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Health Infrastructure In Rural India: Issues And Challenges

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Abstract

Health is a fundamental human right and a worldwide social goal. Health is necessary for the realization of basic human needs and to attain the status of a better quality of life. Health sector is complex with multiple goals, multiple products and different beneficiaries. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where only 27% of the population lives. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the life expectancy (63 years), infant mortality rate (80/1000 live births), maternal mortality rate (438/100 000 live births); however, over a period of time some progress has been made. To improve the prevailing situation, the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in an holistic way, with a genuine effort to bring the poorest of the population to the centre of the fiscal policies. A revised National Health Policy addressing the prevailing inequalities, and working towards promoting a long-term perspective plan, mainly for rural health, is imperative. In this paper, we describe status of our health system, health system prevails in the rural India, and the three tier health infrastructure existed in the rural area, the role of national rural health mission and also the role of rural health insurance.

The Context

Health is a state subject under the Indian Constitution and the State is responsible for the delivery of health services. India's health care system is characterized by a mixed ownership pattern practicing different systems of medicine. There are two major groups in the provision of health care services in the country. These are the public health sector and the private health sector. Recent national surveys have shown that in both rural and urban areas, dependence on private sector for outpatient and inpatient services has substantially increased over the last decade. The private health sector is the dominant sector in the health care system of the country.

With more than one billion people, India is the second most populous country in the world accounting for 17% of the world's population. Following independence, India has pursued a policy of planned economic development until the early 1990s, when it shifted to structural adjustment policies and liberalization. Subsequently, the Indian economy grew at a fast rate though concerns on equity and poverty persist. The country has recently become one of the world's fastest growing economies with an average growth rate of over eight percent in last three years. At the same time, new public health challenges have emerged in the form of changing demographics and environmental conditions; emerging infectious diseases and anti-microbial resistance, behavioral issues influencing health and the increasing focus on non-communicable diseases. Globalization and trade agreements, technological advances in genetics and medicine, and health informatics hold forth the potential for more rational, evidence-based management in health care. The health system in India has witnessed major changes in public health in the recent decades. Post independence, the country has made significant strides on many health fronts and these must be rightfully acknowledged such as increased life expectancy, reduction in maternal and infant mortality and eradication of smallpox. However, the country is still far from achieving its population health goals. High levels of maternal mortality, infant and child mortality and malnutrition continue to plague many parts of the country, coupled with significant variations across states.

Together with maternal and newborn conditions, communicable diseases including HIV, TB, malaria, diarrhea and acute respiratory infections account for nearly half of India's disease burden. The pressure of a burgeoning population, 72% of which is rural, with widespread illiteracy and social deprivation, pose a formidable challenge for the health sector's functioning. Added to this is the response that is needed, in times of disaster and during sudden unexpected outbreaks of disease.

The perception of human resources in India depends on the eye of the beholder: it can appear as a half empty glass or just as equally it can appear half full. Leveraging the country's existing human resources and planning for tomorrow is an ongoing challenge. Nonetheless, it is important to approach the underlying issues with a forward-looking perspective that brings together the pragmatism of resource planning with the strength of evidence. Health workforce is central to advancing health. The health sector, more than any other sector, depends on people to carry out its mission. In any health care system, it is health workers— professionals, technicians, and auxiliaries—who determine what services will be offered; when, where, and to what extent they will be utilized; and as a result, what impact the services will have on the health status of individuals. The success of health activities depends largely on the effectiveness and quality with which these resources are managed. Health workers are not just individuals but integral parts of functioning health teams in which each member contributes different skills and performs different functions. Developing capable, motivated and supported health workers is essential for achievement of national and global health goals.

Health in Rural India

Rural people in India in general and tribal populations in particular, have their own beliefs and practices regarding health. Some tribal groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo. They therefore seek remedies through magico-religious practices. On the other hand, some rural people have continued to follow rich, undocumented, traditional medicine systems, in addition to the recognised cultural systems of medicine such Ayurveda, *Unani*, *Siddha* and naturopathy, to maintain positive health and to prevent disease. However, the socioeconomic, cultural and political onslaughts, arising partly from the erratic exploitation of human and material resources, have endangered the naturally healthy environment. The basic nature of rural health problems is attributed also to lack of health literature and health consciousness, poor maternal and child health services and occupational hazards.

