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RURAL HEALTHCARE MANAGEMENT

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ABSTRACT

Healthcare is one of India's largest sectors, in terms of revenue and employment, and the sector is expanding rapidly. Indicators such as infant mortality rate, maternal mortality ratio, life expectancy at birth, malnutrition, etc., have improved significantly over the last few decades; they remain far below that of countries at similar stage in their economic growth. Furthermore, within the country, there are significant disparities in healthcare infrastructure, spending, and outcomes across states and between urban and rural areas. In order to remove the disparity in the progress of healthcare and to bring health care services in rural, health policy envisages a three tier structure comprising the primary, secondary and tertiary health care facilities to reach the people. The primary tier is designed to have three types of health care institutions, Viz., Sub-Centre (SC), Primary Health Centre (PHC), and a Community Health Centre (CHC) as referral centre for every four PHCs. The study was conducted to analyze and evaluate the Rural Healthcare System in India with the objectives to analyse the trends in progress of Rural Healthcare System and its relation with its progress in the selected states viz., Assam, Himachala Pradesh, Madhya Pradesh, Odessa, Rajasthan and Uttara Pradesh which were selected among 18 states considered as the states with weak healthcare indicators/ infrastructure by National Rural Healthcare Mission. The analyses were made considering Public Healthcare Indicators for Sub-centres with reference to facilities. The study reveals that there is a significant difference among the progress of states in Sub-Centre (SC) indicating that there is no homogeneity in the Progress of development in Rural Healthcare in India. The study also shows that all Healthcare Centres confirms that Progress of Rural Healthcare in India had a strong relation with progress of Healthcare Centres. When progress of healthcare indicators of in Sub-centres of each states are compared with that of India, results reveals that, two healthcare indicators among viz., ANM quarters and ANM living in Quarters are weak in entire Rural India. Similarly, The study brings out the fact that the Healthcare Units have not been able to deliver the intended health care and medical services to the people in the rural areas because of weak facility parameters. The constraints to utilization of their services as identified are the inadequacies in infrastructure, non-availability of medical specialists and para medical staff and non-functional complementary facilities. Suggestions were made to find the strategies to streamline the progress of Rural Healthcare System in Sub-centres so as to ensure the availability, adequacy and functionality of health infrastructural facilities including the medical and para-medical staff in Healthcare Units.

KEYWORDS
healthcare units, sub-centres, national rural healthcare mission.

1. INTRODUCTION

From the survey, it was found that, 700 million people living in 636K villages, 66% of rural Indians do not have access to critical medicine, 31% of the population travel more than 30kms seeking health care in rural India. Hence, the study was organized to analyse and evaluate the Healthcare System in Rural India.

2. STATEMENT OF THE PROBLEM

Healthcare Units viz., Sub Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC), were established with the objectives of minimizing the hardships of the rural people arising out of lack of specialized medical services in the nearby areas and their inability to have access to District and other rural referral hospitals which are already overcrowded. Hence, the need to evaluate the scheme was felt. The study would bring out reasons for not providing the intended health care and medical services to the people in the rural areas considering the weak facility parameters. The study would provide useful inputs to the policy makers and the implementers for taking corrective measures on bottlenecks, disparities, etc., if any, in the functioning of Healthcare Units.

3. OBJECTIVES OF THE RESEARCH

Analyze and evaluate the Rural Healthcare System in India with the following objectives:

1. To analyse the trends in progress of Rural Healthcare System viz., Sub-centres and its relation with its progress in the selected states.
2. To analyse Public Healthcare Indicators in Rural Healthcare System for Sub-centres with reference facilities.
3. To analyse the impact of weak rural healthcare indicators on the development of Rural Healthcare Unit in India.
4. To suggest the strategies to streamline the progress of Rural Healthcare System in Sub-centres, Primary Healthcare Units and Community Healthcare Units.

4. SCOPE OF THE STUDY

Scope of the study is restricted to evaluate the progress of Rural Healthcare System viz., Sub-centres in six states viz., Assam, Himachala Pradesh, Madhya Pradesh, Rajasthan, Odessa and Uttara Pradesh, which has been considered as the states with weak healthcare indicators/ infrastructure by National Rural Healthcare Mission.

