RURAL HEALTH : EMERGING CHALLENGES

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Healthcare delivery in rural India is now uniquely poised to undergo a change at all its stages — prevention, diagnosis, and treatment, as the government focus on the sector has increased a lot in the recent past. The real change will come when public and private sectors come together to fill in the gaps and ensure that medical personnel are deployed in adequate numbers in rural India. The sector can evolve with the use of innovation to bridge intent and execution. The future ahead appears promising.

As said across the world, healthcare is the right of every individual but lack of quality infrastructure, dearth of qualified medical functionaries, and non- access to basic medicines and medical facilities thwarts its reach to more than half of India's population. And the worst sufferers are people in villages, where the condition of medical facilities is deplorable, even though improvement has been there in recent years. Though a lot of policies and programs are being run by the Government but the success and effectiveness of these programs is questionable due to gaps in the implementation and unavailability of quality healthcare personnel.

In rural India, where the number of Primary health care centers (PHCs) is limited, 8% of the centers do not have doctors or medical staff, 39% do not have lab technicians and 18% PHCs do not even have a pharmacist. According to latest health survey, India also accounts for the largest number of maternity deaths, majority of which takes place in rural India. Although rural India has seen a spurt in unregulated private sector, the facilities are dismal with mostly unqualified persons running these centres.

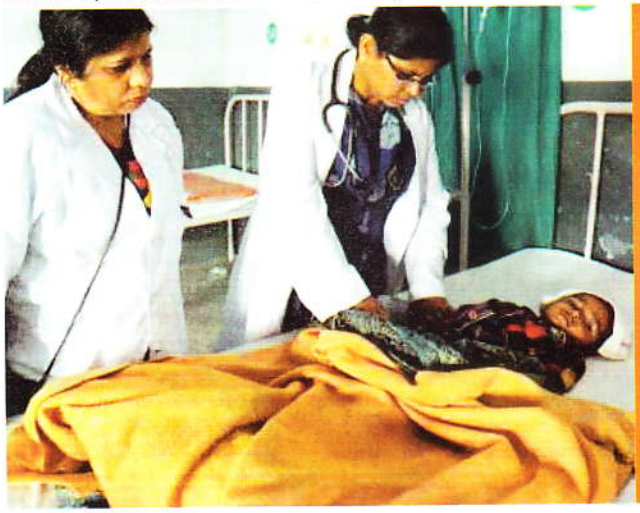
Sub Centre:

The Sub Centre is the most peripheral and first contact point between the primary health care system and the community. Sub Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes.

Each Sub Centre is required to be manned by at least one auxiliary nurse midwife (ANM) / female health worker and one male health worker. Under National Rural Health Mission (NRHM), there is a provision for one additional second ANM on contract basis. One lady health visitor (LHV) is entrusted with the task of supervision of six Sub Centres. The past few years has seen a significant increase in number of sub-centres with over two lakh of them functioning as on 31st March, 2018. There is significant increase in the number of sub-centres in the states of Rajasthan, Gujarat, Chhattisgarh, Karnataka, Jammu & Kashmir, Odisha, Tripura, Madhya Pradesh and Kerala.

Primary Health Centre (PHC):

PHC is the first contact point between village community and the medical officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained



More beds, more facilities, more hospitals and more doctors

- 20 new super speciality AIIMS like hospitals being set up
- Since July 2014, 1675 hospital beds added in the six functional AIIMS (including 850 beds added in the last one year)
- 2 new AIIMS announced for Jharkhand and Gujarat in 2017-18
- 73 government medical colleges being upgraded
- Total 92 medical colleges (46 government and 46 private) have been set up in last four years, which resulted in increase of 15,354 MBBS seats
- Total 12,646 PG seats have been increased in last four years

by the State governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services (BMS) Programme.

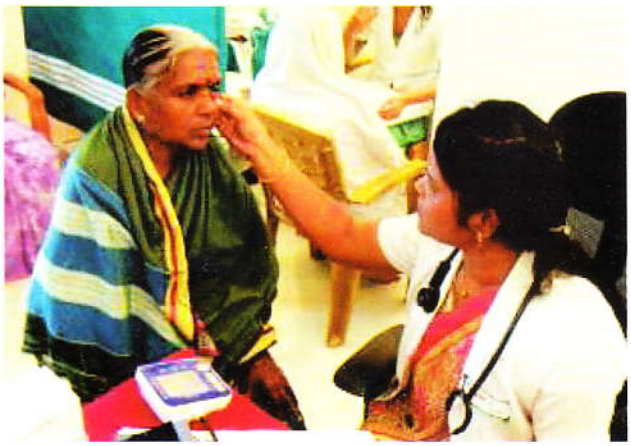
As per minimum requirement, a PHC is to be manned by a medical officer supported by 14 paramedical and other staff. Under NRHM, there is a provision for two additional staff nurses at PHCs on contract basis. It acts as a referral unit for 6 Sub Centres and has 4-6 beds for patients. The activities of PHC involve curative, preventive, promotive and family welfare services.

