CHAPTER IX

HEALTH CARE FACILITIES
Health care is the primary necessity of the society. The term health care includes health services which in turn implies organization, delivery, staffing, regulation and quality control. Health has been declared a fundamental human right. This implies that the State has a responsibility for the health of its people. The health of an individual, a family, a nation depends for the most part of factors outside the purview of the medical profession. In broader term the idea of health care embodies factors like adequate food, cleaned and ventilatory housing, primary sanitation, healthy life styles; protection against environmental hazards and communicable diseases. It can be illustrated like this that health care covers a broad spectrum of personal health services ranging from health education and information to prevention of diseases, early diagnosis and treatment and rehabilitation.

Health care has global magnanimous coverage. WHO also in its conference, 1985 at 'Alma Ata' laid down the following broad principle to implement the scheme of health care.¹

1. Every-one without exception has the right to health care.
2. Every-one without exception, has the right of access to the different levels of complexity of the health system.
3. Every-one, without exception, has the right to live in a

cultural, social-economic and physical environment inherently conducive to health.

4. Every-one, without exception, has the right and duty to be an active and decisive partner in looking after his or her own health and that of the community.

5. There must be a significant reduction in the enormous and disgraceful differences in the health level of different population groups both outside countries and within countries.

6. There must be a significant reduction in the enormous and disgraceful difference in the way national societies allocate resources (physical, technological, human, financial etc.) for the health care of their peoples.

7. To sum up, 'health for all' is a concept that incorporates a way of implementing a human right that the right of health within principles of universality equality and social justice.

There are three-tier system of medical facilities in the study unit. Primary health centre is the smallest unit and key point of medical facilities. The centres are generally located at the headquarters of the community development block. Sub-centres have been also recently established to rural people and is a part of PHCs which help them and provide adequate health coverage to such a large population.
In the study area PHC is the key point from which government provides the medical facilities to the people. Now-a-days government has also provided contact care facilities. If the patient is referred to hospital, it is secondary care. These facilities give the real picture of health condition of the people of an area or region. Mini PHC is the sensitive unit of the rural area the places which are situated far away from the PHC headquarters. Medical care is to cover their operational responsibility maternal and child health services, family welfare, nutrition, control of communicable diseases, protected water supply and environmental sanitation.

PHCs are connected with district hospitals and cover roughly 300 kilometres area. Generally, Primary Health Centres have vehicles, indoor facilities, male and female doctors, nurses, health visitors, vaccinators and other paramedical staff and are the only source of medical care for rural population. Most of the rural population do not get the facilities from PHC due to poor condition of roads and long distance.

District hospitals are the next health care centres where specialized treatment facilities are available. Primary health centres generally refer the complicated surgical, serious medical cases to the district hospitals. It differs from PHCs in the following respects:
<table>
<thead>
<tr>
<th>S.No.</th>
<th>District</th>
<th>Total Number of</th>
<th>Other Special Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Doctors Hospitals Beds</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Tikamgarh</td>
<td>65 15 165</td>
<td>Rural and urban welfare planning centre, Blood bank, Leprosy, Dental clinic, T B clinic, Public health laboratories, X-Ray machine.</td>
</tr>
</tbody>
</table>

Source: Joint Director, Divisional Health Office, Sagar.
1. Hospitals services provide mostly curative, preventive and promotive facilities.

2. It has no definite area of responsibility. Patients may come from any part of the country.

3. There are mixed teams of medical and para-medical workers, viz. doctors, compounders, nurses, etc.

4. There is one Chief Medical Officer (CMO) with three deputy CMOs. Deputy CMO being in charge of one third of the PHCs in the district.

Generally district hospitals have maternity homes, children hospitals, TB clinics, public health laboratories, X-ray machines etc. facilities separately. Besides this, Blood Bank, family welfare centres, dental clinic, eye-clinic, expanded programme of immunisation are also available in these places. District hospitals may also refer the serious/complicated cases to the medical colleges or specialized treatment centres of the country.

Medical college hospitals provide modern treatment facilities. At present Madhya Pradesh has six medical colleges but the study area has no facilities of this type of college.

There are equitable distribution of rural urban welfare planning centre, blood bank, dental clinic, TB clinic, public health laboratories in each of the five districts of the area whereas STD clinics (VD) and filaria laboratory are
located in Chhatarpur and Panna districts. These two types of units are not to be seen in other districts.

PRIVATE SECTOR

Private practitioners also have a largest area of the study unit. But extra ordinary the distribution of private doctors is highly equitable. Private doctors are mainly concentrated in district headquarters. It is a miserable fact that in Sagar city no famous doctor having high qualifications seeks any place for his profession in the neglected areas of the region. The number of doctors specialized and others are greater in Sagar district while other district places lack this class of doctors.

