Putting People First: Inclusive Health Care through Primary Health Centers

Nanjunda

Abstract

In India, Primary Health Centers (PHCs) are the keystone of healthcare. PHCs play a vital role as the first level of contact and a connection between individuals and the health system, bringing healthcare delivery as close as possible to where people live and work. Primary health care services are incomplete if they lack appropriate and efficient referral systems to secondary and tertiary care hospitals. Also PHCs have to provide precautionary, remedial and rehabilitative care. Even though there are numerous reasons for a meager performance of PHCs, almost all of them stem from weak stewardship of the sector, which results in a deprived inducement structure. Primary healthcare being crucial, it is based on sensible, systematically sound and culturally appropriate methods. Information about it is made available to individuals in the community through their full involvement and at a cost the community and country can afford to sustain. This helps self-reliance and self-determination. This paper is based on the author's experience in various health care issues and provides a solid platform for discussion about the role of PHC in inclusive health care for the marginalized section of society.

Key words: *Health, PHC, Inclusion*

Author: Dr.Nanjunda, UGC-CSSEIP Research Center, Manasagangotri, University of Mysore, Mysore, India, Email: ajdmeditor@yahoo.co.in

Background

Health is one of the vital indicators reflecting the quality of human life and it is a well-established fact that there is a positive correlation between health of the population and the economic development of the country. Alma Ata Declaration of 1978 by WHO adopted Primary Health Care (PHC) Programme as a strategy for 'Health for All'. Primary health care forms an integral part of the country's health care system and is the driving force behind determining policies. Primary health care can be defined as: socially appropriate, universally accessible, scientifically sound first level care provided by a suitably trained workforce supported by integrated referral systems and in a way that gives priority to those most need, maximizes community and individual self-reliance and participation and involves collaboration with other sectors. It includes the following:

- health promotion,
- Illness prevention, care of the sick, advocacy, community development etc (Kumari, 2009).

Long before the Declaration of Alma Ata, India adopted a primary health care model based on the principle that incapacity to pay should not put people off from accessing health services. Based on the recommendations of the Health Survey and Development Committee Report (the "Sir Joseph Bhore Committee Report") of 1946, the Indian Government decided to focus services on rural people. This with programmes such as the national family planning program, launched in 1952, and the policy of one community health worker per 1,000 people in the 1970s. India had already committed to most of the Alma Ata principles when the global primary health care movement began.

Studies show that the strength of a country's primary care system is associated with improved population health, decreasing all-cause mortality, all-cause premature mortality, and cause-specific premature mortality, from major respiratory and cardiovascular diseases. This relationship is significant at the macro-level and micro-level. Unfortunately, in India, not only is there

pre-existing inequality in healthcare provisions, but this is further enhanced by difficulties in accessing it, which is due to geographical, socio-economic or gender distance. Studies from developed countries demonstrate that an orientation towards a specialist based system enforces inequity in access. Health systems in low income countries with a strong primary care orientation tend to be more pro-poor, equitable and accessible (Sharma, 2009; Anand , 1993).

Recent National Health Policy (2006) has laid stress on people centered primary health care approach. Few ICMR reports have revealed that more than 80 percent of the population has no access to any form of health care. However, curative service, people perception about functioning of PHCs, preventive activities and attitude of the health staff need to be properly evaluated through various research approaches yet. In 2005, the United Progressive Alliance Government launched the National Rural Health Mission (NRHM) to improve access to quality health care, especially for poor rural women and children, to strengthen primary health care institutions, increase equity and the decentralization of services, and encourage states to generate alternate sources of financing. While the mission covers the entire country, its emphasis is on 18 states with the poorest infrastructure including Karnataka state. It is found that NRHM is very effective in certain states and fairly failed in certain states.

Primary care services are incomplete if they lack appropriate and efficient referral systems to secondary and tertiary care hospitals. Primary health care services considerably affect the rural population; however many factors weaken the excellence and effectiveness of primary healthcare services in rural areas. In India, although there are many reasons for poor primary health care performance, almost all of them stem from weak stewardship of the sector, which produces a poor incentive framework. The World Health Organisation (WHO) specifically points out that to some extent, the deterioration in health status is attributed to inadequacies in primary health care implemen-tation, neglecting the wider factors that have

been responsible for this deterioration such as lack of political commitment, inadequate allocation of financial resources to primary health care and stagnation of inter-sectoral strategies and community participation in rural areas. The main ones being bureaucratic approach to healthcare provision, lack of accountability and responsiveness to the general public and incongruence between available funding and commitments (Jones 2009).

