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Article : Primary Health Care Services in Rural Area: Facts and Challenges

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Health is an essential input for the development of human resources and the quality of life and in turn the Social and economic development of the nation. A positive health status is defined as a State of Complete Physical, Mental and Social well being and not merely the absence of disease or infirmity [WHO,1946]. Health is regarded a priority for sustained development interventions both at the individual, community and national levels. Improved health is a part of total Socio-economic development and is regarded as an index of Social Development.

Provision of basic health care services to rural community is the primary objective of the government as well as non-governmental organisations in the context of rural development. Rural health services, safe drinking water, sanitation, nutrition etc., have therefore been brought together in the form of an integral package to improve the social, economic and health conditions of the people. Therefore, the primary goal of any health care delivery system is to organise the health services in such a manner as to optimally utilise the available resources, knowledge and technology, with a view to preventing and alleviating diseases, disabilities and sufferings of the people.

BASIC HEALTH CARE SERVICES

Primary Health Care is defined as "essential health care and universally accessible to all citizens and acceptable to them through their full participation and at a cost that the community and country can afford" . [WHO,1978]. It addresses the main health problems in the community through preventive, curative,

promotive and rehabilitative medical and health services. Thus, the delivery of primary health care is the foundation of rural health care system and forms an integral part of the National Health System. The primacy accorded to primary health care reflects the essence of a rural health care system that seeks to integrate itself meaningfully into the national health system. India is one of the very new countries that had, from the very beginning, planned health services as an integral part of general Socio-economic development and health was made a part of it.

The first level contact of an individual with the national health system that brings primary health care to the people's home is the PHC system. A pyramid like health infrastructure has been established to cover the rural areas in the country through sub-centers, primary health centers and community health centers. The primary Health Centre constitutes the backbone of the present rural health care services in the country. It is peripheral yet the most vital outpost around which rural health services are being built. It provides an integrated health service to the rural population. It is the focal point for delivery of health and Medicare services in rural areas. The health package of primary health care provided such inputs which promote the well being and good health of the people. Efficient and effective delivery of primary health care is considered the core activity of any health care system.

PRIMARY HEALTH CARE SERVICES IN THE FIVE YEAR PLANS

The establishment of the first primary health centre in October 1952 was a major landmark in the development of health care services in the country. Since Independence, the aim of the health policy in India has been to secure a change in the health status of its population so that the cycle can be checked and all round socio-economic upliftment of the people can be achieved. The objective of rural

health services is to provide primary health care to the rural people. The Government of India planned several approaches for health care delivery in rural areas.

The primary Health Care strategy as outlined in the Alma Ata Declaration of 1978 envisaged a revolutionary strategy which recognised that health for the majority of the people could not be achieved through the conventional hospital star- based health system on the assumption that benefits would eventually trickle down to reach the poor. The Alma-Strategy of primary Health Care upholds that health care would not only be available but it should be accessible, affordable, acceptable and appropriate to the needs of the people. The 6th Plan envisaged the implementation of Minimum Needs Programme [MNP] of Rural Health Care. The MNP was also intensified during the first five year plans. A critical review was made of the approaches in the first five year plans. Based on these, a long-term perspective plan was outlined by the Government of India to achieve 'Health for All' [HFA] goals. Also, efforts were initiated, for the informulation of a National Health Policy [NHP], keeping in view the 'Health For All' principles and the primary health care approach. These were also incorporated in the 6th plan .

INDIA'S HEALTH POLICY

The most important event during the 6th plan was that of adopting the National Health Policy [1983] by the Government of India. The adoption of NHP in this plan period signaled the higher water mark in the Indian Health Scenario. The NHP, which was based largely on the Socialist model whereby the state is responsible for provision of comprehensive primary health care services to the people. It aims at promotion of health as an integral part of the human resource

development. The policy embodies the philosophy of placing people's health in people's hands, with a pledge to ensure that the entire health services system to be geared to support the people by responding to their needs. India is a signatory to the Alma Ata Declaration of 1978 and is committed to attaining the goals of HFA by 2000 A.D. through primary health care approach. The NHP is the blue print for such concerted action by the government voluntary organisations and the people for the attainment of HFA. The strategy and plan of action for achieving the goals of HFA was laid down specifically during the Sixth plan and implemented in the Sixth and Seventh plans. The policy gave a thrust to the specialised goals to be achieved by the year 2000 A.D.

