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PRIMARY HEALTHCARE FACILITIES FUNCTIONAL, AND INCREASES THE UTILIZATION: A CASE STUDY IN MYSORE CITY MYSORE DISTRICT.

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Abstract:

The last few decades have witnessed a number of innovative approaches and initiatives to deliver primary healthcare (PHC) services in different parts of India. The lessons from these initiatives can be useful as India aims to strengthen the PHC system through Health and Wellness Centers (HWCs) component under Ayushman Bharat Program, launched in early 2018. Primary Health Care centers are established with the intention to provide accessible, affordable and available primary health care to the common people at their door step, with specific focus on the rural and vulnerable sections. The success of PHC lies in the maximum utilization of its services by the people. But many reports (NFHS-2, NSSO) and studies have pointed out that utilization of PHC services is low both in rural and urban areas, as it is influenced by numerous factors. Unless these factors are identified and the measures taken, the goal of "Universal Health Care and Health for All" may not be achieved. In this background the present paper attempts to study the extent of utilization of PHC services in rural areas and tries to track the factors influencing the accessibility of PHC services. For this purpose, a Case Study of Mysore city PHC in Mysore district has been undertaken. Accessibility, Distance, Health Care Services, Mysore city Primary Health Centre.

Keywords: morbidity prevalence, PHCs, health care, socio- economic factors

INTRODUCTION

Health care in India is delivered through a three tier structure of health services comprising the primary, secondary and tertiary health care facilities with the objective of bringing health care services within the reach of the people of both the rural and urban areas. The primary tier would have three types of health care institutions, namely, a Sub-center (SC) for a population of 3000-5000, a Primary Health Centre (PHC) for 20000 to 30000 population and a Community Health Centre (CHC) as referral center for every four PHCs. The district hospitals are to function as the secondary tier for the urban population. The tertiary health care is to be provided by health care institutions in urban areas which are well equipped with sophisticated diagnostic and investigative facilities.

However, in spite of a vast network of health care institutions in India, there exists a wide gap between the rural and urban areas in terms of availability and accessibility of health care infrastructure, as the urban areas are found better equipped with these facilities. Moreover, health being a state subject, there are imbalances and variations in availability and accessibility of these services in the rural areas across the states. 1.3 The lopsided emphasis on health policy in favour of urban areas has led to disparity in the health status of the rural people, as reflected in the high birth, death and infant mortality rates. For instance, the rural health indicators, such as, birth rate, death rate and infant mortality rate stood at 30.3, 10.1 and 80 respectively during 1995, which are still higher as compared to the corresponding figures of 23.1, 6.3 and 48 respectively for urban areas. 1.4 The data available on the number of hospitals and beds with Directorate of Health Services during the year 1993 indicate that there were 13692 hospitals and 596220 beds in India, of which the rural areas accounted for only 4310 (31.48%) hospitals and 122109 (20.48%) beds. This tends to suggest that our health policy and planning have not facilitated the growth of health infrastructure in the rural areas, given the fact that about 74 per cent of the population lives in the rural areas. 1.5 Since a disproportionate emphasis has been laid on the establishment of curative health centers between the rural and urban areas as majority of these centers are located in the urban areas, the people residing in the rural areas have to travel a long distance to reach the nearest curative health centre for seeking relief from ailments which could have otherwise been readily handled at the CHC level. Besides, for want of a well-established referral system, those seeking curative care have the tendency to visit various specialized health care centers, thus further contributing to congestions, duplication of efforts and wastage of resources. 1.6 However, the inadequacies in the policy measures and planning have been recognized and attempts have been made to address this imbalance in access to health care services by strengthening the rural health infrastructure. The creation of CHC as a referral centre equipped with modern facilities is an attempt to bring down the disparity in access to public health care services between the urban and rural areas and to make the facilities available in the tertiary health care hospitals to the rural people by improving the physical accessibility of such services. As a result, substantial resources have been flown into the programming and implementation of health and family welfare programmes since beginning of the Planning Process in India.