Primary Health Centers (PHC)

The PHC concept implied delivery of integrated health services through an appropriate institutional framework to the smallest unit of population possible. The PHC in itself embodies an integrated approach to health services development through Curative, Preventive and Promotive service. The operational responsibilities of the PHC are to cover medical care, maternal and child health services, family welfare, nutrition, health, education school health, control of communicable diseases, protected water supply, environmental sanitation and collection of vital statistics. In spite of the criticism they have faced regarding quality of care and poor infrastructure, they continue to be the major primary care provider for the majority of India's population in rural areas (Banerji, and others 2004).

A typical Primary Health Centre covers a population of 20,000 in hilly, rural, or difficult areas and 30,000 populations in plain areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 sub-centers and refer out cases to Community Health Centers (CHC) (30 bedded hospital) and higher order public hospitals located at sub-district and district level. In each Community Development Block, there is one primary health centre and eight or ten sub-centers at present. An average primary health centre in a community development block covers a geographic area of 400 sq km, with a population of 1, 00,000 to 1, 20,000 persons living in about 100 to 125 villages. Medical relief in primary health centers is designed as an institutional service. PHCs and Sub Centre's (SC) are designed to make primary health care services available throughout the rural areas. Mudaliar

Committee (1955) Chadha Committee, (1963) Arthar Singh Committee (1973) and Shrivatsva Committee (1975) Bajaj Committee, (1986) have also highlighted the importance of upgradation of PHCs (MHFW, 2006)

The National Health Policy (NHP) 1983 envisaged a three-tier structure of primary, secondary and tertiary health-care facilities to bring health care services within the reach of the rural population. The whole concept of infrastructure for primary health care services in our country revolves around two major components of static service centers in the form of the PHCs and SCs (sub centers) and providing of extension services to villages and individual families through planned and continuous visits to villages and individual families by the doctors and para medicals. Studies show infrastructural facilities should be adequate to accomplish the multiple tasks (curative, preventive and promotive health care), family welfare, and material and child health service assigned to the PHCs for the successful implementation of the programmes. Performance of PHCs will be greatly affected due to the absence of material resources like building, equipment, vehicle, medicines, and vaccines etc (Varatharajan, 2004).

PHC's are functioning as peripheral health service institutions with little or no community involvement. Increasingly, these centers came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities and plagued with corruption. Various high level committees have found both rural and urban PHCs are not spared from issues such as the inability to perform up to the expectation due to (i) lack of man power (ii) scarce physical infrastructure and facilities; (iii) deficient quantities of drugs; (iv) lack of accountability to the public and lack of community participation; (v) lack of set standards for monitoring quality care etc.

Experts felt the performance of any health care delivery organizations can be assessed against the set standards. Standards are a means of describing the level of quality those health care organizations are expected to meet or aspire to. Key aim of these standards is to underpin the delivery

of quality services which are fair and responsive to client's needs, which should be provided equitably and which deliver improvements in the health and wellbeing of the population. Standards are the main driver for continuous improvements in quality.

Studies have also shown that, in the improved access to primary health centers and its timely function, lead to less hospitalization, less utilisation of specialist and emergency centers and less chance of patients being subjected to inappropriate health interventions. In low-income settings, the cost effectiveness of PHCs compared to other health programmes has been reinforced by World Bank findings; selected primary healthcare activities such as infant and child health, nutrition programmes and immunization appeared as 'good buys' compared to hospital care. Such interventions could avert a large number of deaths and it is demonstrated that even in resource-poor settings, it is possible to implement and sustain basic PHC services. Few debates also stressed about handing over the responsibility of PHCs gradually to Panchayats (local self Govt.) with technical support, guidance and leadership from State Health Services. However, there are several problems and shortcoming in the PHC system of many states which the district Panchayat has not been able to address effectively (Ranga Rao, 1993; Laveesh, 2009).

