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A REVIEWED STUDY OF RURAL HEALTH SYSTEM IN INDIA

Anil kaila[1], Dr.Jugesh Aspal [2]
[1]Research Scholar, [2]Supervisor
[1,2]Malwanchal University
Indore, Madhya Pradesh

ABSTRACT
Rural Health is one of vital elements of rural life. India being a nation of villages requires an intensive approach towards rural health. Nearly 75 per cent of health infrastructure and other health resources are concentrated in urban areas. Even if several government programmes for growth of rural healthcare have been initiated, the procedural delay in implementation leads to its ineffectiveness. Rural areas have been infected with various contagious diseases like diarrhea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections. The insanitary conditions of households aggravate expansion of these diseases which is further promoted by apathy of people and government. Although unit level institution under rural healthcare takes care of sanitation through its outreach services yet, there is a long milestone to upgrade our health scenario. Rural Health Care services in India are mainly based on Primary health care, which envisages attainment of healthy status for all. The Primary Health Centre (PHC) has been stated to be prime location for diagnosis and first referral of these patients. The coordination between primary and tertiary level institutions needs to be strengthened for overcoming present challenges.
***Keywords*:** Rural Health, Primary Health Care

INTRODUCTION
Most health workers especially the 'doctors' do not want to serve in the rural areas due to overall infrastructural inadequacy and lack of incentives. The public health expenditure in India has been quite minimal in comparison to that of various developing countries. India's public health expenditure is only 17.9 percent out of total expenditure on health as per census of 2001 (Bhat, Ramesh and Nishant Jain, 2004). The public health expenditure of other developing countries has been pegged at 90.6 percent for Bhutan, 83.5 percent for Maldives, 73.4 percent for Democratic People's Republic of Korea, 59.5 percent for Timor-Leste, 57.1 percent for Thailand, 48.9 percent for Srilanka, 44.2 percent for Bangladesh, 29.7 percent for Nepal, 25.1 percent for Indonesia during the same period(Bhat, Ramesh and Nishant Jain, 2004). This scenario is intensified by this fact that Out of Pocket (OOP) expenditure as percentage of total health expenditure in India is higher than that of several Asian, North and South American countries (Basu, Sambit and Saurabh Ghosh, n.d). While this Out of Pocket expenditure in India is 61.7 percent, it is pegged at 30.6 percent for Brazil, 14.2 percent for Canada, 36.5 percent for Chile, 35.3 percent for china, 17.2 percent for Columbia, 27.9 percent for Ghana, 47 percent for Mexico, 14 percent for Thailand and 11.8 percent for the U.S (Basu, Sambit and Saurabh Ghosh, n.d). In comparison with public funding, private funding of healthcare is quite high in India. This private funding consists of household health expenditure, private funds, funds from NGOs which is contributing a major chunk in Indian health care funding as compared to public funding. For detailed analysis, the data of public funding has been compared with private funding within a span of 4 years which is highlighted through below-mentioned table-1. In addition, a significant share of the spending is directed toward curative and tertiary health care services as opposed to preventive, primary, and secondary care. According to the latest National Health Accounts data for 2004-05, about 28 percent of total public expenditure was allocated for tertiary health care services, significantly higher than the target of 10 percent recommended by the National Health Policy of India (Rao, M. Govinda and Mita Choudhury, 2012). Therefore, inadequate public funding on primary health care institutions leads to

degradation of preventive care services. Due to ineffective functioning of these primary level institutions, most of deliveries nearly 3 out of 5 happen at home only (International Institute for Population Sciences (IIPS) and Macro International, 2007). According to NFHS-III, deliveries at home are more common among women who received no ante-natal check-ups. Only 15 per cent of home deliveries were followed by a post-natal check-up. Therefore, it may be inferred from this status that these service delivery mechanisms are leading to various inter-related risks. The problem is not limited till delivery but persists up to infant health care also. The Infant Mortality Rate (IMR) in rural areas is higher than urban areas. In 2009, it was 55 per 1000 live births. Neo-natal mortality in India varies between 60-75 per cent in various states. The death of infants in rural areas is caused by a number of factors ranging from water-borne infections, infectious diseases, malnutrition, insanitary environment which get intensified if furthered by poor rural healthcare. Infections, which are more difficult to deal with, include malaria, filaria and kala-azar. More than 85 per cent of rural children are undernourished in India. According to NFHS -III, the IMR in India has been 57 per thousand live births (Iyengar, Shreekant, Ravindra H. Dholakia, 2011). The underutilization of human and material resources at all these levels leads to ineffective functioning of rural health system. Therefore, it is imperative that there may be provision for up gradation of existing rural health system based on analysis of respective shortcomings.

Challenges for Rural Health System - An Overview

The poor state of the health system in rural areas is not the outcome of a particular occurrence but a consolidated outgrowth of degraded system. It signifies not only lacunae in existing policy and infrastructure but blockage in potential development also. The expenditure on public health has not only been ignored by the state but by common man also. The Common man terms expenditure on public health as useless. In their view, the quality of treatment and medicines in government-run hospitals has degraded. Their diverted investment in private practitioner and private hospitals has worsened public health system in India. The disillusionment and frustration with the growing ineffectiveness of the government sector is gradually driving poor people to seek help of the private sector, thus forcing them to spend huge sums of money on credit, or they are left to the mercy of 'quacks'. Therefore, it is very essential for us to review primary elements for degradation of Public health system in India.

