CHAPTER V: SUMMARY AND SUGGESTIONS

1.1 Introduction

Good health is considered as a precondition for economic development and social welfare. Improvement in the health status of the people contributes in a great way to the economic growth rates of the countries. Alma Ata Declaration (1978) stressed that primary health care approach should focus on preventive and promotive services rather than curative services. The access to primary health care was seen as the basic right.

To provide the primary health care services to the rural community, governments have designed Primary Health Centres as the second tier in rural health care structure. These health centres cater integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects.

Since the attainment of Independence, the country has made progress in improving the health status of its people. However the progress is not satisfactory and sufficient. The vast majority of the country’s population in general and rural community in particular still has no access to decent health care.

The present study makes an attempt to understand the gaps existed between supplying health care services by the Primary Health Centres according to the norms which they are expected to provide and the extent and pattern of utilisation of those services by the households who constitute the demand side.

Having studied the health care services which are being provided by the Primary Health Centres and the pattern of utilisation of those services by the households in two taluks namely Siddapur and Kumta which constitute the study
areas selected from Uttarkannada district. Findings and conclusions are derived from the study have been included in this chapter.

The chapter is divided, in two sections.

Section - I : This section deals with the summary of the main findings of the study and the problems faced by the beneficiaries of the health care services and the health care providers.

Section - II : This section throws light on the suggestions and policy issues to strengthen the quality of health care services provided by PHCs.

SECTION - I

1.2 The Main Findings of the Study :

The main findings of the study are briefly given below.

- The number of patients who suffered from the diseases is found to be comparatively more in Kumta taluk (24.01 percent) than in Siddapur taluk (16.46 percent). This confirms the fact that the rate of incidence of morbidity and hot coastal climate of Kumta taluk has a positive correlation.

- The households are invariably affected by common ailments, communicable diseases and by chronic diseases in the study areas. Among 984 sample population in Siddapur taluk, 8.3 percent of the population is affected by the common ailments, 4.78 percent from communicable diseases and 3.35 percent from chronic diseases. However the proportion of reported illness in Kumuta taluk is comparatively more. For instance among 937 sample population 12.81 percent of patients found to be affected by common ailments while patients suffering from communicable diseases and chronic diseases recorded to be 5.12 percent and 6.08 percent respectively.
• The proportion of the sample population who suffered from the diseases in the age group 0-6 years and 60 and above is comparatively less than that of the sample population in age groups of 6-12 years and 22-60 years in the study areas. For instance 1.93 percent of children and 2.95 percent of old aged people suffered in Siddapur while this proportion is 2.77 percent and 2.13 percent respectively in Kumta.

• The number of male population suffering from common ailments (53.47 percent) and chronic diseases (51.11 percent) is reported to be more than the female population in the study areas. However in Siddapur taluk the number of female population found to be more suffered in case of communicable diseases (57.45 percent) than their counterpart. In Kumta taluk the number of female population found to be more affected in case of communicable diseases (54.17 percent) common ailments (52.50 percent)

• The SC and ST population are, more prone to communicable diseases in both the taluks. However in comparison with the more developed Kumta taluk, this social class is found to be more adversely affected by the incidence of diseases in Siddapur taluk. For instance 23.17 percent of household members belonging to SC and ST category suffered from common ailments, 29.79 percent from communicable diseases and 18.18 percent from chronic diseases in Siddapur taluk as against 13.33 percent, 16.66 percent and 10.52 percent of the patients who suffered from these diseases respectively in Kumta taluk.

• The households belonging to Middle Income Group (MIG) and Low Income Group (LIG) are comparatively more affected by diseases than the households belonging to High Income Group (HIG) in both the taluks.

• The Middle Income Group household members in both the taluks are more prone to chronic diseases.
- Households belonging to Middle Income Groups are also more prone to communicable diseases hence they need health check-up and proper treatment. But households from this group have not utilised the facilities available at PHCs. Perhaps their poor economic condition could not permitted them in adopting preventive health care measures.

- The sample population suffering from common ailments, communicable diseases and chronic diseases are found to be increased with fall of educational status in both the taluks.