Quacks or unqualified doctors are normally take health care in rural areas. Although they are treating the patients since long time in responsible area and they have their permanent hospitals, so people have also more faith on them in comparison to government doctors if any. In almost every town of 5,000 population such quacks and unqualified doctors can be spotted. They have charming income because of their easy accessibility and good behaviour with the visiting patients. They treat only minor cases but where encountered with a complicated case, they would deal with it at the initial stage or refer them to other doctors of the towns and/or district hospitals.
The only single doctor who runs his Eye Clinic in Khurai town (Sagar district) is seen flooded with patients from all over the adjoining districts. A few private doctors have their own private hospitals which have more facilities like polyclinics, nursing homes, dispensaries and surgical facilities.

Nowadays a new trend in medical profession among government doctors has emerged which can be clearly observed in district places that mostly these doctors have opened their own clinics in the towns of their postings for private practice and they pay more attention to the patients who turn up to their clinics rather than to the patients who contact in district hospitals.

DISTANCE AND HEALTH CARE

Another important aspect in the study of health care is the distance between a place and the health facility centre. The total geographical area of the entire study region is 3820.3 kilometres. Whole of the area is dotted with a network of 38 primary health centres. Besides there are 45 mini PHCs and 43 civil dispensaries functioning in the region. About 41 per cent of the villages and about one third of the total rural population of the country have access to the health facility within two kilometres of distance. On the other hand, more than 80 per cent total urban population have the facilities within two kilometres of the country.
SAGAR DIVISION

Proximity of Primary Health Centres

1986

Distance:
- 10 Km.
- 5 Km.

Source: Divisional P.H.E. Office, Sagar
A separate map having 38 PHCs each showing its operational area in kilometres is annexed. The cursory glance at the map (Plate No. 14) shows that the distance from one PHC to another in Sagar, Damoh, and Tikamgarh districts are less so that the population of this area has not to travel long to reach the PHC for treatment. A patient is generally not able to walk more whereas uneven distribution of PHCs in some of areas of the study unit make them walk more. For example, in Panna district only five PHCs are there which are at a great distance that the patients from certain villages are supposed to cover the distance of even 30 Kms to reach the nearest PHC for them. For example, the personal visit to village 'Laundhi' and 'Mahod' in Panna PHC ascertains that the nearest PHC for the inhabitants of these villages is the Pawai PHC which maintains a distance of 30 Kms and 20 Kms respectively from these villages. This situation makes it clear that the distribution pattern of the PHCs in the study unit is not even so that are not easily accessible. At point it is highly concentrated while on the other, it is found to be improperly and highly scattered. Chhatarpur district also faces this difficulty but not to the extent Panna district does.

The comparative analysis of Sagar, Damoh, Tikamgarh districts on the one hand (being the area of concentration) and Chhatarpur and Panna on the other (being the scattered area) would lead to show that the concentrated areas
percentage in placial and health facilities coverage is higher than that of scattered areas of Panna and Chhatarpur districts.

The former group of districts is equipped with 66 per cent of PHCs in proportion to the total existing in the entire unit, while the area coverage is 59 per cent of the total area. The remaining two PHCs involving the scattered area have their similar percentage at 34 per cent and 41 per cent respectively. It is thus quite evident that villages of concentrated area have more health facilities at the short distance while those of the other have to undertake long journeys facing several troubles in different weathers.

HEALTH FACILITIES

The area coverage the number of existing PHCs and the extent of population involved are the main factors which decide the different ratios of hospitals, doctors and beds. Larger the area, higher the number of PHCs and therefore, more facilities to the population. Table 9.2 depicts that Sagar is the richest in doctor population ratio. Tikamgarh is in population bed ratio and Ajaygarh tahsil is in hospital ratio. These three tahsils have the ratio 1175, 7887 and 17867 respectively.

BED-POPULATION RATIO

Bed facilities depend upon the capacity of hospitals. It is necessary to the patients taking their treatment in the
### TABLE 9.2

**TAHSILWISE MEDICAL FACILITIES**

*(1986-87)*

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Tahsil</th>
<th>Number of</th>
<th>No. of persons per</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Bed</td>
<td>Doctor</td>
</tr>
<tr>
<td>1</td>
<td>Khurai</td>
<td>44</td>
<td>21</td>
</tr>
<tr>
<td>2</td>
<td>Banda</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>Sagar</td>
<td>450</td>
<td>58</td>
</tr>
<tr>
<td>4</td>
<td>Rehli</td>
<td>32</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>Panna</td>
<td>154</td>
<td>30</td>
</tr>
<tr>
<td>6</td>
<td>Pawai</td>
<td>24</td>
<td>9</td>
</tr>
<tr>
<td>7</td>
<td>Ajaygarh</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>8</td>
<td>Damoh</td>
<td>151</td>
<td>25</td>
</tr>
<tr>
<td>9</td>
<td>Hatta</td>
<td>51</td>
<td>14</td>
</tr>
<tr>
<td>10</td>
<td>Niwari</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>11</td>
<td>Jatara</td>
<td>22</td>
<td>10</td>
</tr>
<tr>
<td>12</td>
<td>Tikamgarh</td>
<td>103</td>
<td>34</td>
</tr>
<tr>
<td>13</td>
<td>Laundi</td>
<td>18</td>
<td>11</td>
</tr>
<tr>
<td>14</td>
<td>Chhatarpur</td>
<td>329</td>
<td>26</td>
</tr>
<tr>
<td>15</td>
<td>Bijawar</td>
<td>58</td>
<td>23</td>
</tr>
</tbody>
</table>