Underutilization of existing rural hospitals

On one hand, there is lackness of efficient health infrastructure in rural areas, on the other hand, these infrastructure are not being utilized by people. Many a time, rural patients bypass local rural hospitals despite the availability of comparable medical services. The general conditional analysis of data on patients and hospitals suggests that hospital characteristics (size, ownership, and distance) and patient characteristics (payment source, medical condition, age, and race) influence rural patients' decisions to bypass local rural hospitals (Chilimuntha, Anil K., Kumudini R. Thakor and Jeremiah S. Mulpuri, 2013). The rural population deems urban hospitals fit for any kind of hospitalization. Therefore, the rural hospitals remain closed or wide open but without any patient. In many areas, accessibility is diminished by the lack of all-weather roads, making access subject to weather conditions (Chilimuntha, Anil K., Kumudini R. Thakor and Jeremiah S. Mulpuri, 2013). This leads to widespread absenteeism from service and closure of facility. The public doctors quite often provide private services instead of going to their designated centres (Bhandari, Laveesh and Siddhartha Dutta, 2007).

Inadequate human resources

The rural public health facilities are battling with the problems of inadequate manpower. There exists shortfall across all cadres in rural health system. The deficiency of trained doctors and medical professionals has paralysed the rural health facilities. As of March' 2013, the vacancy rates of doctors at

PHCs has been 12 percent while the same at CHCs has been 47 percent at India level (NRHM, Budget Briefs, 2014-15). Apart from inadequacy, absenteeism is also adding to the problem. The data of survey done by Nazmul Chaudhury, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan and F. Halsey Rogers, reveals that absenteeism among the primary health providers in India, is the highest nearly 40 per cent (Chaudhury, N, et.al, 2006). During this survey,143 public facilities in India were visited weekly during regular hours for an entire year. Around 45 per cent of the doctors were found absent from primary health centres (Chaudhury, N, et.al, 2006). Absence rates among nurses range from 27 per cent in Madhya Pradesh to over 50 per cent in Bihar, Karnataka, Uttarakhand and Uttar Pradesh. This frequency of absenteeism may be attributed to the fact that there is certainly a serious lack of zealous administrative action towards effective service provisioning (Chaudhury, N, et.al, 2006).

Apathetic attitude of medical professionals

Primary health care has been a neglected stream for most of the medical practitioners. In 2010, according to the approach paper for the 12th Five Year Plan, 10 per cent of posts for doctors at the PHCs and 63 per cent of the specialist posts at the CHCs and 25 per cent of the nursing posts at PHCs and CHCs combined, remained unfilled (Govt. of India Approach Paper for 12th Five Year Plan, 2012-17). The situation for support staff is similar with 27 per cent of pharmacist and 50 per cent of laboratory technician posts also vacant (Rao, Mala and David Mant, n.d). A 2007 World Bank investigation of healthcare in Delhi reported that doctors in primary care centres had less competence and made less effort than staff in the private hospital sector (Rao, Mala and David Mant, n.d). The medical education does not prepare the graduate to function effectively in areas of need. Students who have paid high fees for private medical
education, prefer to pursue career where they are able to recover their investment. Among developing countries, India is the biggest exporter of trained physicians with India-trained physicians accounting for about 4.9 percent of American physicians and 10.9 percent of British physicians in 2008(Kaushik, Manas, et. al, 2008).

Dominance of unregulated Private medical professionals

The apathy of public doctors leads to unregulated private practitioners in health sector. Some of them are quacks. In case of Bihar and Uttar Pradesh, less than 15 per cent of households depend on public facilities (Bhat, Ramesh and Nishant Jain, 2004). Nearly 63 per cent of rural households receive medical care from private practitioners. 42 per cent of those classified as allopathic doctors in rural areas, actually have no medical training. This proliferation of unregulated and unqualified private providers demands an effective regulatory system (India Development Report, 2012/13). 80 per cent of general practitioners practise allopathic medicine without proper training.

Non-Preparedness to fight with Epidemic in rural areas

The rural health system is lagging behind in its responses to pandemic eradication. Most of the epidemics in rural areas are not controlled through proper vaccination policies. Every year there are many epidemics which take hundreds and sometimes even thousands of lives like Dengue, Malaria Cholera, Diarrhea, Pneumonia. The government hospitals inherently lack the adequate facilities to deal with the cases of different epidemics and deadly diseases; moreover at many places, the hospitals are understaffed and lack even the basic healthcare facilities like beds, X-ray machines (Kumar, Avneesh and Saurav Gupta, 2012). Encephalitis is just one of those instances which has crippled the government efforts to control its expansion in rural areas. In 2010, there were 3350 reported cases of encephalitis in Uttar Pradesh. Indian policy makers have failed to provide full vaccine coverage to population. It has been estimated that around 20 per cent of Indian population is not covered under the vaccination coverage.

CONCLUSION

The Rural Health in India has been one of the important issues for development. But it has been one of the neglected sectors in Indian economy. The existing state of public health in the country is so dissatisfactory that any attempt to improve the present position must necessarily involve administrative measures. These administrative measures consist of regulation and enforcement in public health, human resource development & capacity building, population stabilization, strengthening of disease surveillance machinery so that direct or indirect association of these factors with health may be robust. The existence of strong surveillance mechanism will assist in monitoring and further policy making. The strong Human Resource in public health sector will assist in imparting management skills and leadership qualities among health professionals. There has been shortfall not only in terms of physical infrastructure but also human resource in rural healthcare. Even though, the posts are sanctioned by the government, many of them are lying vacant. The apathy of various medical professionals also leads to degradation of rural health scenario. Many rural residents are not able to obtain treatment for basic ailments either due to the non-presence of health care services in the vicinity, or due to lack of funds to access the same (Bhandari, Laveesh and Siddhartha Dutta, 2007). The system of Health planning and decision making has been highly centralized and top-down with minimal accountability, little decentralized planning or scope for genuine community initiatives; the failure of most State supported community health worker schemes being one of the most striking consequences of this top-down approach.

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