5. METHODOLOGY OF RESEARCH

As the secondary data has been used in the study for analysis, the desktop method of research has been used. Purposive sampling has been used for the study. For the purpose of analyzing the progress of Healthcare in Rural India, Healthcare Units viz., Sub-centres was selected. To analyse the progress of healthcare in rural India, six states viz., Assam, Himachala Pradesh, Madhya Pradesh, Rajasthan, Odessa and Uttara Pradesh were selected among 18 states which has been considered as the states with weak healthcare indicators/ infrastructure by National Rural Healthcare Mission. Primary data was collected from the Sub-centres in rural Bangalore through interaction with Medical Officers. This has been used for the theoretical understanding. Secondary data pertaining to Number of Sub-centres functioning in rural India and the facilities available in those centres collected from DETAILED STATISTICS, Bulletin on Rural Health Statistics in India, and Statistical Tables Relating to Healthcare in India, Ministry of Family Welfare during the year from 2005 to 2012.

6. ANALYSIS AND INTERPRETATION

The study was organized to analyse and evaluate the Healthcare System in Rural India considering the weak indicators of facilities in Healthcare Centres.

Hypothesis 1: There is homogeneity in the Progress in Rural Healthcare in India.

Progress of Healthcare Units is a prerequisite for the overall progress of the entire Rural Healthcare System. It is expected that, the progressive development in all the selected states is uniform. In order to test the homogeneity among selected states, one-way ANOVA was used.

6.1 TRENDS OF IN PROGRESS OF SUB CENTRES

CONCEPT

Studies were made with the objective to analyse the trends in progress of Sub Centres using Number of Sub-centres functioning in selected six states as proportion to Total number of Sub-centres functioning in India. Data considered for the study is collected for the period from 2005 to 2012.

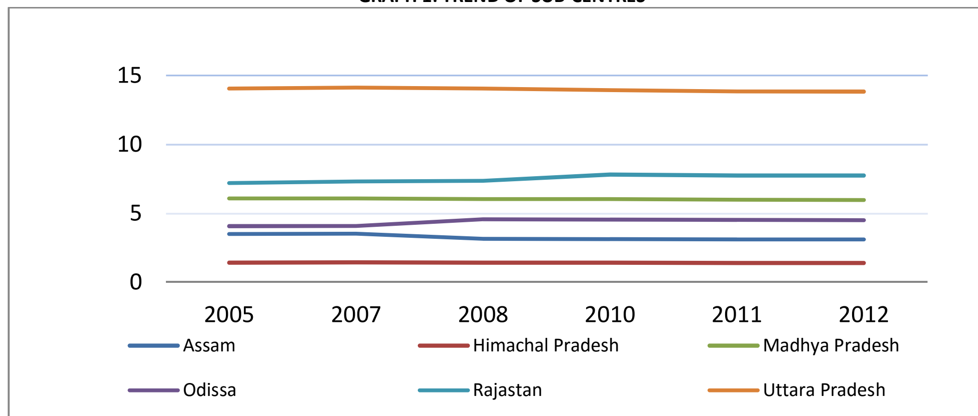
TABLE 1: NUMBER OF SUB-CENTRE AS PROPORTIONATE TO TOTAL NUMBER OF SUB-CENTRES IN INDIA

Sl.No	States	2005	2007	2008	2010	2011	2012	Mean	SME
1	Assam	3.50	3.52	3.14	3.13	3.11	3.10	3.25	0.184
2	Himachal Pradesh	1.42	1.43	1.42	1.41	1.40	1.39	1.41	0.013
3	Madhya Pradesh	6.08	6.08	6.05	6.03	5.99	5.98	6.04	0.039
4	Odessa	4.06	4.08	4.58	4.55	4.52	4.51	4.38	0.223
5	Rajasthan	7.20	7.30	7.36	7.81	7.75	7.74	7.53	0.245
6	Uttara Pradesh	14.05	14.13	14.05	13.95	13.85	13.83	13.98	0.110

Source: DETAILED STATISTICS, Bulletin on Rural Health Statistics in India, RHS-2005-12.

Graphical representation of Sub-centre as proportion to Total Sub-centres for the period from 2005 to 2012 was shown in graph 1. Number of Sub-centres as proportionate to Total number of Sub-centre in each state is plotted against the year.

