the rural areas are completely neglected for mental health care. Policy makers should create a mechanism to create a network of mental health experts such as counsellors, psychologists, and psychiatrists to deal with the mental health issues of rural population.

We need to focus on occupational conditions and health risks of rural population especially those who are engaged in agricultural activities. There is a need to review the inter-sectoral coordination and status of work and its impact in the lives of rural population. Rural population engaged in agricultural activities is exposed to many other health risks. There are many studies which reveal that exposure to pesticides, chemicals, and other toxins in ground water, and other airborne pollutants, exposure to disease and animal waste for those working in animal production are some of the major threats to health status of rural population.

In absence of that basic infrastructure, the rural population has no other option than to approach private or local health care practitioners which are available in the vicinity and they have to bear out of pocket expenditure to get basic health services. Therefore, we need to carefully look at the components of private partnership in order to prevent unethical commercial activities. Private and other partners who wish to work with government and help in strengthening the public health care should be made accountable by community participation and social audit. The National Health Policy 2017 also lays a lot of emphasis on Universal Health Coverage. The government should focus more on quality provision of health care for all rather than quantitative coverage of all.Above all, in order to provide just and fair health care to rural population, the Government of India needs to do justice with the budgetary allocation and development of infrastructure as per need and demand.

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Footnotes

1 Census of India, 2011.

2 *Health manpower in Rural Areas, Section IV, Rural Health Statistics 2016, M/o HFW, GoI.*

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