International Journal of Multidisciplinary Trends

E-ISSN: 2709-9369
P-ISSN: 2709-9350
www.multisubjectjournal.com
IJMT 2020; 2(2): 100-105
Received: 05-07-2020
Accepted: 12-09-2020

Ashutosh Vyas
Associate Professor,
Department of Sociology, M.P. Govt. P.G. College,
Chittorgarh, Rajasthan, India

Corresponding Author:
Ashutosh Vyas
Associate Professor,
Department of Sociology, M.P. Govt. P.G. College,
Chittorgarh, Rajasthan, India

Rural health care in India: Issues and prospects

Ashutosh Vyas

Abstract
Health is a basic human right. It means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy, working condition, and a clean environment. A comprehensive sense National Health Policy addressing the existing inequalities, and work towards promoting along-term perspective plan exclusively for rural health is the current need.

Keywords: Health, sanitation, environment, rural health, policy

Introduction
Health is a basic human right. It means that everyone has the right to the highest attainable standard of physical and mental health, which includes access to all medical services, sanitation, adequate food, decent housing, healthy, working condition, and a clean environment. As defined by World Health Organization (WHO), it is a "State of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity".
The Constitution of India gives its every citizen the right to health as a fundamental right. As per the Constitution of India under Article 21 which says that "the right to life includes the right to health". Health comes under the State list of the Seventh Schedule of the Indian constitution It is the duty of the State to ensure and protect the right to health and sanitation; hospital and dispensaries. Any failure of this right is the violation of the right of life. So, it is a very important for the state to primarily focus on the basic health care system for a healthy society. As per the 2011 Census, the total population of India was 121 crore. Among this, the rural population was 83.3 crore (68.9 per cent) and 37.7 crore (31.16 per cent). It is seen that the rural population is more than twice thane the urban population. The irony of the health system since independence is the basic health care facilities and policies are mainly urban centric. All the main and reputed hospitals are mainly located at the state capital and the district headquarters. The rural villages are always neglected where the basic health facilities are required. 2279 rural villages had increased between the Census 2001 and 2011. In 2001 census, the total number of villages were 6, 38, 588 and in 2011, it increased to 6,40,867. But the health facilities are not available in each village.
In India, There are two land mark initiatives with regard to health care structure. First, the Bhore Committee, 1946 which stated that every citizen of India should get the basic health care regardless of their paying capacity. It was a very clear message to the newly established post-independence Government of India to take care of the population with the provision of basic health care facility. Second, post-independence the Alma Atta Declaration guided all the governments to frame their health care policies. Further, the Government of India started various health care programmes and set up various health care policies mentioned in the table 1.

Table 1: Milestones of Health Care Policies

Policy	Year
Health Survey and Development Committee (HSDC) also known as Bhore Committee	1946
National Family Planning Programme (NFPP)	1952
Alma Atta Declaration	1978
National Health Policy (NHP)	1983
Universal Immunisation Programme (UIP)	1985
Reproductive Child Health (RCH)	1996
National Population Policy (NPP)	2000
National Health Policy (NHP)	2002
National Rural Health Mission (NRHM)	2005

***Source*:** Ministry of Health and Family Welfare

The major health policy in India came into effect as National Health Policy (NHP) in 1983 which was after the 36 year of independence, clearly showed that the government focus was not primarily on the health of people of this country. After that, other major health care initiatives such as universal Immunisation Programme (UIP-1985), Reproductive Child Health (RCH-1996), National Population Policy (NPP-2000) and National Health Policy (NHP-2002) also had been undertaken. At present, the country's healthcare structure is as per the guidance provided under the National Health mission (NHM). Future keeping in view the separate requirement of the health care needs of the rural and urban areas, separate arrangements were made under the manner ship of National Rural Health Mission (NRHM-2005) and National Urban Health Mission (NUHM).