GRAPH 1: TREND OF SUB-CENTRES



ANALYSIS

It was observed that, among selected States, Uttara Pradesh State has a highest mean of 13.98 % and Himachala Pradesh has a mean of 1.41% as the lowest. It was also observed that, number of sub-centres as proportionate to total number of sub-centre has a steady progress from the year 2005 to 2012 as expected. The standard mean error (SME) was found to be as low as 0.013 for state of Himachala Pradesh and as high as 0.245 for Rajasthan State.

6.2 ONE-WAY ANOVA FOR SUB-CENTRES

By one-way ANOVA, Average number of Sub-centres in proportionate to total Number of Sub-centre and F values are obtained. The mean of the value are ranging from 1.41 of Himachala Pradesh to 13.98 of Uttara Pradesh. The calculated F value was found to be 5.92, which is very high compared to that of table value.

TABLE 2: AVERAGE PROGRESS OF SUB-CENTRES

States	Mean
Assam	3.25
Himachal Pradesh	1.41
Madhya Pradesh	6.04
Odessa	4.38
Rajasthan	7.53
Uttara Pradesh	13.98
F- 6.72** CD (Critical difference) = 2.246	

ANALYSIS

It was observed that the average progress of sub-centres is highly significant with 1% level. Further, it was noticed that the homogeneity exists among 'Assam' and 'Himachala Pradesh', 'Madhya Pradesh'' and 'Odessa' when compared by using Critical difference. We found that, there is a highly significant difference between Himachala Pradesh and Uttara Pradesh.

INFERENCE

From the ANOVA results it is found that, F value is significant; and the results indicate that there is contradiction to the general hypothesis for the progress of Sub-centres.

Hypothesis 2: Progress of Rural Healthcare in India had a strong relation with progress of Health Care Units Viz., Sub-centres.

The progress of primary Healthcare System had a strong relation with the progress of Rural Healthcare in India. In order to examine the stated hypothesis, Karl Pearson's Correlation coefficient was computed between them.

6.3 Relationship between Number of Sub-centres functioning in India and each States

CONCEPT

An attempt was made to find the relationship between relationship between number of Sub-centres functioning in India (SC_I) and each States (SC_S) by the way of coefficient of correlation as shown in table 6.7 for six selected states.

TABLE 3: CORRELATION COEFFICIENT BETWEEN NUMBER OF SUB-CENTRES FUNCTIONING IN INDIA AND EACH STATES

Sl. No	States	2005	2007	2008	2010	2011	2012	r
1	Assam	5109	5109	4592	4604	4604	4604	-0.713
2	Himachal Pradesh	2068	2071	2071	2071	2067	2065	-0.760*
3	Madhya Pradesh	8874	8834	8834	8869	8869	8869	0.658
4	Odessa	5927	5927	6688	6688	6688	6688	0.723
5	Rajasthan	10512	10612	10742	11487	11487	11487	0.902**
6	Uttara Pradesh	20521	20521	20521	20521	20521	20521	0
	All India	146026	145272	146036	147069	148124	148366	

* indicates statistical significance at 10% level

** indicates statistical. significance at 5% level

The correlation coefficient (r) is calculated using the between number of Sub-centres functioning in India (SC_I) and in each States (SC_S) and tabulated in table 5.7.The value of 'r' is ranging from -0.713 to 0.902. The significance of 'r' was tested by student's t–test. It was found that the critical value of 'r' for (n-2) degree of freedom at 5% and 10% level of significance is 0.811 and 0.729.

ANALYSIS

From the table 3, it was found that, SC_I has a strong positive relationship with SC_S in Madhya Pradesh, Odessa and Rajasthan and negative relationship with Assam and Himachala Pradesh States. The value of 'r' is significant for Rajasthan and Himachala Pradesh. This means that, as number of Sub-centres in Rajasthan State increases, number of sub-centres in India also increases. Hence, the results confirm the hypothesis 'Progress of Rural Healthcare in India had a strong relation with progress of Healthcare Units' for Sub-centres.

Hypothesis 3: Facilities in Rural Healthcare Units viz., Sub-centres are inadequate.

The National Rural Health Mission (2005-12), has identified 18 states for its weak public health indicators and/or weak infrastructure. It seeks to provide effective healthcare to rural population throughout the country with special attention to these states. In our study six state viz., Assam, Himachal Pradesh, Madhya Pradesh, Odessa, Rajasthan and Uttar Pradesh were selected. We have considered facilities in Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System.