- Almost every health need was better utilised by the households belonging to High Income Group and Middle Income Group. The relation between income of the households and demand for health care is found to be positively correlated with each other.

- Low Income Group and Middle Income Group household members have extensively utilised the PHC services for the treatment of chronic diseases. The proportion of utilization in Siddapur taluk is 69.23 percent and 72.22 percent while in Kumta taluk it is found to be 81.82 percent and 68.42 percent respectively.

- Majority of the High Income Group patients in both the taluks sought the services of private clinics for common ailments, communicable diseases and chronic diseases. This proportion in Siddapur taluk is 72.73 percent, 100 percent and 100 percent respectively. While this proportion in Kumta taluk is 76.92 percent, 80 percent and 50 percent. It clearly shows that, in more developed Kumta taluk HIG households are found to be utilising relatively PHC services for communicable and chronic diseases.

- More educated people have shown more care seeking behaviour and more inclined towards better utilisation of health care facilities.
In the reference period the highest number of patients visited PHCs in both the taluks between January and June, while it is observed that comparatively less number of patients had visited PHCs between July and December. Two factors can be mentioned to explain this trend viz, the influence of climate and season wise economic conditions of the households.

Households belonging to High Income Group approached the PHCs for outpatient curative care for minor ailments while they preferred private clinics for inpatient curative health care services. But majority of the household belonging to Middle Income and Low Income Groups utilized PHCs for inpatient curative care.

Inpatient health care services are found to be better utilised in all the PHCs in the study area of more developed Kumta taluk while no patients had utilized inpatient health care services from any of the PHCs except the one (Kyadgi) in less developed Siddapur taluk.

The health care services of PHCs are better utilised by the households who are residing in the proximity of PHCs than the households residing away from the PHCs. This trend confirms that, distance factor is an important aspect in determining utilisation of PHC services.

No incidence of epidemic or endemic diseases is reported in the study areas during the reference period.

Private health centres are preferred by the mothers belonging to High Income Groups than the Middle and Low Income groups in Siddapur taluk. However PHCs are the choice of majority of the mothers in Kumta taluk.
In Siddapur taluk, out of 34 expectant mothers, 64.71 percent of the mothers utilised prenatal health care facilities from PHCs. This proportion is comparatively better in Kumta taluk as it stood at 78.05 percent.

Expectant mothers belonging to Low Income (80 percent) and Middle Income Groups (66 percent) have extensively utilised PHCs for prenatal health care. While High Income Group (71.43 percent) utilised private hospitals for prenatal consultancy and treatment in Siddapur taluk. But in Kumta taluk majority of the expectant mothers (66.66 percent) from High Income Group preferred PHCs. Availability of doctors would be a reason for better utilisation of PHCs in Kumta taluk.

PHCs are preferred for prenatal health care needs by the sample population who are having low educational profile in both the taluks.

No deliveries are reported to be held at homes in both the taluks. Hence field survey confirms institutional deliveries are preferred by the needy sample population.

All the PHCs in the study area of Kumta taluk are equipped to monitor normal deliveries.

In Siddapur taluk, the scenario of natal care is dismal, as maternity facilities are found absolutely nil in the selected PHCs. Eventually the needy households either depended on Community Health Centres or Private hospitals. In Kumta taluk 24.39 percent of the household selected PHCs for delivery. 30 percent of LIGs, 20 percent of MIGs and 16.67 percent of HIGs have selected PHCs for delivery needs.

Selection of Private hospitals for delivery needs and level of households income are found to be positively related with each other in more developed Kumta taluk.
• The service of Medical Termination of Pregnancy (M.T.P.) is found in only one PHC in Kumta study area. Viz. Bankikodla. The rest of the PHCs lack this facility because of lack of key personnel. For the same reason, this facility is not available in Siddapur taluk also.

• While all the High Income Group in both the taluk (100 percent) and Middle Income Group (100 percent in Siddapur and 93.33 percent in Kumta taluk) have perceived the need for postnatal care, most of the Low Income Group mothers (40 percent in Siddapur and 30 percent in Kumta taluk) did not perceive the need for postnatal care.