Healthcare schemes in Rural India

Under the National Health Mission, the government has launched several schemes like:

- **Reproductive, Maternal, Newborn, Child and adolescent Health (RMNCH+A)**
  RMNCH programme essentially looks to address the major causes of mortality among women and children as well as the delays in accessing the utilizing health care and services. It also introduces new initiatives like the use of Score Card to take health performance. National Iron + Initiative to address the issue of anemia across all age groups and the Comprehensive Screening and Early interventions for defects and birth diseases, and deficiencies among children and adolescents.
- **Rashtriya Bal Swasthya Karyakam (RBSK)**
  This is an important initiative aiming early identification and early intervention for children from birth to 18 years to cover 'D's *viz*. Defects at birth, Deficiencies, Diseases, Development delays including disability. Early and management diseases including deficiencies bring added value in preventing these conditions to progress to its more severe and debilitating form
- **Rashtriya Kishor Swasthya Karyakram**
  The key principle of this programme is adolescent participation and leadership, Equity and inclusion, Gender Equity and strategic partnership with other sector and stakeholders. The progremme enables all adolescents in India to realize their full potential by making informed and responsible decisions related to their health and well-being and by accessing the services and support they need to do so.
- **Janani Shishu Surakhsha Karyakram**
  The government of India has launched to motivate those who still chose to deliver at their homes to opt for institutional deliveries. It is an initiative with a hope that states would come forward and ensure that benefits under JSSK would reach every needy pregnant women coming to government institutional facility. Since the rate of deaths in the country because of communicable and non- communicable diseases is increasing at an alarming rate, the government has introduced various programmes to aid people against these diseases.
  In India, approximately about 5.8 million people die because of Diabetes, heart attack, cancer etc each year. In other words, out of every 4 Indians, 1 has a risk of dying because of a Non-communicable diseases before the age of 70. According to the World Health Organization, 1.7 million Indian deaths are caused by heart diseases.
- **National AIDS Control Organization**
  It was set up so that every person living with HIV has access to quality care and is treated with dignity. By fostering close collaboration with NGOs, women's self-help groups, faith-based Organization, positive people's networks, and communities, NACO hopes to improve access and accountability of the services. It stands committed to building an enabling environment wherein those infected and affected by HIV play a central role in all responses to the epidemic at state, district and grassroots level.
- **Revised National TB control Programme**
  This is a state-run tuberculosis control initiative of Government of India with a vision of achieving a TB free India. The program provides, various free of cost, quality tuberculosis diagnosis and treatment services across the country through the government health system.
- **National Leprosy Eradication Programme**
  It was initiated by the government for early detection through active surveillance by the trained health workers and to provide appropriate medical rehabilitation and leprosy ulcer care services.
- **Mission Indradhanush**
  The government of India has launched the aim of improving coverage of immunization in the country. It aims to achieve at last 90 percent immunization coverage by December 2018 which will cover unvaccinated and partially vaccinated children in rural and urban areas in India.
- **National Mental Health Program**
  In order to address the huge burden of mental disorders and the shortage of qualified professionals in the field of mental health, Government of India has implemented to ensure the availability and accessibility of minimum mental healthcare for all in the foreseeable future.
- **Pulse Polio**
  This is an immunization campaign established by the government of India to eliminate polio in India by vaccinating all children under the age of five years against the polio virus.
- **Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)**
  It was announced will objectives of correcting regional imbalances in the availability of affordable/ reliable tertiary healthcare services and also to augment facilities for quality medical education in the country by setting up of various institutions like AIIMS and upgrading government medical college institutaion.
- **Rashtriya Arogya Nidhi**
  Since there are huge income disparities, therefore, the government has launched several programmes in order to support the financially backward class of the country. As about 3.2 crore people in India fall under the National Poverty line by spending own healthcare from their on pockets in a single year. The most important programme launched by the government is which provides financial assistance to the patients that are below poverty lie and are suffering from life-threatening diseases, to receive medical treatment at any government run super specialty hospital/institution.

