Commentary

An Objective View of Problems in Rural Healthcare Infrastructure in India

Dr. Syed Meraj Ahmed

Associate Professor, Department of Community Medicine, Chettinad Hospital & Research Institute, Chennai, India

Dr. S M Ahmed completed his MBBS and MD in Community Medicine from Jawaharlal Nehru Medical College and Hospital, Aligarh Muslim University. He also holds the DLSHTM and MSc in Public Health degree from London School of Hygiene and Tropical Medicine, University of London, UK. He qualified in the PLAB (UK) licensing examination in 2005 and was working in a GP surgery clinic in UK for more than a year. He is an active member of the Indian Medical Association (IMA) and IAPSM. He is currently working as an Associate Professor in the Department of Community Medicine, Chettinad Hospital & Research Institute.

Corresponding author - Dr. Syed Meraj Ahmed (merajahmed10@hotmail.com)

Chettinad Health City Medical Journal 2014; 2(1): 4 - 6

Abstract

Presently it seems that adequate rural healthcare in India is a virtual pot of gold at the end of a long winding road. While we are making great strides in upgrading our healthcare infrastructure and resources to world standards in the metropolises and other cities, the gap in accessibility to these resources between the urban and rural population within the country is ever increasing.

Overall we still can only compare our medical successes with other developing and poorly developed countries and are still far away from the kind of health changes that has been brought about in developed countries. Previous studies have suggested that majority of the rural deaths which are preventable, are due to communicable, parasitic, respiratory diseases and infections. Easily accessible basic interventions can help in minimizing the sufferings.

Problem areas that needs to be looked into while comparing rural and urban healthcare services are inequality and inadequacy; misallocation of public money and inadequate rural public health expenditure; flagrant commercialization of healthcare and crippling hold of drug manufacturing companies on distribution and pricing of life saving medicines.

The selective, institutionalized, centralized and top – down method of healthcare service delivery needs to be dismantled and a decentralized medical service which can be easily accessed by the people is required for the majority of the rural population. Small changes along with some drastic ones by the people who develop policies are required like the concept of rural medical colleges, family physicians, integration of Indian System of Medicine Practitioners into the registered medical practitioner category. Most important is appropriate allocation of funds and budgets to upgrade/ develop the healthcare infrastructure among the rural population that is actually utilized and shown through regular audits.

Key Words: Rural healthcare, Public private partnership, Stakeholders, Healthcare planning

Problem Statement

Innumerable data have shown that there is a dearth of even appreciable quality healthcare as far as the population who are poor, lives in underdeveloped/ remote areas or even the suburban slums are concerned [1,2,3,4]. An article rightly published that access to health care is defined as the use of healthcare by those who need it and studies have shown that gender, social geography, social groups and class influence access5.

Even when the infrastructure and resources are available for the select few it becomes a harrowing experience to get medical attention since it all becomes too expensive for the common man. A recent article on a major newspaper stated that for a patient around 70% of total health spending is out of pocket, and around 70% of that is on drugs[6]. India faces an acute shortage of over 64 lakh skilled human resource in the health sector with Uttar Pradesh alone accounting for a shortfall of 10 lakh allied healthcare professionals, according to a latest study by the Public Health Foundation of India[7].

Overall we still can only compare our medical successes with other developing and poorly developed countries and are far away from the kind of health services access at the population level that has been brought about in developed countries.

Previous studies have suggested that majority of the rural deaths which are preventable, are due to communicable, parasitic, respiratory diseases and infections. Easily accessible basic interventions can help in minimizing the sufferings.

Roadblocks To Essential Healthcare Coverage

- Expanding middle class population with severely limited access to healthcare services. (Table -1 & 2)
- Communicable diseases once thought to be under control, such as dengue fever, viral hepatitis, tuberculosis, malaria, and pneumonia etc. have returned in force or have developed a stubborn resistance to drugs.

- Over the next 5-10 years, lifestyle diseases are expected to grow at a faster rate than infectious diseases in India, and to result in an increase in cost per treatment.
- Infiltration of unregulated private healthcare services even up to the tertiary secondary and primary health centre and sub centre levels have increased the financial burden on the individual patients as ~80% of the cost is borne out of their own pocket. (Table – 3)
- Inability to counter commercial interests of pharmaceutical companies with the broader social objective of curing disease and preventing epidemics that could literally ravage the Indian subcontinent.

Health Sector Reforms being undertaken

- Strengthening management structures by recruiting health workers on a temporary/contractual basis.
- Getting staff on a contractual basis wherever there is a dearth of nursing and allied health staff.
- Strengthening infrastructure by upgrading health centres and introducing better treatment protocols.
- Public private partnership on a built-own-operate-transfer basis.
- Encouraging outreach activities by NGOs and utilizing their close proximity with the population to improve the healthcare delivery.

