



## An Analysis of Rural Health System in India

Dr.Swarooprani.k

Assistant Professor Dept of Economics-Siddhartha Arts and Commerce Degree College.

### Abstract:

Rural Health is one of vital basics of rural life. India being a nation of villages requires an severe approach towards rural health. Nearly 75 per cent of health infrastructure and other health resources are intense in urban areas. Even if several government programmes for growth of rural healthcare have been initiated, the procedural delay in completion leads to its ineffectiveness. Rural areas have been impure with various contagious diseases like diarrhea, amoebiasis, typhoid, communicable hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections. The insanitary circumstances of households aggravate expansion of these diseases which is further promoted by apathy of people and government. Although unit level association under rural healthcare takes care of sanitation through its outreach services yet, there is a long highlight to upgrade our health scenario. Rural Health Care services in India are mainly based on Primary health care, which envisages achievement of healthy status for all. The Primary Health Centre (PHC) has been stated to be prime location for analysis and first referral of these patients. The coordination between primary and tertiary level institutions needs to be strengthened for overcoming there challenges. Methodology: This article is a review paper based on psychoanalysis of data composed through secondary sources like books, journal articles, government records, NGO reports. The recent paper seeks to locate key challenges of rural health system and possible strategies taken by the state for overcoming them.

**Keywords:** Rural Health, Primary Health Care, Infrastructure, Outreach, Sanitation.

**Introduction:**

India is having attention at global front not only in terms of its outburst population but its health condition also. Even after India's Independence, its population is still brewing under the scourge of degraded health system. There are nearly 716 million rural people who are continually battling for essential healthcare services in their habitat this condition has been aggravated by worsening living situation of rural habitats. The unsafe and insanitary conditions of households, drinking water, living areas promotes expansion of several diseases in rural areas. The popular of rural deaths are caused by infectious, parasitic and respiratory diseases which are somewhere linked with unhygienic environment. About 2.3 million episodes and over 1000 malarial deaths occur every year in India. An estimated 45 million population are carriers of microfilaria, 19 million of which are vigorous case and 500 million people are at risk of developing filarial (Patil, Ashok Vikhe, K.V Somasundaram and R.C Goyal, 2002). In addition, even farming related injuries like mechanical accidents, pesticides poisoning, snake and insects bites are adding to the obtainable rural health problems. This scenario is worsened through existing malpractices going on in rural health care. The ancient beliefs of tribal are that any disease may be cured by magic, have subjugated over the minds of rural tribal population of India. Due to this type of notion, the rural areas are under the pressure of various superstitions which finally leads to blockade in the progress of modern pathology there.

**Challenges for Rural Health System - An indication:**

The poor state of the health system in rural areas is not the outcome of a meticulous occurrence but a consolidated result of degraded system. It signifies not only lacunae in existing policy and communications 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 ordinary man terms spending on public health as useless. In their view, the excellence of treatment and medicines in government-run hospitals has degraded. Their diverted venture in private practitioner and private hospitals has worsened public health system in India. The disenchantment and frustration with the growing uselessness of the government sector is steadily driving poor people to seek help of the private sector, thus forcing them to use huge sums of money on credit, or they are left to the mercy of 'quacks'. Therefore, it is very necessary for us to review primary elements for squalor of Public health system in India.

**Unproductive Physical Infrastructure:**

The sub-centre (SC) is the most peripheral organization or first contact point between Primary Health Centre (PHC) and community. Each sub-centre is manned by one secondary Nursing Mid-wife (ANM) and one flexible Worker (MPW). The sub-centers are needed for taking care of basic health needs of men, women and children. Apart from it, PHC also keeps a significant place in health services. It provides incorporated curative and preventive healthcare to the rural population with an stress on preventive and primitive aspects. At upper level, remains CHC. The major function of CHC is to provide complete coverage of health care to patients referred

from PHC. In this affair, poor communications of the hospitals is a matter of grave concern. As per government records, 49.7 per cent of sub-centers, 78 per cent of PHCs and 91.5 per cent of CHCs are located in decrepit government buildings. There are 12,760 hospitals having 576,793 beds in the country. Out of these, 6795 hospitals are in rural areas with 149,690 beds and 3,748 hospitals are in urban areas with 399,195 beds. Average Population served per Government Hospital is 90,972 and standard population served per government hospital bed is 2,012 (Kumar, Avaneesh and Saurav Gupta, 2012). Even in terms of accessibility of vaccines in these hospitals, the condition is very dismal. The availability of life saving vaccines is also not up to the mark, e.g. the gap among demand and supply of DPT in 2009-10 was above 26 per cent while that of vaccines of Tetanus Toxoid (TT) was about 16 per cent (Kumar, Avaneesh and Saurav Gupta, 2012). Penetration of basic communications availability is very low in all the BIMAROU states (India Development Report, 2012/13). 4 percent of PHCs were functioning without Electricity, and 7 percent were without usual water supply as of March' 2013 (NRHM, Budget Briefs, 2014-15). This situation has been quite abysmal in case of sub-centers whose figure is around 25 per cent lacking regular water and electric supply in India as of March'2012(India Development Report, 2012/13).

