CHAPTER 8

Conclusions and Suggestions
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CONCLUSION AND SUGGESTIONS

Health is the most precious component for prosperity and all around development of the society and nation. Our present thesis ‘examines the role’ of the health sector of rural areas which is covered by PHCs/CHCs and sub-centres and equitable access to basic services and the inefficiencies of PHCs in delivering the health system. Expansion of health and medical services in India had been irregular and unbalanced as well as inadequate in all respects. The ratio of hospital beds to population in rural areas is lower by 15 times from urban areas. The ratio of doctors to population is about 6 times lower than that in the urban population. Government’s expenditure per capita on public health is even seven times lower in rural areas, compared to spending in urban areas. Our study is very important as it examines the health delivery mechanism, health and nutrition programmes, health care delivery system of primary health centres, its organizational structure and progress of PHCs. It also explores the impact of primary health centres on sample patients which in turn assist the planner to improve the working of primary health centres.

Demand for health and medical care is derived from the more fundamental demand for good health. The health demand is the relationship may be used to produce good health. The major factors that influence medical care demand are categorized as patient factors and physician factors. Patient factors include health status, demographic characteristics, and economic standing. Physicians affects demand through their standing as both providers of medical services and advisers to (or agents for) their patients.
Supply side of health depends upon health care services available to its population. Health care services are provided by the government or the public sector and the private sector, hospitals and physicians and health workers. In the rural areas generally government sector or public sector provides health facilities. There also exist private doctors, untrained doctor and health workers. Supply side of health sector depend number of hospitals, dispensaries, nurses and other untrained doctors. In broad term the supply side of health sector depends on numbers of hospitals, drugs availability, infrastructure, machine, bed availability.

PHCs provide health services in the rural areas. District Auraiya has seven blocks: (1) Auraiya, (2) Bhagyanagar, (3) Achhalda, (4) Bidhuna, (5) Ajitmal, (6) Erwakatra, and (7) Sahar. C.M.O. office is responsible for all types of medical services in the district. It provides manpower, basic infrastructure and equipments to all its hospitals/ dispensaries and centres. This office allots funds to all its hospitals/dispensaries and centres keeping in view the health needs. Health indicator depicts the picture of health status of the district. At present there is huge shortage of staff in the form of doctors, paramedical and others in district Auraiya. We have made an intensive survey of eight primary health centres from four blocks and a total of 200 respondents (patients) were surveyed to assess the role of PHCs in providing health care services. Though there is a set of standard by health ministry for PHCs/CHCs and Sub-centres but empirical evidence tells another story.

Our study of primary health care centres shows that Indian health system is facing many problems. The promotion of the health is very important as it affects the quality of life and access to basic necessities. Providing health to all is very important aspect including safe drinking water, sanitation and nutrition. India has made substantial achievement in
the health sector. Our health indicators have increased positively. However, there are many problems in the Indian health system especially the rural sector. The rural poor are neglected. They are unable to make use of available health services. Therefore, few health indicators shows India’s failures in the rural health sectors like- levels of malnutrition, infant mortality, MMR. At present life expectancy of birth, IMR and MMR are worse than those of Bangladesh and Sri Lanka. So there is need to restructure our health sector especially in rural areas. Following suggestions are given for restructuring of health policies and proper working of exiting health centres:-

1) **Health and Inclusive Development:** Health is a basic right, resource and outcome for inclusive development. Health is important across all Minimum development Goals (MDGs). Three of eight MDGs goals focus on health i.e. reducing child mortality, improving maternal health and combating HIV/AIDS, Malaria and other diseases. The aim of development cannot be realistic without checks in the spread of fatal diseases. The assurance of health provides space for the inclusion of each person without discrimination in the development process. So the health care facilities needs to be developed at all levels. In the rural areas role of PHCs is very important in health care. They needs to be strengthened.