6.4 COMPARISON OF FACILITIES IN PRIMARY HEALTHCARE SYSTEM

From the studies it was found that the progress of Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) is a prerequisite for the overall progress of the entire Rural Healthcare System. In order to find the strategy for managing healthcare units, facilities in Healthcare units of each state is compared with that of India.

a) Comparison of facilities in Sub-centres: In order to find the strategy for managing healthcare units, facilities in Sub-units of each state is compared with that of India. Table 4 provides the public health indicators with reference to facilities in proportion to the number of Sub-centres functioning in India and each state.

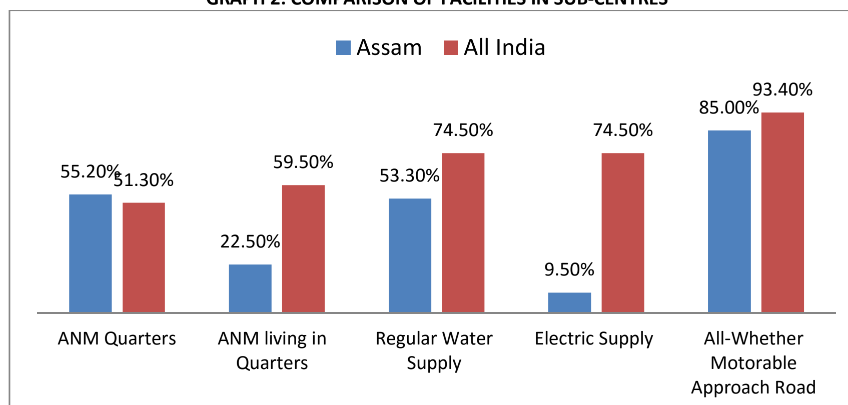
TABLE 4: PUBLIC HEALTH INDICATORS – FACILITIES IN SUB-CENTRES FUNCTIONING IN INDIA AND EACH STATES

Facilities	Assam	Himachal Pradesh	Madhya Pradesh	Odessa	Rajasthan	Uttara Pradesh	All India
ANM Quarters %	55.2	54.2	78.1	53.4	82.5	75.9	51.3
ANM living in Quarters %	22.5	61.0	54.0	75.4	73.2	24.2	59.5
Regular Water Supply %	53.3	81.5	59.3	66.0	79.8	54.6	74.5
Electric Supply %	9.5	87.0	73.1	60.3	93.2	29.0	74.5
All-Whether Motorable Approach Road %	85.0	73.6	81.2	97.3	97.6	92.1	93.4

Source: DETAILED STATISTICS, Bulletin on Rural Health Statistics in India, RHS-2012.

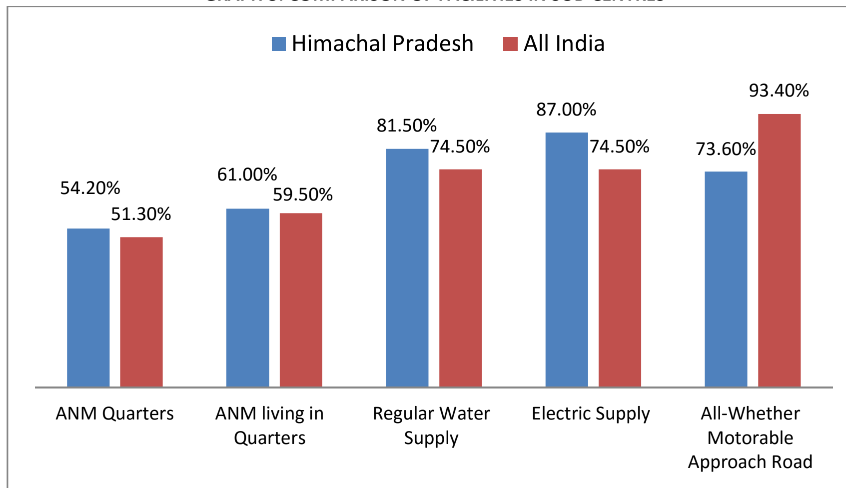
Comparison of public health indicators with reference to facilities in proportion to the number of Sub-centres functioning in each state viz., ANM Quarters, ANM living in Quarters, Regular Water Supply, Electric Supply and All-Whether Motorable Approach Road, is compared with that of India. The graphical representation is shown in graphs 2 to 7 for the states Assam, Himachal Pradesh, Madhya Pradesh, Odessa, Rajasthan and Uttara Pradesh respectively.