• Most of the mothers in Siddapur taluk (71.43 percent) who utilised postnatal care have preferred private hospitals, where as in Kumta taluk 58.82 percent of the mothers have preferred PHCs for postnatal care. Availability of doctors may be a chief reason for their selection of health centre.

• A majority of the household members have opted PHCs for treating the childhood diseases in the study areas. For instance, 62.75 percent of households in Siddapur have selected PHCs for medical checkup and giving treatment to their children.

• In Siddapur taluk, private hospitals are found to be increasingly preferred for treating the childhood diseases as educational status of the household increased. In Kumta taluk, PHCs are given the highest priority by the Sample population irrespective of their educational background.

• In Siddapur taluk PHCs are chosen by the most of the households belonging to all income categories for health checkup of children. However in Kumta, MIGs (51.72 percent) and HIGs (70 percent) have gone for private hospitals for treating the children.
- All the PHCs in the study areas are well equipped in administering all the courses of immunisations. It is interesting to point out that all the villagers in the study areas irrespective of their income, education, caste and occupational status have selected PHCs for immunising the children.

- Family planning operation facilities are not found in any of the PHCs in the study areas. Intrauterine device (I.U.D.) insertion facilities are found in all the PHCs. Out of 16 IUD insertions 87.50 percent have taken place in PHCs in Siddapur taluk and out of 22 IUD insertions 90.91 percent in Kumta taluk. PHCs are most preferred by the sample population irrespective of income, education, caste and occupational status.

- The utilisation of school health programmes increased with the fall in income level of the households. Students belonging to Low Income Group and Middle Income group consumed these services in a better way. However most of the LIG parents casually reported that they have not taken any follow up action. The situation was not much different in case of illiterate parents.

- Intensive propaganda and publicities have created awareness among mothers. However sample population having poor income background, low education background and down trodden groups seem to be unawaring of available health education programmes and implement the same so as to bring a positive life style change.

- None of the PHCs in study areas are equipped to administer family planning operations viz. tubectomy and vasectomy operations. However all the PHCs are well equipped to provide insertion of intrauterine devise (IUD). Condoms and oral pills (OP) are also freely distributed to the needy sample population.
- Majority of the female respondents told that they go to nearby cities to consult lady doctors for their gynecological problems. Shyness and hesitation to consult a male doctor was a chief reason to shun PHCs.

- The major criteria for selecting PHCs for general and specific needs are analysed. Most of the LIGs and MIGs opined that free treatment, nearness of PHCs, advice by PHCs health staff better services, incentives are the reasons for utilisation of services offered by PHCs. HIGs felt, small nature of disease, better services, good treatment and nursing care are some of the factors influenced them to utilise services of PHCs.

- There are some reasons for non-utilisation of health care services available at PHCs. LIGs and MIGs avoided PHCs because of inconvenient clinical timings, lack of medicines, non availability of doctors need of immediate treatment, long distance etc., HIGs shun PHCs for the reasons like poor treatment, long waiting, known family doctor, non availability of service, lack of cleanliness, hesitation to consult male doctors (in case of female respondents).

- Sample population belonging to HIGs, and higher educational background seem to be utilise family planning services in a betterway. PHCs are preferred by majority of the sample population for IUD insertions.

1.3 Problems and constraints of Primary Health Centres Functioning in the study areas.

The Primary Health Centres in general and particularly in the study areas have been facing certain problems. The interaction with the personnel of PHCs coupled with field study has provided us with an insight into the problems and constraints of PHCs in the study areas. The major problems are given here below.
- **In adequate accommodation.**

Fifty percent of the PHCs selected in the study areas of both the taluk are not spacious to accommodate the patients comfortably. The clinical buildings require spacious waiting room and room for consultation.

- **In adequate infrastructural facilities.**

The newly started PHCs viz. Bilgi, Dodmane and Kolsirs in underdeveloped Siddapur taluk and Kumta town PHC in more developed Kumta taluk are suffering from infrastructural inadequacy coupled with shortage of key-personnel.

- **Lack of full time medical officers.**

Lack of permanent full time doctors in PHCs of underdeveloped Siddapur taluk is a big road block in rendering health care services. For instance taluka medical officer of Siddapur CHC has the additional charge as medical officer of Kyadgi PHC. Hence he has to look after both the institutions. In Heroor PHC, medical officer’s post is vacant. Medical Officer from nearby PHC is deputed to this PHC on the part time basis.