2) **Low Percentage of Expenditure in Health:** During the planning period there is huge increase in health expenditure but overall the health expenditure as percentage to GDP is low in India in the health sector. The expenditure in health to total expenditure is 1.1

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per cent in 2009 in India which is very low as compared to developed nations. So there is need to increase investment on public expenditure. Problem specific and location specific attention should be given in the health care. Emphasis should be given to supply of essential drugs, vaccination, clean drinking water and sanitation. Awareness about health education and of clean environment should be created among the people of the country which will be useful in reducing the disease burden of the nation.

3) **Public-Private Participation Programmes:** Public-private participation strategy in the health sector in U.P. will be most beneficial. So government must create conducive atmosphere for this through fiscal incentives. Full and clear support by the government in the health sectors for the PPP programme and specific PPP projects should come from the highest political level of government to the lower level. PPP projects must have clear policy framework regarding objectives, strategies and operationalization of health projects. The public and private sectors must work together, keeping the health projects and the outcomes in focus and collaborate for mutually enduring values. Focus of these should be ‘Health for all’.

4) **Lack of Awareness about Health Education**— Rural health is complex and multi-dimensional which can neither be understand nor can be assessed by the quantitative approach alone. Its qualitative dimensions are equally important. We cannot reach the in depth realities only through data-base studies. The age-old traditions, rituals, practices and the folk-songs reflect a level of awareness about various health related issues. These are, infect not only a source of information, but an institutions for promoting and
safeguarding the harmonious relations, mass-participation, mutual support and maximum transparency.

Education can play an important role in determining the health status of population. One might also expect the health related child care to improve with the level of the mother’s education. In the rural areas of our country health awareness is not found. People neglect many diseases at the primary level. They also fear from vaccination programmes. So health education must become an integral part of all general education and should receive adequate emphasis; in the rural areas. Health education must also be an essential component of all health care and the health care services must assume special responsibility for the health education of the poor who need it most.

5) **Need to Increase Public Investment in Health and Reduce Disparities:** It has been observed that household incurred maximum expenditure on outpatient care and minimum expenditure on contraceptives. Therefore, government must allocate much higher levels of resources for the health sectors. There is a dire need to enhance public investment on medical and public health as well as on family welfare.

The allocation of expenditure in health planning needs to be emphasized. It may be important to focus more attention on reduction in inter-state differences in health expenditure. It is important to argue in favour of public spending on low-income states. Increased public investment on health will help to reduce the burden of health expenditure on the households.
6) **District wise Health Plans:** Some bureaucrats at the top often blame failure of health sector to cover rural poor on low absorption capacity of states and oppose increased budget for health. This is not true because at the level of delivery of health care there is persistent demand for resources. Those who deliver health care, who understand and know the situation and hence can plan and budget the resources, have no role in decision making and those who govern from the state and national capital take all decisions without having a clue to the ground realities. Therefore, health policies must be framed at district level keeping in view the regional demands of that area.

7) **Training Programme for Health Personal:** Many untrained staff in rural areas examine the rural poor. So the treatment of rural poor is not done properly which causes many problems. So there is an urgent need to set up the tempo of training of doctors, nurses, ANMs and other health and paramedical workers through various training programmes. Medical education and training programme should be expanded in tune with requirements temporally and spatially. If the country has to benefit from its potential; there is no alternative but to employ many more health and medical personnel, paid by the public exchequer.

8) **Health Insurance:** Illness is one of the major problems for the families and also less predictable which is associated with physical weakness and income loss. Loss of income invariably affects current and previous income and assets. The consequent effect of illness is to reduce labour supply and production. Health insurance is a suitable relief to reduce the burden of health expenditure of marginalized groups.
However, the poor are unable to pay the premium for these insurance. Hence, the government must provide subsidy for them and also cover exclusive medical insurance schemes for these marginalized groups. At present few health insurance schemes are running but they are not working properly. So there is also need to restructure the present health insurance schemes.

9) **Lack of Health Staff:-** There is a lack of adequate medical personnel in India despite the large number who enter the profession each year. Besides there is an uneven distribution throughout the country, with excessive shortage in rural areas. Compulsory posting of two years in some medical colleges is inadequate. Rural postings are not taken very seriously. Both motivation and commitment is lacking and posting on outskirts of big towns which come in the rural category are preferred to interior areas. Our PHCs are running without doctors and paramedical staff. Hence proper health staff at PHCs must be ensured.