#### **Underutilization of obtainable rural hospitals:**

On one hand, there is blackness of efficient health communications in rural areas, on the other hand, these communications are not being utilized by people. Many a time, rural patients bypass local rural hospitals despite the accessibility 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 state, 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 linger closed or wide open but without any patient. In many areas, convenience is diminished by the lack of all-weather roads, making access subject to weather situation (Chilimuntha, Anil K., Kumudini R. Thakor and Jeremiah S. Mulpuri, 2013). This leads to extensive absenteeism from service and closure of facility. The public treatment center quite frequently provides private services instead of going to their elected centers (Bhandari, Laveesh and Siddhartha Dutta, 2007).

#### **Inadequate human property:**

The rural public health amenities are battling with the problems of inadequate manpower. There exists shortfall across all cadres in rural health system. The shortage of trained doctors and medical professional has paralyzed the rural health facilities. As of March' 2013, the vacancy duty 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 insufficiency, absenteeism is also addition to the problem. The data of survey done by Nazmul Chaudhury, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan and F. Halsey Rogers, reveals that absence among the primary health providers in India, is the uppermost nearly 40 per cent (Chaudhury, N, et.al, 2006). During this survey, 143

public amenities in India were visited weekly during regular hours for an whole year. Around 45 per cent of the doctors were found absent from primary health centers (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 incidence of absenteeism may be attributed to the fact that there is certainly a serious lack of zealous administrative exploit towards effectual service provisioning (Chaudhury, N, et.al, 2006).

### **Apathetic approach of medical professionals:**

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

### **Dominance of unfettered Private medical professionals:**

The apathy of public doctors leads to unfettered 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 collect medical care from private practitioners. 42 per cent of those confidential as allopathic doctors in rural areas truly have no medical training. This proliferation of unregulated and untrained private providers demands an effective regulatory system (India Development Report, 2012/13). 80 per cent of general practitioners practice allopathic medicine without correct training.

### **Non-Preparedness to fight with Epidemic in rural areas:**

The rural health system is lagging after in its responses to pandemic eradication. Most of the epidemics in rural areas are not restricted through proper vaccination policies. Every year there are many epidemics which take hundreds and occasionally even thousands of lives like Dengue, Malaria Cholera, Diarrhea, and Pneumonia. The government hospitals intrinsically lack the sufficient facilities to deal with the cases of different epidemics and deadly diseases; moreover at many places, the hospitals are shorthanded 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 have 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.

### **Inequitable Immunization:**

The government-run vaccination programmes are also not equity-based. An analysis of district level data through DLHS data of 2007-08 shows a sturdy negative correlation between inoculation and child mortality rate (India Development Report, 2012/13). What is worrisome is, share of children fully immunize decreased in 59 districts in these BIMAROU (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand) states amid 2002-04 and 2007-08 (India Development Report, 2012/13). Households in districts with civil turbulence and inaccessible terrain have particularly poor access. For instance, in Bijapur, a Left Wing Extremist exaggerated district in Chhattisgarh which is among the most rearward in the country, only 0.4 per cent of rural households have access to all three facilities (India Development Report, 2012/13). Poorer access to health services amid the STs is partly because they live in isolated rural and forest areas with an inhospitable terrain where medical amenities are often unavailable, or even if obtainable, absenteeism of healthcare providers is high and monitoring difficult (India Development Report, 2012/13).

### **Inclination towards Home-based deliveries:**

The maternal mortality is still a major barricade in the advancement of rural health. The occurrence of home-based delivery is leading to frequent deaths of pregnant women. Most rural women select home deliveries due to poor access to and low value of healthcare in the motherhood centers (India Development Report, 2012/13). As per DLHS data in 2007–08, less than 40 per cent of rural births were at institutions (compared to 70 per cent in urban areas) and only about 6 per cent of home deliveries were conduct by skilled professionals (India Development Report, 2012/13).