- **Under Staffing**

Under staffing is a big problem of PHCs in delivering quality health care services. In under developed Siddapur taluk the vacancy position is dismal. In Kyadgi PHC all together seven posts are vacant. Where as in Heroor PHC eight posts are vacant. In more developed Kumta taluk in Hiregutti PHC seven posts and in Bankikodla two posts are found to be vacant.

There is no sufficient clerical staff in all the selected PHCs which impose additional burden on existing health staff.
- **Over burdening to medical officers.**
  The doctors at PHCs are overburdened with multiple duties. Attending the periodical meetings, undergoing training, organizing training to the health staff, attending the court cases, field visits etc do have their own impact on provision of routine curative and preventive health care services.

- **Gaps between targets and achievements**
  PHC in the study areas find difficulties in achieving numerical targets. Lack of key staff and hence non availability of certain services make the people to repel the PHCs.

- **Doctor patient relationship**
  Multiple responsibilities of medical officers hinder them in devoting sufficient time to listening every patient. This leads to not only dissatisfaction among the innocent patients but also influence doctor-patient relationship.

- **Difficulty in meeting every requirement of curative health care**
  PHCs are basically designed to provide preventive and promotive health care services. Hence PHCs find it difficult to meet every requirement of curative health care.

- **Lack of curative health care facilities round the clock**
  None of the PHCs in the study areas is found to be working on 24x7 basis. Government has withdrawn this facility because of lack of adequate number of patients.

- **Poor quality of inpatient services.**
  Inpatient services are very poor in the selected PHCs of Siddapur taluk. In Heroor PHC, not even a single patient was found to be admitted as inpatient in the reference period.
• **Insufficient laboratory services.**

Fifty percent of the selected PHCs in the study areas of both the taluks do not have junior laboratory technicians. (Heroor PHC in less developed Siddapur taluk and Hiregutti PHC in more developed Kumta taluk). Though the alternative arrangements are made through deputation, patients find inconvenience of utilising the laboratory services during the times of acute need.

• **Poor quality of maternal services.**

Due to lack of full fledged staff and other health resources, treatment and counselling services relating to gynecological problems, medical termination of pregnancy (MTP) are not found in the study areas. No deliveries were recorded in Kyadgi and Heroor PHCs of underdeveloped Siddapur taluk. Lack of doctors was the main reason for non-provision of natal care facilities.

• **Under utilisation of operation theatres**

Operation theatres (OTs) are not fully utilised in all the PHCs of study area, because of lack of qualified surgeons. It is observed that the PHCs in the study areas of both the taluks are not well equipped to provide tubectomy and vasectomy operations.

• **Impediments in spreading the health education.**

The vacancy position of Block Health Education officers and senior health assistant male is another impediment in spreading the health education and creating the health awareness programmes in underdeveloped Siddapur taluk.

• **Lack of own official vehicles.**

Seventy five percent of the selected PHCs in the study areas lack their own vehicles. Except Kyadgi PHC in Siddapur taluk all the other selected PHCs
do not have their own official vehicles. Hence it checks their free movement in the jurisdiction.

- **Poor response of the public about precautionary measures adopted by PHCs.**

PHCs functioning in the study area of both the taluks have observed disinterest and low priority of the public about precautionary measures of the centres. For instance, health staff of the PHCs in Kumta told that majority of the people did not take anti-filaria tablets distributed by the PHCs. In Siddapur taluk, ASHA’s and LHVs have reported that a good number of expectant mothers used to refuse to take folic acid tablets supplied freely by the PHCs and also reluctant to utilise pre-natal care facilities available at PHCs.

- **In adequate health care services.**

Some patients visit PHCs when their diseases become so serious that cannot be treated because of constraints in health resources at PHCs. Health personnel will be targeted for any complications which arise during the process of treatment.

- **Lack of faith on Government doctors**

Normally PHCs provide allopathic treatment. Hence non-allopathic doctors recruited on contract basis find it difficult to prescribe allopathic medicines for technical and legal reasons.