10) **Increase Flow of Funds in the Health Sector-** PHCS required increase in flow of funds for proper functioning. Better infrastructure development, good governance must be ensure at all levels. Favourable investment climate should be created to attract, private and direct foreign investment. It will also increase the health status of rural areas which is very low at present. It will bring better doctors, equipments and pathological laboratory which will finally improve the health status.

11) **Improving the Quality of Public Health Services:-** For improving the quality of public health services it should be ensured that PHCs and CHCs must have proper staff and have sufficient and regular supply of medicines and the facilities of labs for the
conduct of pathological and other tests. If the PHC and CHC provide quality health care services the exodus to the district hospital will automatically be curtailed and the hospital will then be used mainly for the treatment of serious cases referred to it from the PHC or the CHC. There should be shift in government expenditure in favour of PHC and CHCs, which is more equitably shared by people.

In the PHCs where doctors are not willing or available to work full time, public health professionals may be appointed who will be trained to comprehend the backward and forward linkages between prevention and mitigation of illness. If even public health professionals are not available then the PHC should be headed by fully trained nurses/compounders as per the norms in the NRHM.

Management of PHCs and CHCs should be brought under the control of the PRIs, so that they are effectively supervised at the local level and become accountable and responsible to the local people rather than the higher authorities. This will also ensure presence of the medical personnel in the hospitals and Centres.

While providing curative care services at subsidized rates the government must ensure that they are being availed by only the eligible sections of the society. Only people living below the poverty line may be provided free facilities provided they produce their BPL ration card.

12) **Increase in Charges in PHCs/CHCs:** Even in the rural areas people are going to private doctors. Moreover, even the patients who go in for free treatment in the government hospitals are paying money for some medical facilities such as pathological and radiological tests and operations. Thus, people are willing and able to pay for health care.
It is well known that the governmental hospital particularly PHCs and CHCs are invariably faced with the problem of shortage of medicines. In many hospitals and PHCs doctors and other medical staff are not always available. This forces patients to go for treatment to private doctors or clinics. It is only when the people start contributing at least part of the cost that the state government will be able to generate greater revenue which can be used for providing better medical care facilities particularly in the rural areas. Not only the increases in revenue through increased user fees can augment the financing of under-financed recurrent inputs such as medicines and in improving the quality and effectiveness of the health services. User fees can bring about improvement in the equity of health system by charging from those who can afford to pay.

13) Public Provision for Health Services: In the absence of strong public financing of the health care system, a poor household facing to illness may be forced to spend a large fraction of its resources on healthcare at the expense of other goods and services. In fact, smaller role of the public in total health expenditure not only increase the burden of health care financing on the household sector but also it may have a disrupting impact on the living standards of households, particularly in case of health exigencies. Hence, the performance of the health care system in a country can be accessed through the extent to which households are protected from unforeseen expenditures on health care. Thus, the public provision for health services is very important, not only to provide low cost and quality treatment in case of people suffer from diseases/illnesses, but also to promote health status by preventing
occurrence of diseases among people. So public provisions for health services must be enlarged.

14) **Vertical and Horizontal Imbalance in the Health Sector:** The concept of public health was initially developed and implemented by the government of India soon after independence in the field of maternal and child health but was soon adopted for all other disciplines. Since healthy man-power is a basic pre-requisite for development of the nation, the responsibility of maintaining public health rests with the government. India must build up a vast health infrastructure and man-power at primary, secondary, and tertiary health care in government, voluntary, and private sectors which will result in substantial improvement in health indices of the population and a steep decline in morbidity and mortality.

Expansion of health and medical services in India has been irregular and unbalanced as well as inadequate in all respects despite government efforts. The imbalances in health and medical services are of two types; vertical imbalance under which health and medical services improved considerably in urban areas particularly in million plus cities, while the rural areas lagged far behind in all categories of health and medical facilities. The horizontal imbalance reflects the inter-state and intra-state deficiencies in the health infrastructure and services. It is the irony of the system that lakhs of people in far-flung areas of the country still do not have access to basic medical facilities.