Background: The last few decades have witnessed a number of innovative approaches and initiatives to deliver primary healthcare Primary Health Care defined as an essential health care which should be based on practical, scientifically sound and socially acceptable method and technology (WHO & UNICEF 1978). It should be universally accessible by the individuals and the family in the community through full participation. It is to be made available at a cost which the community and the country can afford to maintain at every stage of its development in a spirit of self-reliance and self-determination (Roy, Samantha 1985). The World Bank Organization Alma-Ata Declaration defined Primary Health Care as incorporating curative treatment given by the first contact provider along with promotional, preventive and rehabilitative services provided by multi-disciplinary teams of health-care professionals working collaboratively (<https://ama.com.au/position-statement/primaryhealth-care-2010>). PHC is the first level of contact of the individuals, the family and the community with the National Health System, bringing health care as close as possible to where the common people live and work. Access to Medical services has historically been used as a measure of a fair distribution. The concept of equality of access to health care is a central objective of many health systems. It implies that individuals should be given equal opportunity to use health services without regard to other characteristics

such as their income, ability to pay, ethnicity, or area of residence (Sunder, 2009). "Access" word itself created much perplexity about its meaning and measurement; In this regard many discussions were held and numerous definitions were proposed such as Access as Utilization of healthcare, Access as Maximum Attainable Consumption of Healthcare and Access as Foregone Utility Cost of obtaining Healthcare and so on. But it was found that access in terms of a utilization of healthcare is the most frequently used definition of equal access in empirical studies (Ibid)

REVIEW OF LITERATURE

WHO Chronicle, (1976)). Study introduced the origin of international health cooperatives on international sanitary system. The study examined the correlation between sanitary system and public health care. According to the study, sanitary system can not be ignored by the government in making provision for public health services.

Chernichovsky (1977) study on "Evaluation Health Programs in India." reveals that economics of health programmes in India. It dealt with conceptual framework of health in which investigations are undertaken for family's response to change in its environment with health programmes in India.

Joseph et al (1984)) study on "Health care in India" reveals that primary health care requires strong and continued political commitment at all levels of government with full understanding and support of the people. It recommends the governments to express their political will to attain health for all by making a continuing commitment to implement primary health care as an integral part of the national health systems within overall socio economic development. The involvement of all sectors concerned so as to enable legislation for the development of primary health

centres Szmoiz et al (1990)) study on "Risk Factors and Maternal Study mortality rate in La-Matanzas province of Buenos- Aires", introduced steps to improve the health status of the population since the 1960s. The effectiveness of many of these interventions would need to be monitored but the actual statistics on health information required proper health programmes planning particularly in connections with efforts to reduce maternal morbidity and mortality remain inadequate. There are also gaps in appropriate consideration of the socio-economic status and cultural determinants of health seeking behavior among the poor strata of the society. The reduction in health budget led to a general deterioration of services accessible to the poor.

Conn Taylor and Albele (1991) study on "Myocardial Infarction Survivors, Age and Gender difference in Physical Health Psychosocial Status.", reveals that age and gender differences in physical health psychological state and reigns adhered in study of 19th adults of 197 adults myocardial infarction services aged for 40-80 years. Twelve years after their first myocardial infraction, they found that increased age was associated with heights depression scores, lower quality, less social support, less participation in cardiac rehabilitation.

Maine D (1991), study on "Safe Motherhood Programme:" addressing the weaknesses of PHC argues that many health centers and hospitals are either non functional or functions only few hours a day. Many a time , staff does not stay at the head quarters, In difficult places staff shortage is very commona and equipment are inadequate and supply of drugs are irregular. Training is poor and lacks skill development, team building and motivational components in priamay health care serviecs.

Parks (1991 study on "Preventive and Social Medicines". Reveals that the primary health care level is the first level of contact of individuals to be followed by family and community. At the level of care, it is close to the people where most of their health problems can be dealt with and resolved. It is at this level that health care will be most effective within the context of the area needs. The median contact of primary health care is provided by the complex of primary health centers and their sub-centers through the agency of multi-purpose

health workers, village health guides and trained people. Besides providing primary health care, the village health guides bridge the cultural and communication gap between the rural people and organized health sector.