There were 28,650 PHCs functioning in the country as on March, 2018, an increase of over 3,000 PHCs as compared to the level that existed in 2005. Significant increase was reported from Karnataka, Assam, Rajasthan, Jammu & Kashmir and Chhattisgarh and Bihar. Percentage of PHCs functioning in government buildings has increased significantly from 78% in 2005 to 92.9% in 2018. The number of allopathic doctors at PHCs has increased from 20,308 in 2005 to 29,124 in 2018, which is about 35% increase. Shortfall of allopathic doctors in PHCs was 11.8% of the total requirement for existing infrastructure.

Community Health Centres (CHCs):

CHCs are being established and maintained by the State government under MNP/BMS programme. As per minimum norms, a CHC is required to be manned by four medical specialists i.e. surgeon, physician, gynecologist and pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, labour room and laboratory facilities.

It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. As on March 2018, there were 5,924 CHCs functioning in the country with substantial increase reported from Uttar Pradesh, Tamil Nadu, West Bengal, Rajasthan, Odisha, Jharkhand, Kerala, Gujarat and Madhya Pradesh. Number of CHCs functioning in government buildings has also increased during the period 2005-2017.



In addition to 4156 Specialists, 15,350 General Duty Medical Officers (GDMOs) are also available at CHCs as on March, 2018. There was huge shortfall of surgeons (86.5%), obstetricians & gynaecologists (74.1%), physicians (84.6%) and paediatricians (81%). Overall, there was a shortfall of 81.6% specialists at the CHCs vis-a-vis the requirement for existing CHCs.

First Referral Units (FRUs):

An existing facility (District Hospital, Sub-divisional Hospital, Community Health Centre etc.) can be declared a fully operational First Referral Unit (FRU) only if it is equipped to provide round-the-clock services for emergency obstetric and new born care, in addition to all emergencies that any hospital is required to provide. At present, there are 3,376 FRUs functioning, out of which 94.2% have operation theatre facilities, 96.3% have functional Labour Room while 68.9% have blood Storage/ linkage facility.

To control the spread of diseases and reduce the growing rates of mortality due to lack of adequate health facilities, special attention needs to be given to the health care in rural areas. The key challenges in the healthcare sector are low quality of care, poor accountability, lack of awareness, and limited access to facilities.

Challenges and Opportunities:

As per the latest estimates put forward by the

Ensuring affordable & quality healthcare

- 1,054 essential medicines, including lifesaving drugs, brought under price control regime after May 2014, giving the consumer total benefit of more than Rs. 10,000 crore
- Prices of cardiac stents & knee implants capped by 50-70%, resulting in significant savings to the common man
- Medicines get affordable with Pradhan Mantri Bhartiya Janaushadhi Kendras selling generic medicines throughout the country. More than 3,000 stores are operational, resulting savings of over 50% to the common man
- AMRIT pharmacies provide drugs for cancer and cardiovascular diseases along with cardiac implants at a 60 to 90 per cent discount on prevailing market rates
- Pradhan Mantri National Dialysis Program helps provide free dialysis services for poor and subsidized services to all patients. 497 dialysis units have been made operational and around 2.5 lakh patients have availed services with nearly 25 lakh dialysis sessions held so far

Minister of State for Health and Family Welfare, of the total 28,650 Primary Health Centres (PHC) in the country, 15,700 have only one doctor and 1,974 centres don't have a single doctor. Furthermore, in about 10,000 centres, there are lab technicians needed while 480 are yet to have a pharmacist.

According to a United Nations report on healthcare, around 75% of the healthcare infrastructure, including medical specialists and doctors are concentrated in urban areas in India even though only 27% of the population lives in urban parts. India meets the global average in the number of physicians, but 74 per cent of its doctors cater to a third of the urban population, or no more than 442 million people, according to a KPMG report released in 2017.The country is 81 per cent short of specialists at rural community health centres (CHCs), and the private sector accounts for 63 per cent of hospital beds, according to government health and family welfare statistics. Even though the government is putting in strenuous efforts to enhance the current healthcare systems by opening PHCs and helping the poor via free medical facilities, qualitative and quantitative availability of primary healthcare services is very less in remote areas.

However, a parliamentary committee has very recently recommended that all doctors passing from the Indian medical colleges must serve in the rural areas for at least one year so that the shortage of doctors can be addressed. Some states have made it compulsory for the medical graduates from the government medical colleges to serve in the remote areas. Perhaps, it is a ray of hope but there remains still big challenge for India to face for rural healthcare planning.

Health Minister Shri J.P. Nadda while releasing National Health Profile 2018 said that due to improvement in rural health infrastructure, India has made substantial progress on several indicators in the recent years and stated that its national health indicators like Infant Mortality Rate (IMR), Maternal Maternity Rate (MMR) and Total Fertility Rate (TFR) are declining faster than before. He said India has shown impressive gains with 22% reduction in Maternal Mortality since 2013.