- **National Tobacco Control Programme**
  It was launched with the objective to bring about greater awareness about the harmful effects of tobacco use and about Tobacco Control Laws and to facilitate the effective implementation of the Tobacco Control Laws.
- **Integrated Child Development Service**
  It was launched to improve the nutrition and health status of children in the age group of 0-6 year, lay the foundation for proper psychological, physical and social development of child, effective coordination and implementation of policy among the various departments and to enhance the capability of the mother to look after the normal health and nutrition needs through proper nutrition and health education.
- **Rashtriya Swasthya Bima Yojana**
  This is a government-run health insurance programme for the Indian poor. It aims to provide health insurance coverage to the unrecognized sector workers belonging to the below poverty line and their family members shall be beneficiaries under this scheme.

Status of Health Infrastructure in Rural Areas

The health care infrastructure in rural areas has been developed as a three tier system and it is based on population norms. According to this norms Sub-Centre (Sc) is established in plain area with 5000 population and hilly/Tribal area/ different are with 3000 Population. Similarly PHC established in plain area with 30,000 population and hilly/Tribal area/ different are with 20,000 population and CHC established in plain area with 20,000 population and hilly/Tribal area/ different are with 80,000 population.

Sub Centres (SCs)

The Sub Centre is the most Peripheral and first contact point between the primary health care system and the community. Sub Centres are assigned takes relating to interpersonal communication in order to bring about behavioral changed and provide services in relation to maternal and child health, family welfare, nutrition, Immunisation, diarrhoea control and control programmes. Each Sub center is required to be manned by at least one auxiliary nurse midwife (ANM) /female health worker and one male health worker. There were 1,56,231 Sub-Centres functioning in the country as on 31st March, 2017.

There is significant increase in the number of Sub Centres in the states of Rajasthan (3894), Gujarat (1808), Chhattisgarh (1368), Karnataka (1238), Jammu &Kashmir (1088), Odisha (761), Tripura (448), Madhya Pradesh (318) and Kerala (286).

Primary Health Centre (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. There were 25,308 PHCs functioning in the country as on 31st march, 2017.

Table 2: Status of Health Infrastructure in Rural Areas as per 2011 population in India (As on 31st March, 2017)

Health Infra- structure	Required	In Position	Shortfalls	Percent Shorfal
Sub Centres (SCs)	179240	156231	35145	20
PHCs	29337	25650	6556	22
CHCs	7322	5624	2316	32

***Source*:** Rural Health Statistics 2017, M/o HFW, Go

At the National level, there is an increase of 2414 PHCs by 2017 as compared to that existed in 2005. Significant increase in observed in the number of PHCs in the states of Karnataka (678), Assam (404), Rajasthan (366), Jammu & Kashmir (303) and Chhattisgarh (268) and Bihar (251).Percentage of PHCs functioning in government building has increase significantly from 78% in 2005 to 90.9% in 2017. This is mainly due to increase in the government building in the state of U.P. (1681), Karnataka (841), Gujarat (450), Assam (403), M.P. (410), Maharashtra (232) and Chhattisgarh (336).

Community Health Centre (CHSs)

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 Serves as a referral centre for 4 PHCs and also provide facilities for obstetric care and specialist consultation. As on 31st March, 2017, there were 5,396 CHCs functioning in the country. The data from the Table- 2 reveals that there is still shortfall in health infrastructure against the required needs. In case of sub-centre, the shortfall is of 20 per cent against the required numbers of sub-centres. Similarly, for PHCs and CHCs, the shortfall is of 22 per cent and 32 per cent respectively. This indicates that if government wisher to provide maximum coverage to the rural population with basic health care infrastructure, it needs to fill up the gaps that are existing at present.

If we look at the data from Table-3 with regard to health care manpower in rural areas, it shows that against the required number 153655 of health workers (Female)/ANM at sub centres, there are 18226 vacant positions and there is a shortfall of 3934 positions. Even at PHCs level, Female Health Assistance positions, 9636 are vacant and ther is a shortfall of 12448 positions. For the Doctors, 9389 positions are also vacant at the PHCs level, which is the primary unit for health for health care need.