- **Standardised health budget**

Standardised health budget and fixed supply of medicines tie the hands of medical officers of PHCs to meet the large demand for health care.

- **Private practice of the medical officers.**

Some of the doctors in the study area have the private practice. Villagers have the impression that they can get better services in their clinic. This will likely tend to under utilisation of available health care services in PHCs.
1.4 Suggested Measures:

The analysis of functioning of Primary Health Centres has shown that, they have been rendering both curative and preventive health care services to the community to the extent possible. The efforts of the Primary Health Centres in connection with eradicating traditional epidemics, creating health awareness among the community and bringing improvements in the health status of people are praised worthy.

However, the PHCs are not devoid of their inherent problems and constraints. To solve the problems faced by the PHCs on the one hand and make them more efficient to sub serve the wider interest of the community on the other, following suggestions can be considered.

- **Need of integration between preventive and curative health care services.**

  The basic objective of establishing PHCs is to provide preventive and promotive health care services. However this objective should not sideline the curative health care needs. The study reveals that the majority of the people choose private health care providers only because non availability of certain services in the PHCs. Therefore it is necessary to strengthen PHCs so as to provide essential services to the needy people.

- **Urgency of adoption of preventive health care measures.**

  The pattern of diseases prevailed in the study areas depict the further scope in the adoption of preventive measures. Most of the sample population is affected by common ailments and communicable diseases. PHCs should focus more on preventive and primary health care. Precautionary measures
should be taken against E.P.I. targeted diseases, vector borne diseases, contaminated water supply and unhygienic conditions.

- **Need of increasing the number of PHCs.**

  Demand for health care services is growing with the increase in population. This has and would definitely increase the burden on PHC. To render quick and qualitative health care services, it would be better to progressively reduce the PHC population ratio by increasing the number of functional PHCs.

- **Need of Providing Adequate and suitable Medical and Paramedical Personnel.**

  The available facilities in the PHCs in the study area of less developed Siddapur taluk are under utilised because of lack of sufficient medical officers and other health staff like senior health assistant male, block health extension officers, Junior laboratory technicians etc., Recruitment of health staff will not only minimises over burdening of the existing staff but also increases their level of participation in providing health care services. This in turn increases the accountability of PHCs.

- **Avoiding the Mis-matches between Personnel and Health resources.**

  Most of the PHCs in the study areas are found to be functioning at sub optimal level and hence under utilised because of gross mis matches existed between personnel and available resources. For instance in Bankikodla PHC. (Kumta taluk) 24x7 facility is not accompanied by proportionate health staff. Operation Theatres (OTs) in Kyadgi and Heroor PHCs in Siddapur are under utilised because of lack of full time doctors. For the same reason natal care facility is also not available. In Heroor PHC (Siddapur taluk) and in Hiregutti PHC (Kumta taluk), junior lab technicians are not appointed leading to under utilisation of PHC laboratories.
Therefore priority should be given in removing the mis matches for their optimum utilization.

- **Need of lady physicians in PHCs.**

  Majority of the female respondents demand lady doctors in PHCs. The respondents feel very comfortable to discuss with a lady doctor. In the study areas there is enough scope for employing women physicians which will attract more women and remove their affliction of visiting lady doctors in the distant city. Hence there is a need of recruitment of women physicians in the study areas.

- **Need of Specialised Service in PHCs.**

  Health needs of the people are varied. Hence PHCs can arrange periodically, certain health care services like ENT, skin diseases, paediatric needs, gynecological services, etc from specialists in the wide interest of the rural community.

- **Need of certain complementary health care services.**

  Some health care services are demanded jointly. If one type of service in the group is not available, naturally the other related services will likely to be not utilised. For instance, prenatal care child delivery and post natal services are jointly demanded. Lack of one service may lead to either under utilisation or non-utilisation of the other services. In less developed Siddapur taluk, no PHCs in the study area have child delivery facilities. When an expectant mother comes to know that child delivery facility is not available, she goes to some other maternity home for consulting her prenatal problems where she would like to get maternity facility. Later she will approach naturally the same doctor for her post-natal problem. Perhaps this would be the reason why most of the expectant mothers do not utilise PHC
services. Therefore attention is to be given in providing related health care facilities.