World Bank (1994) study on “World Development Report” Concludes that on an average a hospitalized treatment for an illness cost the equivalent of at least a month’s household consumption expenditure. The study examined the relationship between medical care and household expenditure highlighting the declining role of state in providing health care services to the community particularly in rural areas.

Garifield et al (1997) study on “Jan American Journal of Public Health” analyzed the combined effects on severe economic decline since 1989 and a lightening of the US embargo in 1992 on health and healthcare in Cuba. 37 Different methods were adopted for data collected from surveillance system of nutrition; reportable diseases and then hospital diagnosis were reviewed. Improving the private health sector is a worthy goal as it is a popular resource used by all social classes. It is unlikely that a “one size fit for all” will work, as there many situational, structural, cultural and exogenous factors which influence on policy implementation.

OBJECTIVES OF THE STUDY

1. To investigate the accessibility and utilization Pattern of Primary Health Care services in Study area.
2. To identify the factors influencing the accessibility of Primary Health Care centers in rural area

HYPOTHESES

1. PHC services are better utilized by the people in the place where it is situated or physically found.
2. Distance is a significant factor influencing utilization of PHC.

SAMPLING

By using simple random sampling method 100 individuals were interviewed respectively in four subentries of Mysore city PHC. Also informal discussion was made with the Medical officer and Auxiliary Nurse Midwives and other staff of the PHC to know the current status of PHC and its history.

Methods/Statistical analysis:

The present study is based on both primary and secondary data. The secondary data were collected from various published and unpublished sources from Economic and Statistical Department, records of PHC and Hospitals, Directorate Health Service Mysore city. The primary data were collected from 100 households in Mysore city Mysore district through structured interview schedule.