Primary care services are incomplete if they lack appropriate and efficient referral systems to secondary and tertiary care hospitals. Primary care referrals in India have not received as much attention. In one study (Patro, 2008) concluded that the referral system was availed of by most of the patients and that longer distances to the referral institution reduced favorable outcomes. Next, referrals depended primarily on issues related to the diagnosis and availability of adequate treatment resources. It is also suggested that appropriate referrals had to be necessary for the patient, appropriate in the course of the disease, successful in reaching its aims and cost effective at PHCs. It is also reported that referrals were more common

when the specialist hospitals were located closer to the general practice. Some time the closest referral hospital would be more than 15-20 kilometers away, which is as well the case with the majority rural sub centers/primary health centers in rural parts of India. It could be thus assumed that the referrals that were made would more likely have been out of necessity than otherwise (Raghvan, 2005).

PHC and Rural Health Services

The differences in urban-rural health indicators are a harsh reality even today; infant mortality rate is 62 per thousand live births for rural areas as compared to 39 per thousand live births for urban areas (2007). Only 31.9% of all government hospital beds are available in rural areas as compared to 68.1% for urban population. When we consider the rural-urban distribution of population in India, this difference becomes huge. Based on the current statistics provided by the Government of India, It is found that at a national level the current bed-population ratio for Government hospital beds for urban areas (1.1 beds/1000 population) is almost five times the ratio in rural areas (0.2 beds/1000 population). Apart from this shortfall in infrastructure, shortfall in trained Doctors enthusiastic to work in rural areas is also one of the factors responsible for poor health care delivery systems in the rural areas. The rural areas are still unable to access the services of the qualified Doctors. There's shortfall of 9% doctors in all Primary Health Centers (Ajit, 2005).

Rural health services in India are provided through a network of integrated health and family welfare delivery system. These are mainly dependent upon networking of PHCs which involve in both curative and preventive activities as well as promoting family welfare services. The PHCs are the first contact point between the village community and the medical officer, whereas sub-centers are the most peripheral contact point between the PHC and community. Lack of access to these institutions is a reflection of an overall deprivation and it results on many health indicators. Many

studies indicated that the health services are inaccessible or poorly accessible for the poor and disadvantaged communities of the society.

Some noted studies have highlighted rural PHCs suffered from a variety of limitations (both institutional and financial) and shortcomings across the country. Limitations to rural health infrastructure and services include (a) Inadequate of medical and paramedical staff (b) lack of amenities in PHC buildings; (c) Scarcity of construction materials causing delay in creating infrastructure, especially sub-centre buildings; (d) Unsatisfactory supply and maintenance of drugs and equipments (e) lack of set standards for monitoring quality care (f) Poor maintenance of vehicles at the PHCs etc. These problems throw up several issues that need to be immediately examined. Prominent among these is the funding and maintenance of rural health infrastructure. Scarcity of trained manpower is another major problem. Moreover, qualified medical and paramedical staff is not willing to work in rural areas because of professional, personal and social reasons. Regarding management of health services at the primary health centre level, various problems relating to suitability of the personnel, coordination of work of different health functionaries (CHC/SC), field logistics and facilities, infrastructural support and services, sectoral coordination with organizations related to health, etc., have been noticed (Umamani,2010; Srinivasan1994). This problem was further compounded by bureaucratic procedures and practices relating to postings and transfers of medical and paramedical staff. Even when we judge from the point of view of government expectations, the overall performance of PHCs has been greatly wanting (Mavalankar, 2009; Rajesh,2006; Srinivasa, 2001).

Adequacy and Accessibility of the PHC Service

In the rural areas, a large number of rural people seek medical treatment and health care by the PHCs. In terms of ratio of population and availability of services the rural areas have inadequate services, particularly in some specific PHCs. However, in urban areas the PHCs rendering

various services seems to be adequate enough because the people of the higher rungs of the society do not depend upon PHCs at all. Hence, PHCs are more needed in rural than urban areas. Urban areas have many favorable conditions (availability of multi-specialty hospitals etc) leading to less dependency on PHCs by the people. Therefore, more number of PHCs and sub centers are needed in rural areas in a developing country (Smith, 2009). Sometimes certain services are available in PHCs but people do not get these services due to various reasons. In rural areas, certain services are available and medicines are supplied in plenty. However, the benefits of these facilities do not reach the beneficiaries. This may be due to the factors like lack of propaganda, awareness and education, lack of hygiene, wrong notion about the quality of medicines provide in PHCs, lack of transport system etc (Aldana, 2001).