15) **Health Care for Poor:** The share of private expenditure on health and medical care in total monthly expenditure of household increased considerably as a result of failure of public health care system. The situation draws the attention of the "Expert Group to
review the methodology for estimation of poverty" which was constituted under the chairmanship of Prof. S.D. Tendulakar. Tendulakar committee considered the private expenditure on medical care as an important factor of monthly expenditure of the household and included it in the estimation of poverty. The earlier poverty lines assumed that basic social services such as health and education would be supplied by the State and hence were not accounted for.

In view of the shortcomings of the public health system and the growing personal expenditure on private medical care, the PPP models should put forward as an alternate approach of health care. The PPP model of health care should be incorporate the facilities and infrastructure of private health care, together with the cost effectiveness of the public health care system that will improve the service delivery of health care system and lead to inclusive growth. However, free play of private sector might cause further negligence of down-trodden class so the PPP model must take care of this phenomenon. The interests of deprived sections of the society must be at the centre of the functioning of the PPP.

16) **Focusing on Health Equity:-** It is imperative that a system of National Health accounting, reflecting total government expenditure on health is established. This will enable periodic review and appropriate policy decisions regarding modalities for ensuring optimal utilization of the current government investment in the health sector and also future investments to meet public health needs. Focusing on health equity and increasing the allocation on health will be critical to enhance human capabilities and advancing the progress of Indian society over the next decade.
Health security in India needs to become an urgent national priority. Rapid improvements in health spending are needed not only to accelerate and sustain India’s economic growth; they are also fundamental to India’s gaining recognition as a distinguished country with improved standards of living and reduced levels of human deprivation.

17) **Access to Health Facility:**- Improved health services of, and access to, government facilities will have to continue as a major thrust areas of the policymakers. Unregulated expansion of the private sector health care market and the continuous poor record of the government health facilities implies that the poor will have to rely on the private sector, despite the significant cost differences. There should be successful collaboration between NGOs, the government, insurance companies and communities at large in many parts of India.

Now the time has come to look beyond the pre-dominantly reductionist bio-medical model of healthcare to a holistic model of healthcare that puts human beings in the centre and fulfils the objectives of inclusive growth.

18) **Vision for Health:**- Our health plans must provide an opportunity to restructure polices to achieve a new vision based on faster, board based and inclusive growth. One objective of the Eleventh five year plan is to achieve good health for people, especially the poor and under privileged. In order to achieve this, a comprehensive approach is needed that encompass individual health care, public health, sanitation, clean drinking water, access to food and knowledge of hygiene and feeding practices. The plan intends to facilitate convergence and development of public health system.
and service that are responsive to health needs and aspirations of the people.

19) **Strengthening of Primary Health Infrastructure and Improving Service Delivery:** There has been a steady increase in health care infrastructure available over the plan period. But there is still shortage of 20,486 sub-centres, 4,477 PHCs and 2,337 CHCs as per 2001 population norms. Further almost 40 per cent of the existing health infrastructure is in rented building. Poor upkeep and maintenance and high absenteeism in rural areas are the main problems in the public sector health delivery system. So health plan must seek to strengthen the public health delivery at all level.

20) **Access to Essential Drugs and Medicines:** Drugs and medicines from a substantial portion of the out of pocket spending on health by households. The component of drugs and medicines accounts for only 10 per cent of the overall budget of both Central and state Govt. Timely supply of drugs and good quality that improves procurement as well as logistic management is of critical importance in the health system.

21) **Imbalances in Demand and Supply of Health:** In this changing world the demand for health care system has increased. In U.P. also, this demand is increasing as population is increasing very steadily. Due to technological revolution in the world and also in the different parts of India, the people are very conscious regarding health care system. But what is the condition of demand and supply position in the sphere of health care? It is very unbalanced. It may be mentioned here that the national health policy 2002 aims at good health delivery as per demand of people so health policy should try to balance in achieving an acceptable standard of health
for general population of country. To achieve the objective of good health for the people, especially the poor and the under privileged, a comprehensive approach needs to be advocated which includes improvements in individual health care, public health, sanitation, clean drinking water and access to individual health care.