The health care infrastructure in rural areas has been developed as a three tier system and is based on the following population norms:

Centre	**Population Norms**	
	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Sub-Centers (SCs):

The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM) / Female Health Worker and one Male Health Worker. 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. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. Under the Swap Scheme, the Government of India has taken over an additional 39,554 Sub Centers from State Governments / Union Territories since April, 2002 in lieu of 5,434 Rural Family Welfare Centres transferred to the State Governments / Union Territories. There are 1,47,069 Sub Centres functioning in the country as on March 2010.

Primary Health Centers (PHCs): 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 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. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, promotive and Family Welfare Services. There are 23,673 PHCs functioning as on March 2010 in the country.

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, 2009, there are 4,535 CHCs functioning in the country.

The majority of rural deaths, which are preventable, are due to infections and communicable, parasitic and respiratory diseases. Infectious diseases dominate the morbidity pattern in rural areas (40% rural: 23.5% urban). Waterborne infections, which account for about 80% of sickness in India, make every fourth person dying of such diseases in the world, an Indian. Annually, 1.5 million deaths and loss of 73 million workdays are attributed to waterborne diseases. Three groups of infections are widespread in rural areas, as follows.

1. Diseases that are carried in the gastrointestinal tract, such as diarrhoea, amoebiasis, typhoid fever, infectious hepatitis, worm infestations and poliomyelitis. About 100 million suffer from diarrhoea and cholera every year.
2. Diseases that are carried in the air through coughing, sneezing or even breathing, such as measles, tuberculosis (TB), whooping cough and pneumonia. Today there are 12 million TB cases (an average of 70%). Over 1.2 million cases are added every year and 37 000 cases of measles are reported every year.
3. Infections, which are more difficult to deal with, include malaria, filariasis and *kala-azar*. Malnutrition is one of the most dominant health related problems in rural areas. There is widespread prevalence of protein energy malnutrition (PEM), anaemia, vitamin A deficiency and iodine deficiency. Nearly 100 million children do not get two meals a day. More than 85% of rural children are undernourished (150 000 die every year).

The alarming rate of population growth in rural areas nullifies all developmental efforts. Since 1951, the government has been attempting through vertical and imported programs to combat the problems, but to no avail. However, the new National Population Policy 20005 gave emphasis to an holistic approach; for example, improvement in 'quality of life' for all, no gender bias in education, employment, child survival rates, sound social security, promotion of culturally and socially acceptable family welfare methods.

While the current need for rural areas is medical and paramedical manpower, such as social physicians, public health nurses and midwives and paramedical workers (e.g. laboratory technicians, rural health and sanitation workers, health literacy educators, population educators, community health guides, community oral health guides), the country has been concentrating on producing specialist doctors. Some of the rural health technologies propagated is inappropriate, such as ORS packets instead of locally available water and cooked cereals, sugar–salt solution and herbal teas, which are culturally accepted by the community.

Commercialization of Health Sector

The disillusionment and frustration with the growing ineffectiveness of the government sector is gradually driving poor people to seek help of the private sector, thus forcing them to spend huge sums of money on credit, or they are left to the mercy of 'quacks'. While estimates vary, the government

probably accounts for no more than 20–30% of total health spending. The share of the private sector has grown from 14% in 1976 to 67% in 1993. About 67% of all hospitals, 63% of all dispensaries and 78% of all doctors in India are in the private/corporate sector. Much has been experienced and written on the growing privatization and commercialization of the medical practices and their links with drug and medical instrument manufacturers.

While WHO recommends about 130 essential drugs, as many as 4000 drugs are available on the Indian market. Due to this, 'buying' healthcare has gone beyond the reach of the rural poor. Two recent all-India surveys (NSSO 46th round and NCAER, New Delhi), have shown that medical treatment is the most important cause of rural indebtedness, next only to dowry.