Table 3: Status of Health Manpower in Rural Areas as per 2011 population in India (As on 31st March, 2015)

Manpower	Required	Sanctioned	In Position	Vacant	Shortfall
Health Workers (Female) / ANM at Sub Centres	153655	178480	193191	18226	3934
Health Workers (Male) at Sub Centres	153655	93002	55657	37888	98027
Health Assistance (Female) LHV at PHCs	25308	22993	13372	9636	12448
Health Assistance (Male) at PHCs	25308	23505	12646	11019	15513
Doctors at Primary Health Centres	5396	34750	27421	9389	3002
Surgeon at CHCs	5396	3320	896	2477	4500
Obstetricians & Gynecologists at CHCs	5396	3429	1296	2242	4115
Physicians at CHCs	5396	2772	918	1889	4479
Pediatricians at CHCs	5396	2484	968	1560	4432
Radiographers at CHCs	5396	4167	2150	2032	3406

***Source*:** Rural Health Statistics 2014-15, M/o HFW, Gol.

The CHS that were established to provide referral and specialist services for the rural population are also having the gaps in term of infrastructure provisions. The data shows that there is shortfall in various positions, for Surgeons 2477 positions are vacant, another important position is of Obstetricians & Gynecologists in which 2242 positions are vacant. For the Physicians 1889, Pediatricians1560 and for Radiographers 2032 positions are vacant. The Table-3 indicates the need to review the efforts made to create basic health care infrastructure for the rural population as per the requirement. For the rural population, health care requirements are different then the urban due to various social economic reasons. Significant increase is observed in the number of CHCs in the State of Uttar Pradesh (436), Tamil Nadu (350), West Bengal (254), Rajasthan (253), Odisha (1396), Jharkhand (141), Kerala (126), Gujarat (91) and Madhya Pradesh (80). Number of CHCs functioning in government building has also increase during the period 2005-2017. The percentage of CHCs in Govt. building has increase from 91.6% in 2005 to 96.7% in 2017.

Major Problems of Health Services in Rural India

After Independence there has been a significant improvement in the health status of people in India. But the situation is not much better as per study of WHO. It has placed India in 12th position among 191 countries of the world. The following are the major problem of health services in rural India.

Neglect to rural population

A Serious drawback of India's health service is the neglect of rural masses. It is largely service based on urban hospitals, although these are large no of PHCs and rural hospitals get the urban is visible. According to health information 31.5% of hospitals and 16% hospital beds are situated in rural areas where 70% of total population resides. Moreover the doctors are unwilling to serve in rural areas. Instead of evolving a health system depended on paramedical to strength the periphery.

Emphasis on Culture Method

The Health system of India depends almost on imported western models. It has no roots in the culture and tradition of the people. It is mostly service based on urban hospitals. This has been at the cost of providing comprehensive primary health care to all. Otherwise speaking it has completely neglected preventive, pro-motive, rehabilitative and public health measures.

Inadequate Outlay of Health

According to the National Health Policy 2002, the Govt. contribution to health sector constitutes only 0.9 percent of the GDP. This is quite insufficient. In India, public expenditure on health is17.3% of the total health expenditure while in China, the same is 24.9% and in Sri Lanka and USA, the same is 45.4 and 44.1 respectively. This is the main cause of low health standards in the country.

Social Inequality

The growth of health facilities has been highly imbalanced in India. Rural, hilly and remote areas of the country are under served while in urban areas and cities, health facilities is well developed. The SC/ST and the poor people are far away from modern health service.

Shortage of Medical Personnel

In India shortage of medical personnel like doctors, a nurse etc. is a basic problem in health sector. In 1999-2000, while there were only 5.5 doctors per 10,000 population in India, the same is25 in the USA and 20 in china. Similarly the number of hospitals and dispensaries is insufficient in comparison to our vast population.

Medical Research

Medical research in the country needs to be focused on drugs and vaccines for tropical disease which are normally neglected by international pharmaceutical companies on account of their limited profitability potential. The National Health Policy 2002 suggest to allocate more funds to boost medical research in this direction.