Interventions that can really help

- The rural healthcare system to be modelled on the basis of the requirement at the local level rather than on the vision of the central or state government.
- Performance based incentives to the healthcare institutions both governmental and private in rural areas.
- To vigorously promote the concept of medical colleges having 4-5 villages under them and to provide preventive, curative and promotive health.
- Affordable healthcare insurance that allows access to essential healthcare services[8,9,10].
- A compulsory rotatory posting of new medical graduates to rural areas and attractive incentives provided depending on the performance[11,12].
- A universal mobile number that can be dialled to access a trained healthcare specialist for information on any health related problems at the district level.
- Promotion by the Government of local manufacturers to make medical equipments and diagnostic equipments that is more affordable.

In Conclusion

Policy makers and other stakeholders need to sift through the gargantuan pile of mistakes, failures, lost opportunities and myopic ideas. That means huge investments in healthcare infrastructure well utilized in the right areas and not well spent. Universal healthcare delivery should imply access to it by everyone who needs it irrespective of caste, colour, creed or social status.

Table 1

Per lakh population	beds	hospitals	Dispensaries
Urban	178.78	3.6	3.6
Rural	9.85	0.36	1.49

Source: Review of healthcare in India, 2005. Can be accessed at http://www.cehat.org/publications/PDf 20files/r51.pdf

Table 2

India: Health Workforce and Capacity (2005 – 2010)	
Physicians (per 10000 pop.)	6
Nurses & Midwife (per 10000 pop.)	10
Community Health Workers (per 10000 pop.)	7
Births attended by skilled health personnel (%)	58%
Hospital beds (per 10000 pop.)	9

http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html

Table 3

INDIA: Funding, financing and expenditure	
Health expenditure per capita (PPP; $) (2009)	$124
Total expenditure on health (as percent of GDP) (2009)	4.2%
General Govt. expenditure on health (as % of General Govt. expenditure) (2009)	3.7%
General Govt. expenditure on health (as % of Total expenditure on health) (2009)	30.3%
Private expenditure on health (as % of total expenditure on health) (2009)	69.7%
Out of pocket expenditure (as % of private expenditure on health) (2009)	86.4%

http://www.who.int/gho/publications/world_health_statistics/2012/en/index.html.

References

1) De P et al; Efficiency of health care system in India: an inter-state analysis using DEA approach; Soc Work Public Health. 2012; 27(5):482-506.

2) Purohit BC; Inter-state disparities in health care and financial burden on the poor in India. J Health Soc Policy. 2004; 18(3):37-60.

3) Mathew JL; Inequity in childhood immunization in India: a systematic review; Indian Pediatrics. 2012 Mar; 49(3):203-23.

4) De Costa A et al; Where are healthcare providers? Exploring relationships between context and human resources for health Madhya Pradesh province, India Health Policy. 2009 Nov; 93(1):41-7.

5) http://www.cehat.org/publications/PDf%20files/r51.pdf.

6) http://www.thehindu.com/health/article3850103.ece;

7) http://southasia.oneworld.net/resources/from-paramedics-to-allied-health-sciences-landscaping-the-journey-and-way-forward#.UOVXm28zpJc

8) James CD et al; To retain or remove user fees? Reflections on the current debate in low- and middle-income countries; Applied Health Econ Health Policy. 2006;5(3):137-53

9) Dalinjong PA et al; The national health insurance scheme: perceptions and experiences of health care providers and clients in two districts of Ghana Health Econ Rev. 2012 Jul 23; 2(1):13.

10) Jehu-Appiah C et al; Household perceptions and their implications for enrolment in the National Health Insurance Scheme in Ghana; Health Policy Plan. 2012 May; 27(3):222-33

11) Saini NK et al; what impedes working in rural areas? A study of aspiring doctors in the National Capital Region, India Rural Remote Health. 2012; 12:1967.

12) Lee YH et al; Initial evaluation of rural programs at the Australian National University: understanding the effects of rural programs on intentions for rural and remote medical practice; Rural Remote Health. 2011; 11(2):1602.

American Kids and Mental Health

According to a new report released by Centre for Disease Control (CDC), 20% of all American kids (i.e. 1 in 5) between the ages of 3 and 17 have some sort of a mental health problem. The report was developed in collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute of Mental Health (NIMH), and Health Resources and Services Administration (HRSA). The commonest mental disorder appears to be ADHD (6.8%), followed by behavioral problems (3.5%), anxiety (3%), depression (2.1%), autism related conditions (1.1%) and Tourette syndrome (0.2%). Adolescents aged 12 to 17 years in addition had history of illicit drug use disorder in the last year (4.7%), alcohol use disorder in the last year (4.2%) and cigarette dependence in the last month (2.8%). Most of these problems are found more frequently in males; however, depression and alcohol use disorder were more common in girls. Report also noted that more boys in the age group of 12 - 17 are likely to commit suicide. It is truly alarming! It would be interesting to know how the Indian kids fare http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid=su6202a1_w

- Dr. K. Ramesh Rao