GRAPH 2: COMPARISON OF FACILITIES IN SUB-CENTRES



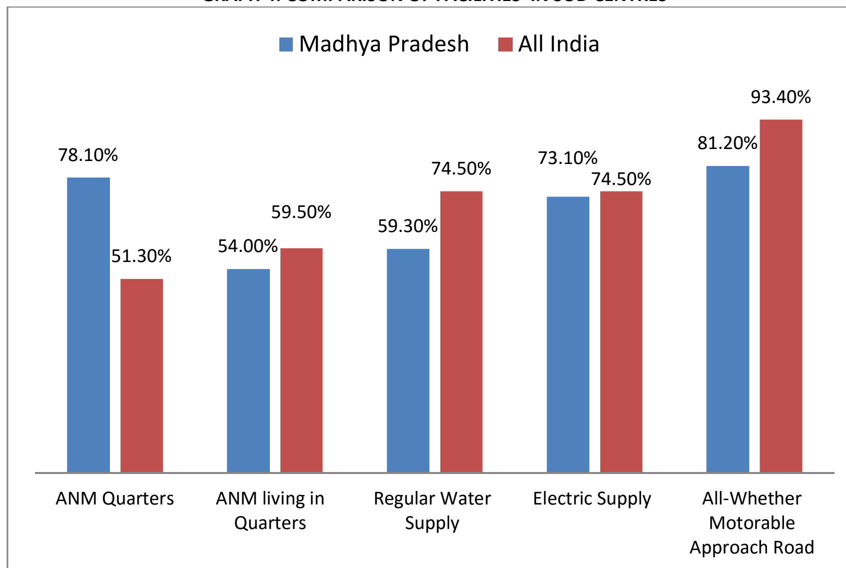
Analysis: It was found that in Assam state**,** ANM Quarters, Regular Water Supply and All-Whether Motorable Approach Road is satisfactory and ANM living in Quarters and Electric Supply is compared unfavorable.

GRAPH 3: COMPARISON OF FACILITIES IN SUB-CENTRES



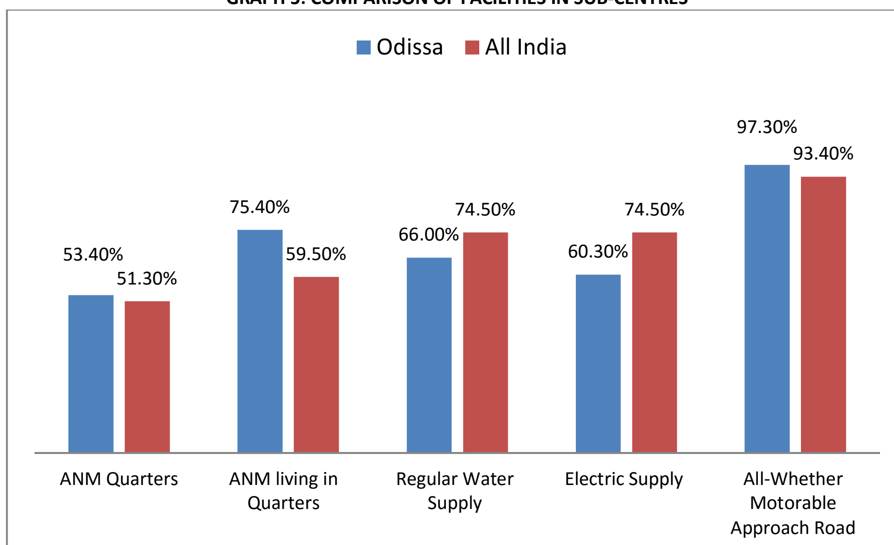
Analysis: It was found that in state of Himachala Pradesh, ANM Quarters, ANM living in Quarters, Regular Water Supply, Electric Supply and All-Whether Motorable Approach Road is favorable when compared to that of India.