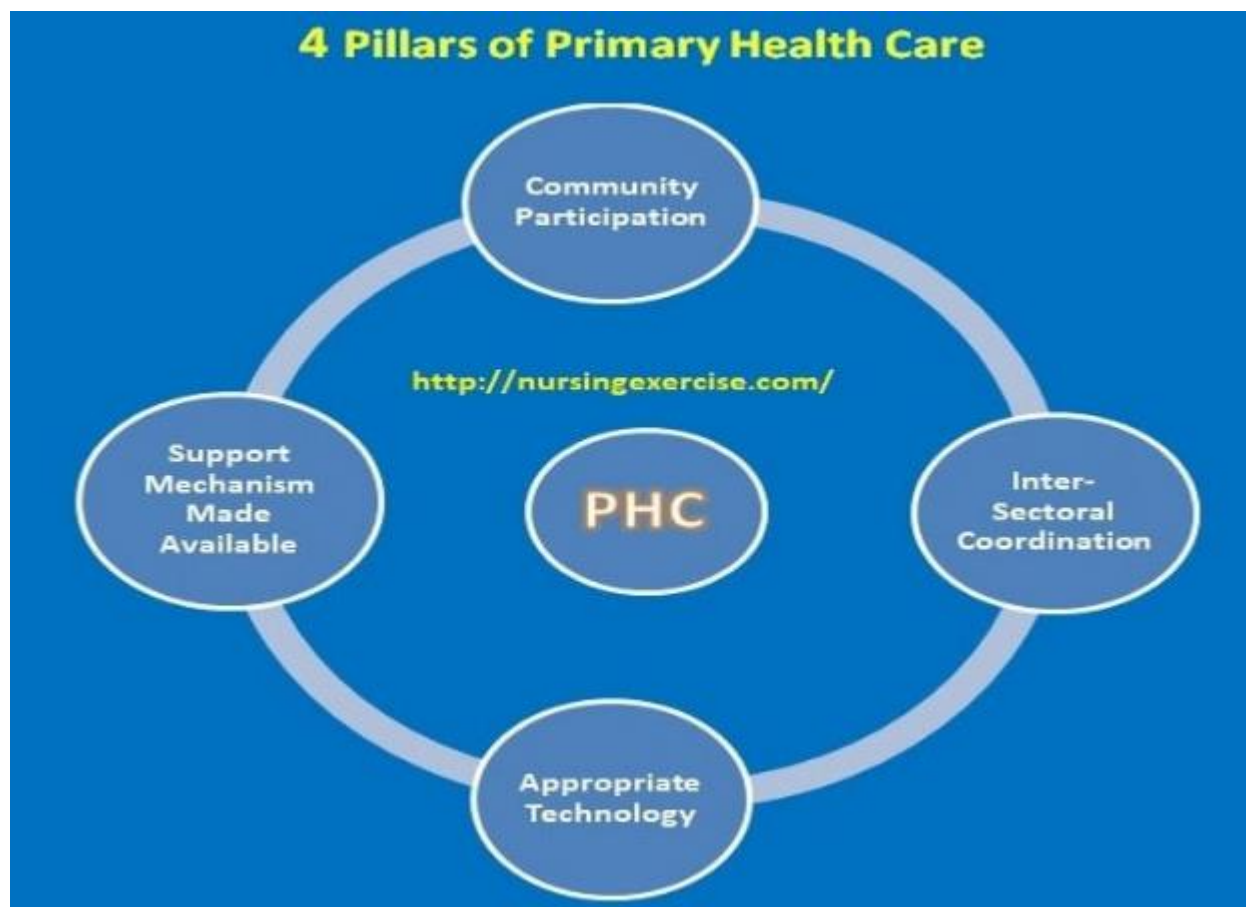
LIMITATION OF THE PRESENT STUDY

The data was collected in the month of February 2018; the response of the individuals may vary according to the time and place. Responses from the individuals have a time bound of one year. Sample size is only 100 which may not be sufficient to universe to assess the accurate and actual results.

MYSORE CITY :

The ultimate goal of primary healthcare is the attainment of better [health](#) services for all. It is for this reason that the [World Health Organization](#) (WHO), has identified five key elements to achieving this goal:^[10]

- reducing exclusion and [social disparities](#) in health (universal coverage reforms);
- organizing [health services](#) around people's needs and expectations (service delivery reforms);
- integrating health into all sectors ([public policy](#) reforms);
- pursuing collaborative models of policy dialogue (leadership reforms); and
- increasing stakeholder participation.



A case study in Mysore city Mysore district

Table1.1 Healthcare seeking from PHC

facility index	30	30%
Very poor	30	30%
Poor	20	20%
Average	10	10%
Good	10	10%

Sources: Field WORK

Table1.2 Average Household Education*** PHC

No Education	20	20%
Primary	30	30%
Secondary	20	20%
Higher	30	30%
TOTAL	100	100%

Sources: **Field WORK**

showing Bivariate analysis of 'healthcare-seeking from PHC' and background characteristics. It can be seen from the table that only 5.8% of the people living in districts with very poor facility index were going at PHC for healthcare seeking, On the other hand, of the people living in districts with very good facility index were seeking healthcare from PHC. It is evident from the table that healthcare seeking from PHC was lower among rich households compared to poor households. It can be seen from the table that the percentage of households seeking healthcare from PHCs were lower among Households with higher average household education compared to households with lower average household education.

Table1.3 Wealth Index** PHC

poorest	40	40%
Poorer	30	30%
Middle	10	10%
Richer	10	10%
richest	10	10%
TOTAL	100	100%

Sources: **Field WORK**

Illustrates the results of multilevel logistic regression showing the odds of visiting PHC for general healthcare seeking. It is evident from the results of both the models that as we move from 'very poor' facility index to 'very good' facility index, the odds of healthcare seeking from PHC increases significantly. People from districts with 'very good' facility index were four times) more likely to visit PHC for healthcare seeking compared to districts with 'very poor' facility index. Average education and wealth index of the household and was also having a significant effect on healthcare seeking from PHC.