- **Need of Gynoecological Services and MTP Services at PHCs.**

  A rural woman cannot go to city to consult experts for her gynecological needs. Cost, distance and poor economic condition of the households check their mobility. Similarly removal of unwanted pregnancy or obstructed pregnancy threatening the life of the expectant mother needs MTP (Medical Termination of Pregnancy) Services. These facilities are found to be not available in any of the PHCs in the study areas. Keeping the reproductive health aspects, it would be desirable to provide gynecological and MTP Services at PHCs in the study areas.

- **Provision of facilities in the newly established PHCs.**

  Three new PHCs are started in the less developed Siddapur taluk in Bilgi, Dodmane and Kolsiri. Mere increase in PHCs is not sufficient what is needed is recruitment of at least key health personnel coupled with essential facilities. If these PHCs are well equipped, indirectly they minimise excess load otherwise would have been borne by the other PHCs in the study areas.

- **Rigorous Health Education and Awareness Camps.**

  The level of health education and awareness was found to be very low in the study areas. Hence PHCs can make these aspects as major goals. The programmes relating to small family norms, precautions to be taken against deadly diseases, waste management, water treatment. Mosquito-malaria relation etc will create awareness among the community. Health Staff of PHC and Village Health and Sanitation Committees (VHSCs) can jointly arrange health education programmes like street play, audio-visual programmes etc., Majority of the rural folks are not even aware about
various health programmes which have been in operation in PHCs. Special efforts are needed to overcome the ignorance and apathy of the people by effective persuasion especially in the remote villages.

- **Ample Supply of Medicines to Treat Chronic Diseases.**

Chronic diseases are not curable permanently. They shorten the patients life of patients. Patients suffering from such diseases are required to take the medicines regularly. Poor people cannot afford these medicines in the open market. Hence PHCs should maintain enough stock of medicines to treat chronic diseases. Similarly, Medicines and injections to treat snake bite and dog bite are found thin in PHCs. Hence authorities should do the needful in maintaining the stock of such life saving medicines.

- **Provision of Adequate, Regular and Need based Medicines and other Health materials.**

It is observed in the field survey, that PHCs receive medicines and other items irrespective of size, structure and disease pattern. Standardisation in budget allocation as well as standardization in distribution of medicines quite independent of local requirements leads to either excess stocks of medicines or acute shortage. Hence there is a need of regular and adequate supply of medicines to PHCs in accordance with local requirements which will not make the doctors embarrassed to give treatment due to non-availability of medicines.

- **Effective Implementation of Family Planning Services.**

Growth in population is a major hurdle in the process of economic development. Government has given a top priority to the family planning programmes by making it an integrated part of MCH (Mother and Child Health) activities of PHCs. Unfortunately none of the PHCs in the study
areas are found to be equipped with rendering tubectomy and vasectomy operations. Hence full-fledged sterilisation facilities are to be provided in PHCs.

- **Need of 24x7 Functional PHCs in the Study areas.**

Demand for health care services can generate at any time. If timely treatment is given, the life of the patient can be saved or will enable the family members to have a breathing time to take the patient to a higher level of health care providers. All these things would mean the need of PHC services round the clock. In the study area of more developed Kumta taluk one PHC (Bankikodla) is functioning on the 24x7 basis. In less developed Siddapur taluk, none of the PHCs in the study area are found to be functioning round the clock. If perennial health care services are available in PHCs, people will make use of them in a better way. This will minimise the pressure otherwise would have been imposed on secondary health care level.

- **Provision of In-patient Services.**

In the study areas of more developed Kumta taluk, in-patient services are relatively better. However in the study area of the less developed Siddapur taluk there is a dismal picture in this regard. In one of the selected PHCs (Kydagi) due to lack of a full time doctor and other health staff the available inpatient services are under utilised. In another PHC (Heroor) not even a single patient utilised in-patient service, during the reference period. Lack of a full time doctor is the main reason. Hence inpatient services should be provided keeping in the mind the dire need of poor people.