GRAPH 4: COMPARISON OF FACILITIES IN SUB-CENTRES



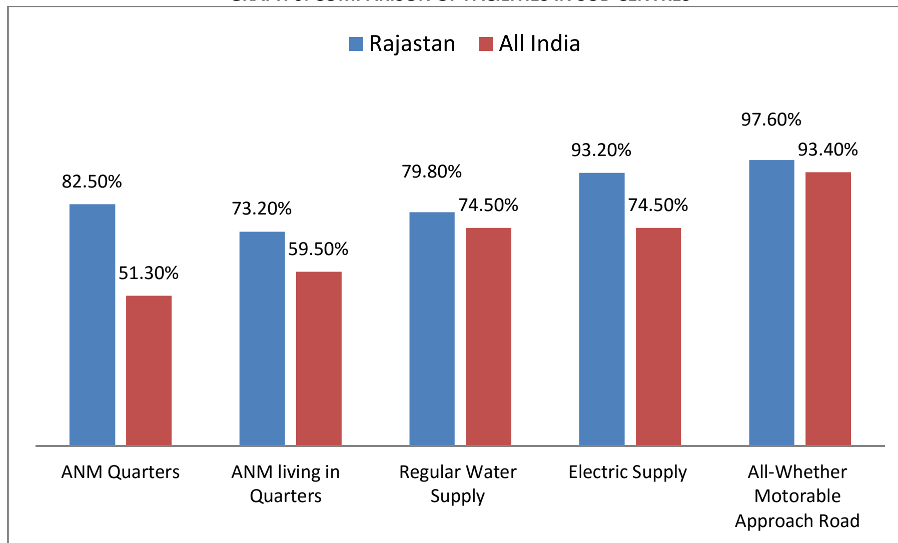
Analysis: It was found that in state of Madhya Pradesh, ANM quarters ANM living in Quarters, Regular water supply, Electric supply and Motorable approach road is satisfactory when compared to that of India.

GRAPH 5: COMPARISON OF FACILITIES IN SUB-CENTRES



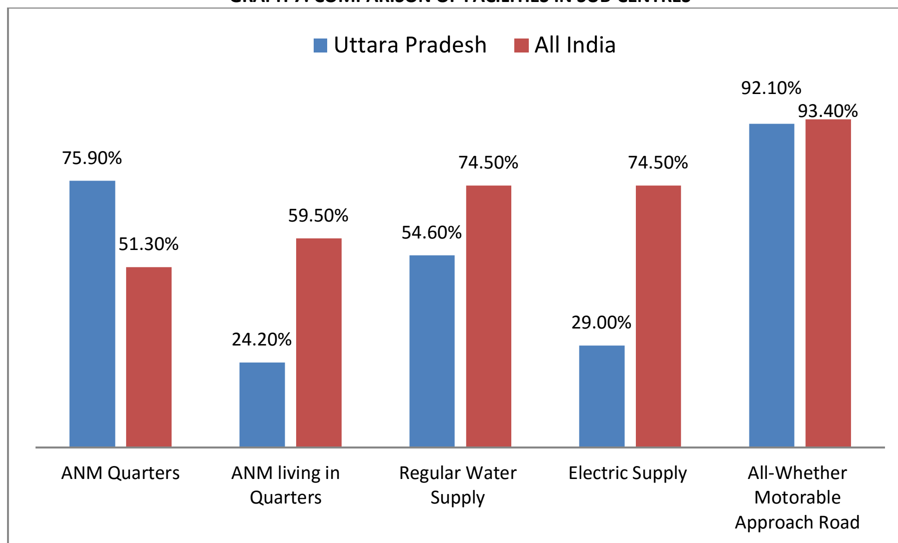
Analysis: It was found that in state of Odessa, ANM quarters ANM living in Quarters, Regular water supply, Electric supply and Motorable approach road is satisfactory when compared to that of India.

GRAPH 6: COMPARISON OF FACILITIES IN SUB-CENTRES



Analysis: It was found that in state of Rajasthan, ANM quarters ANM living in Quarters, Regular water supply, Electric supply and Motorable approach road is satisfactory when compared to that of India.

GRAPH 7: COMPARISON OF FACILITIES IN SUB-CENTRES



Analysis: It was found that in state of Uttara Pradesh, ANM quarters, Water Supply and Motorable approach road is satisfactory where as ANM living in Quarters and Electric supply, when compared to that of India.

Inference: From the comparison of facilities in Sub-centres it was found that, two healthcare indicators viz., ANM quarters and ANM living in Quarters are weak in entire Rural India. Assam and Uttara Pradesh shows its weakness in Electric Supply.