Table1.4 Religion*** PHC

Hindu	40	40%
Muslim	30	30%
Christian	20	20%
Sikh	10	10%
TOTAL	100	100%

Sources: **Field WORK**

Table1.5 Caste*PHC**

General	10	10%
Scheduled Caste	40	40%
Scheduled Tribe	30	30%
OBC	20	20%
TOTAL	100%	100%

Sources: Field WORK

Table1.6 Health Insurance Coverage*PHC**

40	40%
60	60%

Sources: Field WORK

Discussion

In the present study, we tried to assess the association between the availability of facilities at PHCs and healthcare-seeking from PHCs in rural areas of the country. We found that more people were visiting PHCs for general healthcare seeking in areas where availability of facilities at PHCs was relatively better. We empirically demonstrated that the degree of availability of facility at PHCs in rural areas is positively associated with people's decision to seek healthcare from PHCs. So on the basis of our findings we can expect that if the government improves the quality and availability of facilities at PHCs then it is more likely that people will choose PHCs for general healthcare-seeking.

One of the biggest problem in rural India is that the public health facilities are facing difficulty in attracting and holding on the presence of quality and trained medical professionals.⁷ The data of Rural Health Statistics is showing that almost all cadres of rural health infrastructure are facing significant shortfall across the country.⁸ At PHCs there is dearth of trained doctors and other medical professionals and even if the manpower is there, their participation level in healthcare production is lower than the required due to deficient supply, insufficient equipment, poor monitoring, etc.²⁰ The shortage of health workforce and facilities certainly has huge repercussions on the healthcare services being provided to the people. The shortage of workforce implies that there are too few healthcare providers at the health centers when patients demand for healthcare, which creates overburdening of the staffs that are present at that time and also long waiting time for the patients. Solution to the problem of manpower and facility shortages in rural areas requires consolidated actions at various levels, especially on the part of the state arrangements, training institutions, and healthcare facilities. Apart from this there has been a significant amount of absenteeism among health providers which needs to be addressed seriously.²¹ As a result, the major proportion of India's population, even the poor, choose expensive healthcare services largely provided by unregulated private sector. It is the poor who bear double burden of poverty and ill-health, the expensive healthcare expenditure can push even the non-poor into poverty These problems related to quality and economic healthcare delivery in rural areas requires an immediate attention and rigorous efforts of policy makers and stakeholders.

Since 2005, the government is trying to improve the healthcare facilities in rural areas through National Rural Health Mission (NRHM). Ayushman Bharat scheme launched in 2018 also focus on rural areas as this scheme targets to upgrade 1,50,000 SCs and PHCs into health and Wellness Centers (HWCs) by 2022, these centers will provide extensive primary healthcare which will incorporate palliative care geriatric health care and rehabilitative care. The National Health Policy (NHP-2017) proposes to improve rural health infrastructure and availability of human resources in high priority districts by 2025.²² These are some of the programmes which envisage of alleviating the healthcare facilities in rural areas of the country, but the problem arises on the implementation level, these programmes and policies focus on achieving the respected targets and objectives and ignore micro/ground-level problems which vary from place to place with respect to geographic and demographic factors.⁴ Ultimately they result in an ineffective and flop program. So there is an urgent requirement of a potential, comprehensive, and integrated approach that will make a significant impact on the

ground level and help the poor population of rural India. The contours of the national health policy have to be evolved within a fully integrate planning framework which seeks to provide universal comprehensive primary healthcare services especially in rural areas, relevant to the actual needs and priorities of the community at a cost that the people can afford.

CONCLUSION:

Utilization of health care services has become one of the great concerns in the area of equitable distribution of health services. In this regard the present paper made an attempt to study the utilization pattern of Primary Health Centre services in rural area in form of Gender, Education, Income and Distance. It was found that in the study area 82% people are utilizing PHC services. The results support earlier findings on relationship between Utilization of PHC service and Education level, Income and Distance (NFHS-2, NSSO, Ghosh.BN and others). The study identified negative correlation between education level and awareness on government programmers. It was found that utilization of PHC is negatively associated with education level, income and distance. The distance was found to be the only statistically significant determinant. The study findings also supported by the reasons sated by the non-users of the PHC services that even though the Mysore city PHC is situated just beside the highway respondents find longer distance, poor road and transport facilities as major constraints in their accessibility.

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