Way Forward:

The only way to bring a ray of hope is by implementing defined policy with a set of proper guidelines, which will ensure sustainability of rural healthcare plans. Health experts say this idea is also going to attract the private sectors, wherein investors would be interested in making an investment in rural healthcare segments like remote diagnostics, telemedicine services and operation of other rural health-related services. Thereby, these private players could address the emerging health issues and fill the healthcare gaps that exist because of limitations in public funded infrastructure.

The Union Budget 2017-18 has given a lot of impetus to rural health with allocation for the sector increased by around 27% but the investment can bring huge change only if the private sector provides a matching investment to boost rural health care infrastructure. However, so far the private sector has been unwilling to invest in the rural sector considering the returns are poor. But, they need to as the future market is there.

Information Technology (IT) can play a big role with IT applications being used for social-sector schemes on a large scale to improve access to heathcare in rural parts. Hospitals empanelled under the government insurance scheme are IT-enabled and connected to servers in districts. Beneficiaries can use a smart card that allows them to access health services in any empanelled hospital. For that, more private hospitals are needed in the rural areas.

Ayushman Bharat: Rural Healthcare Redefined

Under the Rashtriya Swasthya Suraksha Yojana, although all poor families are covered, but they are not getting real benefit as healthcare facilities in rural areas are not up to the mark, forcing them to travel to urban areas. This year, however, the government has increased the annual limit per family increased from Rs 30,000 to Rs 1,00,000, with an additional "top-up" of Rs 30,000 for senior citizens. Officials estimates that enrolling all BPL families in the country in health-insurance programmes would cost anywhere from Rs 2,460 crore to Rs 3,350 crore.

However, an unanticipated unplanned healthcare emergency is one of the topmost causes of financial ruin in India. The country has one of the lowest per capita healthcare expenditures in the world. Government contribution to insurance stands at roughly 32 per cent, as opposed to 83.5 per cent in the UK. The high out-of-pocket expenses in India stem from the fact that 76 per cent of Indians are yet to get health insurance.

Karnataka, Tamil Nadu and Andhra Pradesh governments have good government run cashless health insurances schemes for all benefitting rural

population to a large extent. North states are, however, lacking in providing comparative healthcare facilities. Delhi government last year announced a new scheme that provides comprehensive health insurance cover.

The situation may dramatically change soon as the government is introducing universal health protection scheme called Ayushman Bharat. Twenty five states have already signed with the Union Health Ministry till end of June to start the scheme.

Union Health Minister further said that Ayushman Bharat will provide comprehensive healthcare to the people as 1,50,000 sub-centres will be converted into Health and Wellness Centres (HWCs). "The H&WC would provide preventive, promotive, and curative care for non-communicable diseases, dental, mental, geriatric care, palliative care, etc, he said. "It will be cashless and paperless access to services and will be available for the beneficiary families at the point of service in both public and private empanelled hospitals across India," He further said that the beneficiaries under the scheme can avail services anywhere in India and it is expected to bring a visible relief to the target families by mitigating the financial risk arising out of catastrophic health episodes.

The scheme will cover over 10 crore poor and vulnerable families (approximately 50 crore beneficiaries) providing coverage upto 5 lakh rupees per family per year for secondary and tertiary care hospitalization. Ayushman Bharat - National Health Protection Mission will subsume the on-going centrally sponsored schemes - Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme (SCHIS).

At the national level to manage, an Ayushman Bharat National Health Protection Mission Agency (AB-NHPMA) would be put in place. States/ UTs would be advised to implement the scheme by a dedicated entity called State Health Agency (SHA). They can either use an existing Trust/ Society/ Not for Profit Company/ State Nodal Agency (SNA) or set up a new entity to implement the scheme. States/ UTs can decide to implement the scheme through an insurance company or directly through the Trust/ Society or use an integrated model.

According to officials of Health Ministry, the expenditure incurred in premium payment will be shared between Central and State Governments in specified ratio as per Ministry of Finance guidelines in vogue. The total expenditure will depend on actual market determined premium paid in States/ UTs where Ayushman Bharat - National Health Protection Mission will be implemented through insurance companies. In States/ UTs where the scheme will be implemented in Trust/ Society mode, the central share of funds will be provided based on actual expenditure or premium ceiling (whichever is lower) in the pre-determined ratio.The mission will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data covering both rural and urban. The scheme is designed to be dynamic and aspirational and it would take into account any future changes in the exclusion/ inclusion/ deprivation/ occupational criteria in the SECC data.

Conclusion:

Healthcare delivery in rural India is now uniquely poised to undergo a change at all its stages — prevention, diagnosis, and treatment , as the government focus on the sector has increased a lot in the recent past. The real change will come when public and private sectors come together to fill in the gaps and ensure that medical personnel are deployed in adequate numbers in rural India. The sector can evolve with the use of innovation to bridge intent and execution. The future ahead appears promising.

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