Lack of organization between Medical Research Institution and Health Service delivery institute and innovation. In some of cases, even the researchers from supposed medical centers are not capable of diagnosing the problems. For ex-In June 2011, more than 50 children died in Bihar since of a mysterious disease which included the symptoms of high fever and unconsciousness, the doctors from the National Institute of Virology visited the hospital full of impure children after some days but even they could not identify the disease (India Development Report, 2012/13). Apart from diagnosis of disease, the capable medical research institution is required for formulating epidemic answer plan also. They can help in indigenizing global technologies and ensure its accessibility at economical rate. The collaboration between different research institutions across globe will help in terms of sharing of resources. Downstream research requires the recognition of well-tested knowledge in

relevant areas of health and the processes to facilitate the application of that knowledge for espousal in health sector and policy development. Applied research may address adequately the issues related to scrotal junction by partnership development amid the community, health service providers and the Government. The medical research institution may have possible for updating the technical knowledge of existing medical professionals. Therefore, it is privilege that there must be coordination and cooperation between dissimilar research centers and health service delivery institution in India.

### **Lack of Community Participation:**

The Public health system particularly in rural areas has been quite disconnected from rural masses' needs. The demands of population in terms of treatment, diagnosis, prevention of various disease, have been ignored which result into plague. The absence of consultation with inhabitants of areas leads to ineffective monitoring of bug and maintenance of hygiene and sanitation. The outbreak of epidemic is driven by the fact that there is zero communication flanked by health professionals and residing masses of the worried locality. Therefore, community should be involved in scheming, staffing, and performance of local primary healthcare centers and in other forms of support.

### **Remedies in Rural Health System:**

There have been some strategies and missions initiated for improvement in rural health scenario. The Government has taken assorted steps for institutionalizing the existing rural health framework.

### **National Rural Health Mission (NRHM):**

One of key achievements in the area of rural health is National Rural Health Mission (NRHM). It was ongoing in 2005 with an aim to address infirmities and problems across primary health care and bring about development in the health system and the health position of those who live in the rural areas. It provides nearby, affordable, effective, accountable, and reliable healthcare to all populace and in particular to the poorer and susceptible sections of the population, reliable with the outcomes envisioned in the Millennium Development Goals and general values laid down in the nationwide and state health policies. NRHM is a flagship scheme of central government to improve the stipulation of basic healthcare facilities in rural India by undertaking an architectural correction in the obtainable healthcare delivery system and by promoting good health through improvement in nutrition, sanitation, hygiene and safe drinking water. Under the NHRM, several steps have been taken for the transformation of rural health infrastructure so that degraded situation of infrastructure may be improved.

### **Janani Suraksha Yojana (JSY):**

Janani Suraksha Yojana is a flagship programme of Government of India under NRHM which is deliberate to promote institutional delivery to decrease maternal and neo-natal mortality. It provides cash incentives for women to deliver in a government or credited private medical facility (India Rural Development Report,

2012/13). Under JSY, the ASHA workers augment luggage of institutional deliveries through escorting pregnant women, proper medical facilities for ante-natal care. They work as border between rural health system and community. The study findings of Development Research Services (DRS) of UNFPA indicate that 73 per cent of the births during the year 2008 in Madhya Pradesh and Orissa were conducted in health ability. with these institutional deliveries, those conducted in government centers and in credited private hospitals were found to be 68 per cent in MP and 67 per cent in Orissa (UNFPA Report, 2009).

### **Health Insurance through Ashtray Swarthy Bema Yojana (RSBY):**

Rashtriya Swasthya Bima Yojana (RSBY) is one of landmark schemes in the area of Rural Health. The RSBY offers a micro-insurance artifact for households designated as “below the poverty line (BPL)” and aims to cover up to 60 million households during the country over the next five years (2008-2013) (Das, Jishnu and Jessica Leino, 2011). The objectives of the RSBY are to supply financial protection for households affected by major health shocks and recover health outcomes for poor households (Das, Jishnu and Jessica Leino, 2011). It was launched in 2008. RSBY insures BPL families for hospitalization costs and allows them to choose between public and private hospitals. Beneficiaries must pay a supposed registration fee while the cost of premium payments is common by the central and state governments (Sethi, Sonam, n.d). First, indemnity companies are selected by spirited bidding in each district and receive a premium for every household enrolled by them in the system (Das, Jishnu and Jessica Leino, 2011). Secondly, oath companies empanel in-patient care facilities (ICFs), they then reimburse ICFs for in-patient care provided to enrolled households. ICFs may be either public or private, public amenities may retain payments from the RSBY in self-governed societies known as Rogi Kalyan Samitis (Das, Jishnu and Jessica Leino, 2011).