Expensive Health Service

In India, health service especially allopathic are quite expensive. It hits hard the common man. Prices of various essential drugs have gone up. Therefore more emphasis should be given to the alternative system of medicine. Ayurveda, Unani and Homeopathy system are less costly and will serve the common man in better way. Concluding the health system has many problems. These problems can be overcome by effective planning and allocating more funds.

Evolution of Healthcare in Rural India

In the field of health lot of changes in India since independence before we dwell on the issue, we have to keep in mind some statistics on the healthcare. National Sample Survey Organization (NSSO) in 2011-12 highlights the following facts for a period between 200 and 2012 which needs attention. Total family expenditure on medical bills increased by 317 per cent in urban areas and 363 percent in rural areas for institution care, while 'at-home' medical

expenses increased by about 200 percent in both urban and rural areas. For institutional care in hospitals and nursing homes, costs of tests increased by a 541 per cent in urban areas. Even for the at-home patient, cost of diagnostic test increased by over 400 per cent in the same period. During the period, doctors' fees in hospitals increased by 133 per cent in rural areas compared to 362 per cent in urban cities. Similarly, hospital charges went up by 454 per cent in rural areas compared to 378 per cent in urban areas. Medicine costs in hospitals went up by 259 per cent in rural versus about 200 per cent in urban areas. The number of families that reported expenditure on hospitalization dipped from 19 percent to 14 percent in urban areas and from 19 percent to 15 percent in rural areas. Lack of paper facilities at accessible distances was reported to be a key factor in dipping cases of hospitalization in rural areas. Conversely, families that spent on patient care at home increased from 61 percent to 75 per cent in urban areas and from 62 per cent to 79 percent in rural areas.

The Union ministry of health and family welfare indicate the life expectancy in India has gone up by five years, from 62.3 years for males and 63.9 years for females in 2001-2005 to 67.3 years and 69.6 years respectively in 2011-2015. India will miss the target of reducing maternal deaths (maternal mortality ratio or MMR) to 109 per 100,000 deliveries by 2013. The national MMR is likely to remain at 139 in 2015. Crude birth rate in rural India declined from 38.9 per thousand in 1971 to 23.7 per thousand in 2010. On the other hand, urban areas of the country also witnessed a declined in birth rate from 30.1 per thousand to 18.0 per thousand during the same period. It is evident that birth rate in rural areas came down at a faster rate as compared to urban areas. Death rate in rural areas also came down from 16.4 per thousand to 7.7 per thousand during 1971-2010. Due to extension of medical and health facilities at an accelerated pace in rural areas of the country, the rural urban gap in death rate came down from 6.7 per thousand to 1.9 per thousand during the period 1971-2010. Infant mortality rate is also an important indicator of level of economic development of a country. There has been a sharp decline in rural infant mortality rate from 138 per thousand in 1971 to 51 per thousand in 2010. Urban areas also witnessed a decline from 82 to 31 per thousand in infant mortality rate during this period. Infant mortality rate is high in rural areas which are matter of concern but the National Rural Health Mission (NRHM) will help immensely to overcome this bottleneck. The rural urban differentials in infant mortality rate narrowed down from 56 to 20 per thousand during the period under context. But this is not the complete picture, health related situation could be very different. The private medical care system is an expensive, others may have had to pay bribes in so called free public hospitals. In rural area there are no doctors available in rural health certres. Health care system, many have felt helpless as they did not know why they were given the treatment because the busy doctors never explained. Health care is expensive and there are economic barriers to fulfilling the right to health. An institutional delivery service is included in health quality parameters. Many Women are poor mostly dalit, tribal, and living in remote village who have their delivery at home are denied health support and consequently their right to health remain unfulfilled and unprotected. Two-third of the population in rural India consists of women of child bearing age and children under the age of fifteen years. Since they constitute a particularly unalterable group, they suffer most severely from consequences of socio-economic development. The existing health service being provided through a network of government hospitals, dispensaries, and primly health centres do not reach or remain underutilized by women, especially in rural areas. Otherwise also the health care provided to rural areas is glaringly disproportionate to the needs and abnormally low as compared to urban areas. Under these circumstances, it was considered worthwhile to take a stoke of the health status of rural women. In rural India fifty per cent of rural women are daily wage-earners and they cannot afford to go to hospital for fear of losing their wages. As a consequence of this vicious circle, indecent medical facilities in rural areas and poor resources to obtain treatment from private medical practitioners, women in village often become a nation of number of health problem. The cost of service is major barrier. Caste is consistently cited as the main deterrent to using mental health services. It is observed that out of 75% rural residents who did not receive health care because of the high cost, 60 per cent were women. A lack of health insurance is a significant barrier to treatment and rural areas have disproportionate populations of uninsured and underinsured.