Ganguly (2008) opined that some time rural PHCs are usually under-utilized because they fail to provide their clients with the desired amount of attention and medication, inconvenient locations, and long waiting time. Utilization of health services is a complex phenomenon, which is affected by various factors like people's perception about illness, severity of illness, need for health care, knowledge about healthcare services, economic and social accessibility of health system, and biases of the healthcare providers. The economic viability of the PHCs solely depends on the visit by the patients. This is dependent on the basic conditions of the Centers. The government invests more money every year for medicine, staff, bed and other logistics but neglects the variables that affect the annual turnout of patients. It is at this point the PHCs fail to attract beneficiaries. Therefore, they remain economically not viable (Jones and others, 2009).

Approximately one-third of the people of our country, particularly living in the rural, hilly and arid as well as feudal areas have critical health status. Active participation of the people in managing their own health and that of the communities where they live, are associated with the issues of food security, hygiene and underdevelopment. The health of this population

is directly linked to their economic, social and political status and all of them directly depend on PHCs for their health needs. Major thrust should be to help them reverse the situation through a well-planned, adequately financed community-oriented Integrated Health and Development Programmes with substantial participations from voluntary organizations. There have been several efforts in the Planning Commission in identifying these vulnerable areas. Interventions for enhancing community participation in health and family welfare services were designed and implemented. The interventions mainly focused on the active participation of Panchayati Raj Institutions (PRIs) and non- government organisations (NGOs). Dynamic participation of voluntary organisations in the scheduling, supervision and completion of health programmes, mainly in the susceptible areas is more necessary than ever (Kamat, 1995).

Public-Private Partnership (PPP) and PHCs

Public-Private Partnership (PPP) has emerged as one of the important strategies for health sector reforms in the country. Various states have taken Initiatives by NRHM, Health & FW Dept to undertake effective PPPs in health services including RCH-II and other national health programmes like Malaria, TB etc. Studies found that the quality of PHCs service have improved considerably after an effective PPP in many rural areas of the country. In Many states through PPP, PHCs have initiated variety of activities including Community Health Insurance, Telemedicine, Tele-agriculture and farmer advisories (with ISRO), Mainstreaming of Traditional Medicine in Primary care with herbal gardens at PHC, Integration of mental health care, Improved community participation, Health Management Information Systems, stipulation and administration of necessary drugs, accomplishment of normal treatment strategy and drugs and therapeutics board in all-PHCs-etc. Further, to augment the PPP initiatives, it is proposed to have Regional Resource Centre (RRC) to provide technical support for PHC- PPP – NGO activities in various States.

Moreover For an unrestrained development of PHC, flexibility and adaptation in long established bureaucracies are essential at both within the administration and at community level and emphasis on preventive approaches (Dipankar, 2005; Laveesh, 2009).

Till date, hardly one or two studies (Srinivasa,2001; Nanjunda, 2011) have been conducted on primary health care and found that in rural areas, health services provided by the PHCs suffer from quality degeneration because of non-availability of emergency services in time, absenteeism and lack of laboratory facilities or equipment. Difficulties in communication and information usage of expired drugs etc are the causes for low quality service by the PHCs in rural areas of Karnataka. Sometimes, staff of the PHCs have to work in an unsecured zone. Situation in many rural pockets are really bad where PHCs are working in rented congested spaces. News paper report says there are delays in the receipt of funds for drugs by the district government and in the procurement and delivery of drugs to PHCs; and PHCs do not conduct proper accounting. Corruption exists in purchasing medicines. Communities and NGOs lack access to pertinent information on health services, and they are not involved in supervising the programmes and the service providers. Hence, it is essential to look further into the problem .Also no such systematic and holistic study undertaken so far in understanding the effective functioning of primary health centers in the rural areas of the country. The present attempt may go a long way in bridging the gap between the philosophy of working of primary health centers and the reality of the situation.

Conclusion

It is essential to get an insight into the functioning of the PHCs which were established with the objective of minimizing the hardships of the rural people arising out of lack of specialized medical services in the nearby areas or to district and other rural referral hospitals which are already

overcrowded. Evaluating the scheme will make available useful pointers to the policy makers and the implementers for taking corrective measures on bottlenecks, disparities, etc., if any, in the functioning of rural PHCs.