Status of Health Infrastructure in Villages

Infrastructure/Services	Percent Villages
Connected with Roads	73.9
Having any Health Provider	95.3
Having Trained Birth Attendant	37.5
Having Anganawadi Worker	74.2
Having a Doctor (Private & Visiting)	43.5
Having a Private Doctor	30.5
Having a Visiting Doctor	25.0

Note: Any Health Provider includes: Private Doctor, Visiting doctor, Unani doctor, Ayurvedic doctor, Homeopathic doctor etc

Strengthening of Rural Health Infrastructure under National Rural Health Mission

Rural India is suffering from a long-standing healthcare problem. Although more than 70 per cent of its population lives in the village, only 20 per cent of India's hospital beds are located in rural areas. Most of the health problems that people suffer from in the rural community and in urban slums are preventable and easily treatable. In view of the above issues, the National Rural Health Mission (NRHM) was launched by the Government of India (GOI) in April 2005. It seeks to provide effective healthcare to the rural population throughout the country with special focus on eighteen states, which have weak public health indicators and/or weak infrastructure. These states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal, and Uttar Pradesh. The GOI will provide funding for key components in these eighteen high focus states. The NRHM will cover all the villages in these eighteen states through approximately 2.5 lakh village-based 'Accredited Social Health Activists' (ASHA) who will act as a link between the health centres and the villagers. One ASHA will be raised from every village, or cluster of villages, across these eighteen states. The ASHA will be trained to advise village populations about sanitation, hygiene, contraception, and immunization to provide primary medical care for diarrhoea, minor injuries, and fevers; and to escort patients to medical centers. They would also be expected to deliver direct observed short course therapy for tuberculosis and oral rehydration, to give folic acid tablets and chloroquine to patients, and to alert authorities of unusual outbreaks of disease. ASHA will receive performance-based compensation for promoting universal immunization, construction of house hold toilets, and other health care delivery programmes.

The goals of the NRHM iclude:

- Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio (MMR);
- Universal access to integrated comprehensive public health services;
- Child health, Water, Sanitation and Hygiene;
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases;
- Population stabilization, gender, and demographic balance;
- Revitalization of local health traditions and main-stream Ayurvedic, Yoga, Unani, Siddha, and Homeopathy Systems of Health (AYUSH);
- Promotion of healthy lifestyles.

The strategies to achieve the goals include:

- Train and enhance capacity of Panchayat Raj Institutions (PRIs) to own, control and manage public health services;
- Strengthening sub-centre through an untied fund to enable local planning and action (each sub-centre will have an Untied Fund for local action at Rs 10,000 per annum).

- Provision of 24 hour service in 50 per cent PHCs by addressing shortage of doctors, especially in high focus states, through mainstreaming AYUSH manpower;
- Preparation and implementation of an inter-sectoral District Health Plan prepared by the District Health Mission, including drinking water, sanitation, and hygiene and nutrition;
- Integrating vertical Health and Family Welfare programs at National, State, Block, & District levels.

Limitations of NHRM

- There is no data from pilot studies on the technical, operational and administrative feasibility of NRHM implementation in any state of the country. There is no corrective action plan in case of failures.
- Currently, regular village level health functionary at a salary of Rs 8000–10,000 per month is not easily available. It is envisaged that this lacuna will be bridged by ASHA, who being a local resident, would be available in the village and act as a link in the provision of primary health care services to the community. In fact, the introduction of ASHA, rather than enhancing the ANMs performance, may actually increase the existing indiscipline amongst the regular village level health functionaries. There appears to be some ambivalence in the role and location of ASHA. She is to act as a bridge between the ANM and the village and, at the same time, she is to be accountable to the panchayat. When the ANM (who is a functionary of the Health Department) herself is not accountable to the panchayat, how is the ASHA supposed to do the balancing act between the ANM and the panchayat?
- A greater part of the mission's tenure will be spent on training with little or no time to assess the impact.

Rural Health Insurance

Around 70 per cent of India's population lives in villages. Of this, less than 2 per cent is insured. Though the rural health insurance market is huge, it has so far remained untapped. The private sector is likely to be a significant investor in health care infrastructure in rural areas, as rural incomes increase, and the spread of the road network improves accessibility. Recently, IRDA constituted a committee to chalk out a plan for spreading health insurance in rural areas. Various micro-health insurance schemes are to be studied under the proposed plan. Around 25 such schemes currently run in rural India, most of which are attached to micro-finance institutions.

Karuna Trust, Karnataka

Karuna Trust is an NGO that has been working successfully on health and development issues for nearly two decades. In 2002, Karuna Trust, in partnership with the United Nations Development Programme (UNDP), decided to implement a pilot health insurance scheme for its target population. The NGO collaborated with the state-owned National Insurance Company (NIC) in designing a health insurance product that complements the public healthcare infrastructure and compensates for some of its weaknesses. Karuna Trust acts as an agent for NIC. The insurance product compensates the insured for the loss of income in case of hospitalization at a public health facility. Furthermore, a drug fund has been set up to supply medicines that are unavailable in public facilities. People with incomes around the poverty line receive treatment in public health facilities free-of-charge. A tight network between the insurance scheme and the public infrastructure has evolved.