- **Provision of Reproductive and Child Health care Facilities.**

National health care policy aims at, providing hundred percent coverage of expectant mothers for prenatal care, postnatal care and natal care facilities. However in the study area of under developed taluk, there is a wide gap in
the fulfillment of the target. Hence special attention should be given in providing sufficient health man-power. Simple surgical intervention required in obstetric cases is to be made available in PHCs coupled with facilities of care corner for new born babies and treatment.

- **Improvement in Reproductive Health Care in PHCs will minimise the burden on Community Health Centres.**

Lack of maternal health care, especially for child delivery in PHCs will make the people to opt community Health Centres i.e. the Secondary level of health care. This leads to more pressure on the health resources of CHCs. Hence there is a dire need of provision of quality maternal care services in PHCs.

- **Provision of Essential Medical and Non-Medical Components.**

The survey done in the study areas reveals the demand list for some medical and non medical components for the enhancement in the provision of quality health care services.

- Need of own vehicle to cover the jurisdiction allotted to PHCs.
- Power back-up to PHC buildings to keep proper functioning of refrigerators and preserve life saving drugs and vaccines.
- Infant warmers.
- Replenishing ASHA’s kits without any delay.
- Oxygen Cylinders
- A blood bank, at least at CHC level.
- A medical library containing medical books and magazines.
- Computers with internet facilities.
- Suggestion Boxes to have a feedback from the beneficiaries.
- **Systematic survey of the Beneficiaries.**

Health related socio-economic survey of the household provides a bird’s eye view of the health scenario which will be useful in designing micro planning at PHC level. If the data collected is computerised, the health staff will be able to have a quick-look about the morbidities – in terms of family wise and area wise. Household surveys show that majority of the sample population belonging to down trodden classes and those who have poor economic and educational status are unawaring about the health related government schemes and facilities available at PHCs. Systematic survey will enable the PHCs not only to achieve the targets but also in providing the services to the needy people.

- **Need of mobile medical services.**

The health team of the PHCs can provide primary domiciliary treatment and counselling for stigma related diseases like leprosy, tuberculosis to age old and physically challenged patients who cannot visit the PHCs easily. This service is not only helpful to the needy people but will also improve the rapport of the PHCs. These ‘villagers friendly’ visits bring the PHCs closer to villagers and improve doctor-patient relations.

- **Adoption of the Improved Methods of Health Care Services in PHCs.**

The advantage of information and telecommunication technology can be reaped in rendering expertise services to the community. Telehealth network, tele medicines and tele counselling services can be provided in diagnosing the diseases and getting suitable prescriptions from distant experts. This facility can be given to the community periodically. Hence PHC should be equipped with basic diagnostic equipments.
- **Enhancing the quality of health care services.**

Mere provision of services cannot serve the purpose unless they are better attuned to consumer's requirements. Most chose the private sector in spite of the availability of those services in PHCs. It indicates that rural consumer is willing to pay higher amounts for better quality and more appropriate services. This calls for bringing the PHCs more in line with, incorporating quality components in their services.

- **Need of convenient Clinical Timings.**

As a policy matter PHCs (except 24x7 type) function between 9 a.m. and 12.45 noon, with a gap of forty five minutes, resume functions at 1.30 p.m. and continue till 4.45 p.m. This fixed timings imposes inconvenience to the daily wage earners, agricultural workers etc. They find it very difficult to wait for their chance in the long queue to access health care services from PHCs for themselves or for their dependents. Hence government may think in this regard and do the needful.

- **Need of Improving Doctor-Patient Relation.**

According to the perception of some respondents about good trait of a doctor is patience of doctor in listening the patient about his diseases. A doctor in PHC is over burdened with attending meetings, field visits, court cases etc. This will make him hardly devote sufficient time for consultation. His limited availability in the centre on the one hand and accordingly low rate of average consultancy with patients on the other, make the patients unhappy. Therefore PHCs must have a minimum of two doctors. At least one of them should be available in the centre to attend curative needs. Regular availability of doctor will increase the rate of consultancy and hence improves doctor-patient relation. This inturn leads to better utilisation of available services of PHCs.
1.5 Some Policy Recommendations:

The quality of health care services of PHCs are also depends upon certain external factors. In this connection a few policy measures can be suggested.