### **Mobile-based Primary Health Care System:**

The Mobile-based Primary Health Care System is having critical role in the area of rural health. Primary health care military based on mobile devices ensures improved access to primary healthcare (Murthy, M.V Ramana, n.d). This system of mobile healthcare which was initiated in 2005 uses a mobile phone to transmit a person’s vital signs. The health professionals may be able to distantly monitor patients suffering from constant diseases across the country. This implies payment a wide range of services such as health education, support of nutrition, basic sanitation, the provision of mother and child family welfare services, immunization, sickness control and suitable treatment for illness and injury (Murthy, M.V Ramana, n.d). In this affair, the initiative has been taken by a Bangalore-based firm called Centre for growth of Advanced Computing (CDAC). The Software apparatus under development are Patient Database management, communication between doctor and a patient, capture of Medical data acquisition- such as ECG, imagery of heart, lung, eye etc. and Scheduling management (Murthy, M.V Ramana, n.d). A Central repository of Primary Health Center organization System with a Web interface is planned to be developed in an Open source database (Murthy, M.V Ramana, n.d). It also provides growth of Localization Support in nationwide and other Indian languages in mobiles by provide interface for translation.

**Indira Gandhi Matritva Sahyog Yojana Indira Gandhi Matritva Sahyog Yojana (IGMSY):**

Was started in 2010 with a purpose of hopeful women to follow Infant and Young Child Feeding (IYCF) practices counting untimely and exclusive breast feeding for first six months. IGMSY is a centrally sponsored scheme which would be implemented through the State ICDS Cells with 100 per cent financial help from the Ministry of Women and Child Development. It has been piloted in 52 districts across the country. It has been implemented through existing district ICDS cell. Under this scheme, there is a stipulation for cash transfers to all pregnant women and lactating mother in chosen districts. It promotes the demand for mother and child care services through provide incentives based on fulfillment of specific conditions. Under IGMSY, register within four months of pregnancy would be the first landmark for receiving cash benefits of Rs.1500/- at the end of second trimester. Every registered mother under the IGMSY would have a Mother and Child defense Card (IGMSY Report, Govt. of India, 2010). IGMSY would strive to guarantee the optimal immunization of every pregnant woman in close collaboration with the health workers. The scheme would also guarantee accessing provisions for counseling, iron and folic-acid supplement that are vital for the health of both the mother and the child (IGMSY Report, Govt. of India, 2010). Research studies about the world highlight that globally, the universal perform of exclusive breastfeeding for the first six months of life reduces young child mortality by 13 per cent (IGMSY Report, Govt. of India, 2010). In this way, this scheme is very vital for the purpose of hopeful mother and child health development. Apart from this, cash incentive to the Anganwadi Workers (Rs. 200/-) and Anganwadi Helpers (Rs. 100/-) would be provided which would together be Rs.300/- per recipient. Under the overall supervision of the ANM, the ASHA would support all health related intervention under the IGMSY in organization with the AWWs (IGMSY Report, Govt. of India, 2010).

**Conclusion:**

The Rural Health in India has been one of the significant issues for development. But it has been one of the deserted sectors in Indian economy. The obtainable state of public health in the country is so dissatisfactory that any endeavor to improve the present position must necessarily engage administrative measures. These administrative measures consist of regulation and enforcement in public health, human reserve development & capacity building, population stabilization, intensification of disease surveillance machinery so that direct or indirect relationship of these factors with health may be robust. The existence of muscular surveillance mechanism will help in monitoring and further policy making. The strong Human Resource in public health sector will assist in imparting organization skills and leadership qualities among health professionals. There has been shortfall not only in conditions of physical infrastructure but also human resource in rural healthcare. Even though, the posts are certified by the government, many of them are deceitful vacant. The boredom of various medical professionals also leads to squalor of rural health scenario. Many rural residents are not able to obtain action for basic ailments either due to the non-presence of health care services in the vicinity, or due to lack of funds to contact the same (Bhandari, Laveesh and Siddhartha Dutta, 2007). The system of Health planning and



decision creation has been highly centralized and top-down with minimal answerability, little decentralized planning or scope for authentic community initiatives; the failure of most State supported community health worker schemes being one of the most signal sentence of this top-down approach. Therefore, it is imperative for us to revitalize the existing rural health system from both structural and practical points of view.

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