7. SUMMARY OF FINDINGS

The study was conducted to analyse and evaluate the facilities in Sub-centres and Summary of findings are shown below:

- Growth in the progress of Healthcentres in respect of Number of Sub-centres is in steady state, in which Uttar Pradesh has highest growth rate as13.98 % and Himachala Pradesh has a lowest growth rate of 1.41%.
- It is found that, there is a significant difference among the progress of states in all Sub-centres and it contradicts the general Hypothesis 'There is homogeneity in the Progress of development in Rural Healthcare in India'.
- It was found that, Healthcare Units viz., Sub-centres, confirms the general Hypothesis 'Progress of Rural Healthcare in India had a strong relation with progress of Healthcare Units.'
- In Sub-centres, 'ŗ' is significant in Assam and Rajasthan, indicating that Rajasthan's progress reflected in the progress of healthcare in India, where as decline in the progress in Assam effected the progress of healthcare in India.
- Results reveals that in Sub-centres, two healthcare indicators among viz., ANM quarters and ANM living in Quarters are weak in entire Rural India. Assam and Uttara Pradesh shows its weakness in Electric Supply.

8. SUGGESTIONS

The study brings out the fact that the Healthcare Units have not been able to deliver the intended health care and medical services to the people in the rural areas because of weak facility parameters. The constraints to utilization of their services as identified are the inadequacies in infrastructure, non-availability of medical specialists and para medical staff and non-functional complementary facilities[1]. Notwithstanding these constraints and sub-optimal utilization, the majority of the beneficiaries expressed their preference for the services of public health care institutions to those of other alternatives. The following suggestions are made for improving their performance.

[1] Rural Healthcare Statistics 2012

- To ensure the availability, adequacy and functionality of health infrastructural facilities including the medical and para-medical staff in Healthcare Units, there is an urgent need to emphasize the systemic mechanism of supervision, monitoring and review of the functioning of primary health care institutions. This will not only help improve the quality of health delivery system, but also ensure optimum use of public resources.
- The existing Healthcare Units should be made equipped with essential infrastructure and diagnostic facilities which will help increase the utilisation rate. Besides, medicines should be made available in Healthcare Units for those who are living below the poverty line.
- To overcome the hardships being faced by the people in the rural areas due to non-availability/absenteeism of doctors, it is suggested that the local village level health workers as paramedics should be trained on basic medicine, health care, hygiene and nutrition for posting in Healthcare Units and their functioning should be monitored and supervised
- There is an urgent need for setting up of a Technical Committee to go into some basic issues relating to the operational aspects of the rural health care institutions.viz.,
- Review the existing guidelines (framed during Fifth/Sixth Plan) in the light of the advances made in medical sciences, change in health and demographic scenario, appearance of new emerging and re-emerging health problems like, HIV, Plague, Dengue, Hepatitis, Japanese encephalitis, etc, and the performance as revealed in the Programme Evaluation Organisation (PEO)[2] evaluation study.
- Review the existing norms for establishment of PHCs/CHCs in view of the findings that location and geographical area coverage are important determinants of access and utilization of these institutions.
- Suggest ways and means to bridge the gap in the availability of manpower (including unwillingness of doctors to serve rural areas) and complementary infrastructure (e.g. the services of anaesthetists).

9. CONCLUSION

Evaluation Study of National Rural Health Mission (NRHM) clearly highlights that utilization of public health facilities for the delivery care is primarily increasing because of motivational efforts and support of key health workers like ASHAs/ANMs/VHNs. Proximity to public health facility depicts strong impact on its utilization. Since peripheral health facilities like Sub Centers and Primary Health Centers are primarily utilized for antenatal and postnatal care, family planning services and children's immunization, further training and retraining of key health workers would further promote their utilization. Healthcare is at a paradigm shifts in terms of changing disease patterns, increasing dual disease burden for both rural and urban India. On the supply side there has been uneven distribution of healthcare infrastructure and resources posing various challenges to the sector. A multi-pronged approach from key stake holders is necessary to address the issue. Both the public and private sector need to work in tandem to make healthcare available, accessible and affordable. India would need various solutions towards this end.

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[2] PEO Evaluation Studies on Functioning of Community Health Centres (CHCs)

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