22) **Improvement in Health Equipments:** Lack of medical equipments/pathology facilities, x-ray machine etc. is major obstacle in the field of improving health status of the villagers. These medical equipments and pathological facilities are very essential for improving the health status. PHCs must be allotted special funds for improving these health facilities which will help the health personnel to diagnose the problems of ill health and in recommending proper drugs.

23) **Strengthening Sub-centres:** Following suggestions are given for strengthening sub-centres:

   a. Each sub-centre must have sufficient fund for local action.
   b. Sub-centre must be ensured with supply of essential drugs, both allopathic and AYUSH.
   c. Multipurpose workers (male)/ Additional ANMs wherever needed, sanction of new sub-centres as per 2001 population norm, and upgrading existing sub-centres, including building for new sub-centres functioning in rented premises must be considered.

24) **Strengthening Primary Health Centres** Following suggestions are given for strengthening PHCs for quality, preventive, promotive, curative, supervisory and outreach services, through paramedical officers:

   a. Adequate and regular supply of essential quality drugs and
equipments (including supply of auto disabled syringes for immunisation) to PHCs.

b. Provision of 24 hour services in at least 50% PHCs by addressing shortage of doctors, especially in high focus states, through mainstreaming AYUSH manpower.

c. Observance of standard treatment guidelines and protocols.

d. In case of additional outlays, intensification of ongoing communicable disease control programme, new programmes for control of non-communicable disease, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need.

25) Strengthening Community Health Centres:- Following suggestions are given for strengthening CHCs:

a. Operationalising existing Community Health Centres (30-50 beds) as 24 hours first referral units, including posting of anaesthetists.

b. Codification of new Indian Public Health Standards” setting norms for infrastructure, staff, equipment, management etc. for CHCs.

c. Promotion of Stakeholder Committees (Rogi kalyan Samitis) for hospital management.

d. Developing standards of services and costs in hospital care.

e. Develop, display and ensure compliance to citizen’s charter at CHC/PHC level.

f. In case of additional outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and recurring costs for the mission period could be considered.
26) **Suggestions regarding ASHA:-** Every village/large habitation should have a female Accredited Social Health Activist (ASHA) chosen by and accountable to the Panchayat to act as the interface between the community and the public health system. States to choose state specific models regarding services of ASHA and their linkages with doctors and paramedical workers. Following suggestions are given regarding ASHA.

a. ASHA must act as a bridge between the ANM and the village which is accountable to the Panchayat.

b. She should receive performance based compensation for promoting universal immunization, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programme.

c. She must trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organizations.

d. She must facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and self help group members, under the leadership of the Village Health Committee of the Panchayat.

e. She must be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components should be funded under financial envelope given to the states under the programme.

f. She must have a drug kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit should
be replenished from time to time.
g.ASHA should go through proper training coverage. Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training should continue throughout the year with help of paramedical workers.

27) **Access to Medicines, Vaccines and Technology:** Price controls and price regulation, especially on essential drugs, should be enforced. The Essential Drugs List should be revised and expanded, and rational use of drugs ensured. Public sector should be strengthened to protect the capacity of domestic drug and vaccines industry to meet national needs. Safeguards provided by Indian patents law and the TRIPS Agreement against the country’s ability to produce essential drugs should be protected. MoHFW should be empowered to strengthen the drug regulatory system. It will help in cheap supply of drugs and easy access to medicines, vaccines and technology.

28) **Health Accessibility:** It is one major issue, especially in rural areas where habitations are scattered and women and children continue to die on route to hospital. Nutritional supplements must be supplied to them. PHCs and CHCs should be connected by all weather roads so that they can be reached quickly in emergencies. Accessibility to hospital should be measured in travel time, not just distance from nearest PHC. Home based neonatal care should be provided including life saving measures. Concerned action should be taken such as enabling, pregnant women to have skilled attendance at birth. Our health plan must ensure availability of essential drugs and supplies, vaccines, medical equipment along with the basic infrastructure like electricity, water supply, toilets, telecommunications and computers for maintaining records.