Yeshasvini Trust, Karnataka

The Yeshasvini Cooperative Farmers Health Scheme is a young but incredibly successful micro insurance scheme in Karnataka. Having started in 2003 with 1.6 million insured right away, it covered 2.2 million lives in its second year of operation, but in the third year it dropped to 1.45 million members after the premium was doubled. This amazing success was made possible by a tight partnership with the cooperative sector enabled through the Karnataka Department of Cooperation. The department used its influence to encourage cooperative societies to market the product actively. The marketing strategy applied by the societies' secretaries varied: while most convinced their members to join, a few simply enrolled their members unilaterally.

Healing Fields Health Insurance

Healing Fields Health Insurance Scheme is run by Healing Fields Foundation, an NGO along with grassroot Micro-Finance Institutions (MFIs) and HDFC General Insurance Chubb, covering 25,000 lives in seven districts of Andhra Pradesh since one year. It is run with eighteen network hospitals and several self-help groups managed by fifteen NGO partners.

Limitations of Rural Health Insurance

Lack of awareness about various schemes has been one of the hindrances in spreading rural health insurance. If the government wishes to cover the population for lessening debt burden and promote the cause of poverty reduction, then insurance policy should cover common illnesses for which people take loans. Each of these schemes has its own strengths and shortcomings. For instance, Yeshaswini Insurance Scheme which had 16 lakh farmers enrolled in the first year faced a large dropout in the second year as the scheme covered only surgeries and not routine medical problems. Also the risk is not covered by an insurance company and is subsidized by the government. Experts feel that there should be an insurance company or a separate mechanism to fund the scheme. Others like Healing Fields, though successful, cover only a small section of the population.

Conclusion

Rural Health care services suffer from a shortage in public sector infrastructure. The failure of the public delivery system today is an outcome of systemic breakdown of accountability relationships within the institutional framework. There is a shortfall not only in terms of physical infrastructure but also human resource, measured even against the minimal norms prescribed by the government. Most health workers especially the 'doctors' do not want to serve in the rural areas due to overall infrastructural inadequacy and lack of incentives. The public doctors quite often provide private services instead of going to their designated centres. Even though a well-structured public health care system exists, the infrastructure as well as the staff that is required to provide the health care services is inadequate from many different perspectives. Many rural residents are not able to obtain treatment for basic ailments either due to the non-presence of health care services in the vicinity, or due to lack of funds to access the same. Even for basic health care services such as reproductive and child health, we find that significant proportions continue to remain untreated. Today private sector health care provision in rural areas is *greater* than that by the public sector. Under the new scenario, regulatory mechanisms and the role of new information technologies have come under the scanner as possible solution baskets in providing accessible and effective quality healthcare to the vast Indian rural populations. Thus, ineffective and inadequate public service has paved way for the growth of the private sector health care in the country. The private sector is not only filling up the gaps left by the public sector but is also emerging as the key player in terms of service provision. But in terms of quality of service both the public and the private sector have failed

Introducing mobile medical vans in the rural areas can solve the problem of accessibility. Mobile vans equipped with basic medical facilities could supplement a primary health centre and travel to those areas where the primary health centers do not exist or have failed to meet the requirements of the people. These vans could have a schedule of visits in particular areas and could also be called in times of emergency. The introduction of adequate mobile vans could solve the problem of accessibility to a great extent and more efficient and quality services could reach at the grassroot level. The quality of service can be improved by increasing the awareness level of the users. Government along with private providers should try to establish the consumer information and redressal cells more effectively. This will not only improve the quality of service but also increase the accountability of the service provider. It is expected that if the Common Service Centre programme (rural computerization) of the government is functional within the stipulated time period then many of these problems could be minimized if not solved completely. Regulations will require an overseeing mechanism that is not feasible or practical in the current scenario. Over all, the private sector is here and will be the dominant force in all sectors including rural health care. This should not be ignored, rather it should be considered as a starting point for all future thoughts on health care policy formulation. The best way to control poor

practices is through greater consumer awareness, consumer redressal mechanisms, and through community action. These are now increasingly possible due to changes in information and medical technologies.

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