Note: *The author acknowledges the support of ICMR for this project.*

REFERENCES

1. Ajit, K. Dalal, (2005). Integrating Traditional Services Within Primary Health Care , *Journal Of Health Management,* Vol.7, No.2.
2. Aldana J.M, Piechulek H, Al-Sabir A. (2001). Client Satisfaction And Quality Of Health Care in Rural Bangladesh, *Bull World Health Organ* ,Vol.79, No 2.
3. Anand K, Kapoor S K, Pandav CS. (1993). Cost Analysis of A Primary Health Centre In Northern India, *Natl Med J India.* Vol.6, No 4.
4. Banerjee A., Esther C. Duflo, And Angus Deaton (2004) .'Health- Care Delivery In Rural Rajasthan', *Economic And Political Weekly,* Vol.39, No.5.
5. Dipankar Rao K, Peters D.H., (2005). Quality Improvement and Its Impact On The Use And Equality Of Outpatient Health Services In India, *Health Econ*, Vol.16, No.5.
6. Ganguly E, Deshmukh P, Garg B, (2008). Quality Assessment Of Private Practitioners In Rural Wardha, Maharashtra, *Indian J Community Med*, Vol. 33 No 5.
7. Jones P, Hillier D, Comfort D.(2009). Primary Health Care Centers In The UK: Putting Policy Into Practice, *Property Management*. Vol.27 No.2.
8. Kumari R, Idris M, Bhushan V, Khanna A, Agarwal M, Singh S. (2009), Study On Patient Satisfaction in The Government Allopathic Health Facilities Of Lucknow District, India, *Indian J Community Med*, Vol. 34, No.3.
9. Laveesh Bhandari and Siddhartha Dutta (2009), Health Infrastructure in Rural India (internet article)
10. Mavalankar D.(2009). Primary Health Care Under Panchayati Raj: Perceptions Of Officials From Gujarat, *Asian Journal Of Development Matters,* Vol,4 No.2,
11. Mendoza Aldana J, Piechulek H, Al-Sabir (2001). Client Satisfaction And Quality Of Primary Health Care In Rural Bangladesh, *Bull World Health Organ* . Vol.79, No. 51.
12. Nanjunda (2012). Functioning of Primary Health Centers in the Selected Rural districts of Karnataka-India: Some Preliminary Observations, *Indian Journal of Public Health Research & Development*, Vol.3, No-1 (January–June).
13. Patro B K, Kumar R, Goswami A, Nongkynrih B, Pandav C.S (2008). Study Group. Community Perception and Client Satisfaction about the Primary Health

Care Services In An Urban Resettlement Colony Of New Delhi. *Indian J Community Med* , Vol.13, No.2.

14. Rajesh. (2006). Rural Primary Health Centers In India, *Int J Qual Health Care* ,Vol. 18 No.3.Raghvan K.(2005). An Analysis Of Primary Health Care Administration in Pune District. *World Health Journal.* Vol.6, No.2.
15. Ranga Rao, (1993). Administration Of Primary Health Centers In India: A Study, Mittal Publications, New Delhi.
16. Srinivasa (2001). An Analysis Of Primary Health Care Administration In Karnataka. *Punjab University Journal.* Vol.12 No.6.
17. Sharma (2009). National Rural Health Mission: Time To Take Stock. *Indian J Community Med*, Vol.34,No 2.
18. Smith J.A. (2009). Critical Analysis Of The Implementation Of The Primary Health Care Strategy And Framing Of Issues For The Next Phase, Wellington: Ministry Of Health.
19. Srinivasan , (1994). A Study Of Health Care Delivery System With Special Reference To Primary Health Care, *Health And Population - Perspectives & Issues* Vol.7, No. 3.
20. Varatharajan , Thankappan , Jayapalan, . (2004). Assessing the Performance Of Primary Health Centers Under Decentralized Government In Kerala, *India. Health Policy Plan*, Vol.19, N0. 2
21. Vinay R. Kamat ,(1995). Reconsidering the Popularity Of Primary Health Centers In India: A Case Study From Rural Maharashtra, *Social Science & Medicine*, Vol. 41, No.2.