*Includes PHCs, dispensaries etc.*

Source: Joint Director, Divisional Statistics Office, Sagar.
hospitals. Sagar tahsil has the highest bed facilities while Banda tahsil has the lowest facilities i.e. 1175 and 15248 persons per bed respectively. The average bed facilities of the unit is 2920. Chhatarpur and Panna get the second and third positions in bed facilities, i.e. 1335 and 1593 persons per bed respectively. While Madhya Pradesh hospital bed population ratio is 2444 persons per bed.

DOCTOR-POPULATION RATIO

Doctor is the important person of the hospitals; without doctor there is no meaning of hospitals. In Sagar, where overall medical facilities are maximum of the unit, one doctor is available for 9118 persons while in Jatara tahsil, one doctor is for 25767 persons. In doctor population ratio Tikamgarh gets first position, Panna gets second and Sagar gets third position among other respective tahsils, i.e. 7887, 8176 and 9118 persons per doctor respectively. While in M.P. doctor-population ratio is 10436 persons per doctor.

HOSPITAL-POPULATION RATIO

Hospitals are the main source of health care. At present a good number of PHCs are located at block headquarters and cover a long distance and subdivisional health centres cover a population of 5 lakhs. Ajaygarh tahsil reported highest hospital facilities while Jatara reported the lowest, i.e. 17867 and 85792 persons cover one hospital. The average 30717 persons cover one hospital in the unit as against only 10314 persons in the State.
SAGAR DIVISION
Medical Facilities 1986

A. DOCTOR-POPULATION RATIO

B. BED-POPULATION RATIO

Based on Govt. data
RURAL HEALTH SCHEME

Primary health care is based on four principles:

(i) Health services should be accessible to all sections of the society with special attention to the needy and vulnerable groups (ii) community participation in which are involved individual families and communities promote health and welfare (iii) multi-sectorial approach i.e. joint efforts of the health sector with health related sectors like agriculture, social welfare, housing etc. to achieve favourable conditions and (iv) appropriate technology which is needed for scientifically sound materials and methods that are socially acceptable like domiciliary treatment of tuberculosis etc.; the government of India established PHCs at block level in the country and take many operational methods. The government of India have further has gone to extend in having community looker called as village guide and Dios in each village.

VILLAGE GUIDE

Now this scheme has been stopped before the expiry of the Sixth Plan period in 1985. In order to scheme people's participation in the case of their own health and to have alternative systems of providing health care services at the village level, the government of India planned to allot the work to the local person of a particular area. This worker is called the village health guide. This was selected from within the village itself. They are target fundamentals of
health services including treatment of minor ailment, first aid during emergency and accidents, health education about environmental sanitation and personal hygiene education and motivation about family planning. But his activities are limited to village itself. He refers the cases to nearby PHC.

TRAINED DIAS

The training of the local Dai is an important component of the rural health scheme. She is to deal with the delivery cases and serves as an important link between the families in her village and the health workers.

OTHER FACILITIES

There have been introduced many important national and international organisations/institutions for health care in the study unit. These schemes do not relate to any specified area but they are designed only to have connection with relative problems of an area; that is why it is noticed that the study unit though not covered by some schemes is directly or indirectly influenced by the implementations of these health schemes. Some of which are as under:

1. Indian Red Cross Society
2. Hind Kusht Niwarak Sangh
3. Indian Council for Child Welfare
4. Tuberculosis Association of India
5. Bharat Sevak Samaj
6. Central Social Welfare Board
7. Family Planning Association of India
8. All India Women's Conference (M.C.H. Clinics)
9. The All India Blind Relief Society
10. Professional Bodies etc.
11. The Kasturba Memorial Fund
12. The Indian Medical Association

These institutions chalk out their separate programmes and implement them according to their laid down scale. Beside above, India government have been undertake several measures to improve the health of the people known as 'National Health Programmes'. These programmes have been start off by the Central Government for the control of communicable diseases, improvement of environmental sanitation, nutrition etc. Some of the following programmes have been aided by the WHO, UNICEF, etc.

1. National Malaria Eradication Programme
2. Diarrhoeal Diseases Control Programme
3. National Filaria Control Programme
4. National Tuberculosis Control Programme

The centres of administration and implementation are primarily located in important cities and towns of the study unit.

Besides, there are many foreign organisations functioning in the area. The channel of these institution
are mainly aimed at preventive and protection of the prevalent diseases, viz. Nations International Children's Emergency Fund (UNICEF), The United Nations Development Programme (UNIP), Cooperative for American Relief Everywhere (CARE) etc.