- **Task of Building Social Infrastructure**
  
  There is a need of strengthening social infrastructure, conducive for public health in a way that comprehensive primary health care becomes a reality. The public health approach should focus on determinants of health such as food and nutrition, safe drinking water supply, and sanitation to a greater extent.

- **Provision of Basic Infrastructure and Incentive Structure.**
  
  Provision of basic infrastructure and incentive structure of course not necessarily monetary but in terms of decent job environment will make the health staff not to feel isolated from towns and cities. This inturn will motivate them enough to do their job in a more concentrated way.

- **Local Recruitment of Doctors.**
  
  Vacancy position of key posts should be filled immediately either on temporary basis or contract basis.

- **Accreditation**
  
  PHCs need to prove that the quality of health care services offered by them is good. One of the ways to prove the quality consciousness is to get accreditation of health care facilities to remain competitive.

- **Medical Insurance Coverage**
  
  There is a need to provide comprehensive health insurance coverage to rural community.
• **Appointment of at least one allopathic doctor.**
  Curative services in PHCs are mainly depended on allopathic medicines. An AYUSH doctor technically cannot prescribe allopathic medicines. Hence care is to be given in this regard.

• **Need of Overall Increase in the Health Budget.**
  Underfunding to health sector leads to rationing of essential medicines. Hence there is a need of increasing the health budget.

• **Linkage between PHCs and NGOs (Non Governmental Organisations)**
  Public – Private partnership in the health sector can bring needed health resources which will enable the PHCs to provide quality health care services. Contracting out the PHCs to the private subject to stringent conditions in favour of the communities interest can also be fruitful.

• **Proper Policies to Increase the Level of Income of the Community.**
  Health will get a top priority if the problem of lively hood is solved. Level of income of the community and utilisation of health care services usually go hand in hand. Hence measures can be taken in increasing the level of Income of the Community.

• **Scope for Establishing Medical College**
  There is a need and scope for establishing allopathic medical college in the district. Expertise service of specialists of the college can be utilized in PHCs.
1.6 Conclusions

It is very clear from the ongoing analysis that good health is regarded as the key to attaining economic prosperity. Availability of efficient health network stimulates economic development through improving human productivity. More the opportunities to access health care facilities, the more likelihood of improved health status to emerge.

Primary health care, as the first resort care is an important constituent of the health care network. In India, services relating to primary health care are provided by Primary Health Centres and their Sub-Centres. The National Health Care Policies aim at hundred percent coverage of mothers for prenatal, postnatal and institutional child deliveries. Similarly controlling the communicable diseases, reducing the morbidity and mortality rates, increasing the life expectancy and other health related goals have been given the top priorities.

However the ground realities clearly show that there is a wide gap in the fulfillment of the target. Poor infrastructure, shortage of medical and paramedical personnel, non-availability of certain medicines, lack of certain essential health care services in Primary Health Centres impede fuller utilisation of the available health care facilities also.

Therefore special attention should be given by the health team of the Primary Health Centres in order to improve the health status of the population, especially of under privileged and socially and economically vulnerable classes.

As it is aptly said 'a single flower makes no garland', so as efforts of personnel of the Primary Health Centres alone cannot achieve all the things. Co-operation and Co-ordination between health staff and rural people is an essential condition in order to achieve predetermined health objectives.
In this regard, Primary Health Centres should give more importance to preventive and promotive measures like sanitation, nutrition, clean drinking water, hygiene, health education, and awareness creation among the rural folks. Governments should provide good infrastructural facilities and supply of regular medicines and other consumables besides recruiting sufficient health staff. People should be fully aware of the available medical facilities and utilise them properly. The collective participation of the government, Primary Health Centres and people can definitely improve the health scenario of the study areas.

Mere increase in number of PHCs is not sufficient to solve the problem. A philosophy of providing integrated health care delivery is also needed. Enhancement of managerial skills of health personnel will ensure increase in the productivity. However, only health care services cannot be able to solve the problems arising out of ill health. There is also a need of awareness of good health and components of longevity. I personally feel that good hobbies and physical exercise are also need of the hour. And as far as possible one must not have any bad habit. Thus both preventive measures and curative practices should go hand in hand.