Many studies suggest that to meet the health care need of the rural populations, the assessment of the infrastructure should be based on the availability and accessibility to the basic health service. The shortage in the basic infrastructure and manpower not only have direct impact on availability and accessibility of the health care service by rural populations, but also have greater impact on the health status of the people. It is important to look at social determinates of health and its relation with the health status of the people. The WHO also emphasized on the need to consider the social determinants of health before making policy and programmes. To improve the prevailing situation, the problem of rural health is to be addressed both at the macro (National and State) and micro level (distinct and regional), in a holistic way with genuine effort to bring the poorest of the population to the centre of the policies, a paradigm shift, from the current biomedical model to a socio cultural model is remained to meet the needs of the rural populations. A comprehensive sensed National Health Policy addressing the existing inequalities, and work towards promoting a long-term perspective plan exclusively for rural health is the current need.

References

1. Census. Literacy Rate of India-Population Census 2011. Accessed; c2011 Jan 17. http://www.census2011.co.in/literacy.php.
2. Centre for Enquiry into Health and allied Themes. Review of Healthcare in India (Survey No. 2804 & 2805), Mumbai: Gangolli, Leene V., Ravi Duggal and Abhay Shukla; c2005.
3. Dev RS. Rural Health Care infrastructure in India, New Delhi Kurukshetra; c2016.
4. Gautam HR, Sharma HL. Health Care in rural areas-need of the Hour, New Delhi Kurukshetra; c2015.
5. Government of India. Ministry of Health and Family Welfare, National Population Policy New Delhi; c2011.
6. Kumar Avneesh, Saurav Gupta. Health Infrastructure in India: Critical analysis of Policy Gaps in the Indian Healthcare Delivery, (Occasional paper), Vivekananda

International Foundation (excerpted from); c2012.
7. Kishore J. National Health Programmes of India", Centuary Publications; c2005.
8. Mukhopadhyay A. Srinivasan R, Bose ETD. Recommendations of Independence Commission on Health in India; New Delhi; voluntary Health Associate of India; c2001.
9. Mohan P, Kumar R. Strengthening primary care in rural Indi: lessons from Indian and global evidence and experience, Journal of Family Medicine and primary care; c2019.
10. Ministry of Health and Family welfare. Rural Health Statistics, New Delhi; c2015.
11. Rao Govinda M, Mita Choudhary. Health Care Financing Reforms in India, National Institute of Public Finance and Policy; c2012. (excerpted from www.nipfp.org.in/media/medialibrary/2013/04/wp_2012_100.pdf).
12. Singh Sharad Kumar, Ravinder Kaur, Madhu Gupta, Rajesh Kumar. Impact of National Rural Health Mission on Perinatal Mortality in Rural India, Indian Pediatrics. 2011;49:136-138. (excerpted from medind.nic.in/ibv/t12/i2/ibvt12i2p136.pdf).
13. Srinivasam. R. Health Care in India-vision Issues and Prospects, New Delhi; Planning Commission, Govt. of India; c2004.
14. Sundararaman T. Health Sector in India Perspective and way Forward, New Delhi Yojana; c2016 Feb.