However, the policy was criticised by many experts on the following grounds :-

i) it talks of poverty alleviation but does not speak on Social Justice which is an essential pre-requisite for HFA.

ii) no definite programme has been suggested for promoting community participation in health.

iii) It is not an integral part of a broad movement of radical redistribution of economic assets and political power and of deep transformation of ideas, attitudes and values, which are essential for achieving HFA by 2000 A.D. Health and family welfare programmes were restructured and reoriented for achieving the objectives of the policy during the seventh and eight plans with moderate success. Therefore, the Government of India, at that time planned to either revise the existing National Health Policy or reformulate a new one. The Significant achievement of the sixth plan was vast extension of rural health infrastructure and

development of promotive and preventive primary health care services along with curative services. Emphasis was given mainly on consolidation of the existing health infrastructure rather than expansion during the right plan. The Mid Term Appraisal of right plan revealed that there have been shortfalls in the achievements of setting up of primary health care infrastructure. Specific efforts have been made to ensure that the on-going economic restructuring does not lead to any adverse effects on provision of essential care to meet the health needs of the most needy segments of rural population. Some of the major steps taken in this direction include specific efforts to consolidate and strengthen the primary health care infrastructure [Planning Commission, 2001]. The India's Health Policy needs modification and was accorded high priority by the planning commission in its approach to the Ninth Five Year Plan implementation. This is needed not only because the quality of health services is poor but also due to low credibility of services.

STRATEGY CHANGE IN 11TH PLAN

The objectives during the eleventh Plan period for Health and Family Welfare include :

i) rebuilding and strengthening of existing health infrastructure at primary health care level and extending outreach of SCs.

ii) devolution of powers, functions, responsibilities and resources to PRIs to have participatory approach at the grassroots level in order to improve the efficiency and sustainability of health services.

iii) implementation of schemes for the benefit of SCs and STs and to reduce population growth through intensified family welfare programme

and improvement in the quality and access of Reproductive and Child Health components through participative planning at the grass root level [Planning Commission, 2001].

With the announcement of the new programme of Reproductive and Child Health, 1997and the National Population Policy [2000], the local bodies or local self-governments are envisaged to be involved in the process of its implementation. The grassroots unit Gram Sabha should be used to raise awareness levels of the people on crucial issues of Reproductive and Child Health [RCH]. It is expected that local self-governments will provide a better set of administrative arrangements for the implementation of the scheme as well as a streamlined health delivery system.

HEALTH FINANCING -

Another area of concern while implementing the health policy, is related to financing of health services. Several mechanisms of financing have been considered such as user charges for government services, community financing and insurance. Health insurance to meet the cost of hospitalisation for major illness may ensure that health care costs do not come a major financial burden to the patients or their families, particularly of the low and middle-income group of population. Thus, there is great scope for extending health insurance in rural areas so that the rural people are benefited by availing the health services of private sector hospitals and nursing homes. Further, if the health services are to be delivered at an affordable cost, it is imperative that the pattern of public health expenditure be changed and private health sector needs regulated and a constructive public-private sector partnership nurtured.

Since health is a state subject, the implementation aspect is the responsibility of the states. Inadequate resource availability in the states may

affect, the policy implementation. However, decentralisation in health and development planning as envisaged under the panchayati Raj Act provides an opportunity for community participation in development programmes. The resources allocated to the health sector from an important determinant of health services in the country. The outlay in health and health related sectors have been increasing over the five year plans. But as the percentage of the total outlay for health has remained constant over the Successive Five year plans at around 2-3 percent of GDP as compared to the figure of 10 percent in developed countries, the major financial expenditure [about 60 percent] is towards the payment of salaries of health personnel in the country.

CURRENT CHANGES

The impact of the development and changes in the health policy were quite divergent and unsatisfactory. Attempts were made to place health and family welfare programmes back on the right track. The National Leprosy control was changed to the National Leprosy Elimination Programme. The Revised National Tuberculosis programme was started in 1993 with the introduction of Directly observed Treatment [DOT]. Modified strategies have been taken up for controlling malaria and tuberculosis with the World Bank. There are many drawbacks in both these control programmes and are unlikely to be effective. A new programme was introduced at a high cost for controlling AIDS and HIV infection. This programme has not been integrated with those of other sexually transmitted diseases.

The approach to the 11th Five Year Plan states that the National Health Policy needs to undergo an appraisal and revision so that it provides a reliable and relevant policy framework for improving health care, measuring and monitoring the health care delivery systems of the people in the next two decades. This task is being undertaken by the government.

CONCLUSION

The problems of health care are enormous. Access to primary health care is inadequate to the majority of the people because of low availability of basic preventive and promotive health care packages, clinics, doctors, drugs and para-medical personnel in rural areas. Greater stress on preventive health care, medicine and health education should be laid. Health literacy efforts should be made integral to preventive, promotive, curative and rehabilitative health care. A meaningful involvement of the private sector and NGOs is crucial in all these endeavors for promoting a people-oriented and a sustainable health care system.

A vast network of rural health institutions has been developed. Rapid expansion has, however, resulted in a considerable drop in the quality of functioning of health institutions. For several reasons, the quality of services and work done by various health institutions and by different categories of Health Personnel are poor, resulting in low credibility among the rural community. Moreover, for want of quality, the efficiency and effectiveness of the programmes and services has been limited and the objectives not fully realised. This is one of the main causes of non-utilisation and or underutilisation of health services and facilities by the people, especially the rural communities.

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