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Editorial

Health and Hamlet

India lives in the villages – is a common saying and as it happens with all common things, a gross aloofness and indifference develops against such things leading to its subtle yet rapid degradation. Rural health care is one such sector which languishes under such inadequacy of health care. While we as Indians preach fraternity and brotherhood and collectively believe in democracy inadequacy of health care in rural sector is a serious short fall. Rural Health care is one of biggest challenges facing the Health Ministry of India. With more than 70 percent population living in rural areas and low level of health facilities, mortality rates due to diseases are on a high.

Healthcare should be the right of every individual but shortage of quality infrastructure, lack of qualified health care workers, and non- accessibility to basic medicines and medical facilities restricts its reach to 60% of population in India. Approximately a majority of 700 million Indians live in rural areas where the condition of medical facilities is far below standard. There is an absolute need of new practices and procedures to ensure that quality and timely healthcare reaches the deprived corners of the Indian villages. Undoubtedly policies are there but they remain null and void due to lack of implementations. In rural India, where the number of Primary Health Care Centers (PHCs) is limited, 8% of the centers do not have doctors or medical staff, 39% do not have lab technicians and 18% PHCs do not even have a pharmacist.India also accounts for the largest number of maternity deaths. A majority of these deaths are in rural areas where maternal health care is poor. Even in private sector, health care is often confined to family planning and antenatal care and do not extend to more critical services like labor and delivery, where proper medical care can save life in the case of complications[1].

Contagious, infectious and waterborne diseases such as diarrhoea,amoebiasis, typhoid, infective hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. However, non-communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population. This is reflected in the high infant mortality rate (Fig 1)[2], high maternal mortality rate[3]; however, over a period of time some progress has been made. To improve

the prevailing situation, the problem of rural health is to be addressed both at macro (national and state) and micro (district and regional) levels. This is to be done in an holistic way, with a genuine effort to bring the poorest of the population to the centre of the fiscal policies. A paradigm shift from the current 'biomedical model' to a 'sociocultural model', which should bridge the gaps and improve quality of rural life, is the current need. A revised National Health Policy addressing the prevailing inequalities, and working towards promoting a long-term perspective plan, mainly for rural health, is imperative[4].

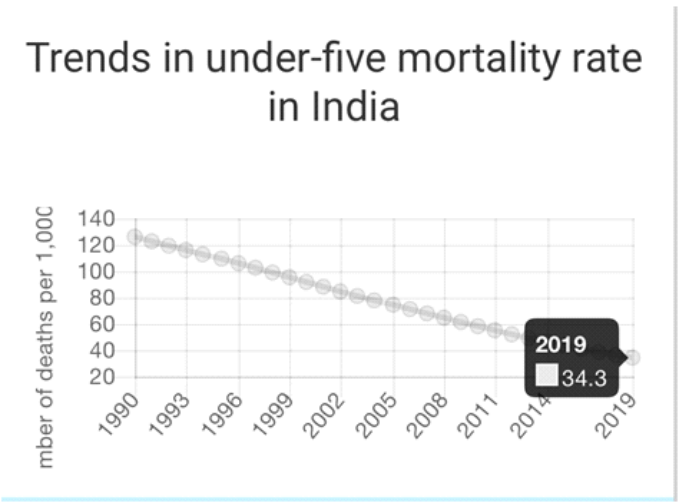

Fig 1

The above discussion clearly showcases the dire condition of rural health in India and we are well aware of it even before reading this article. However something must be done urgently to rectify the situation and to reach out to those population who are in absolute need to get proper healthcare at a proper time. But what are the barriers to health promotion and disease prevention in rural areas.

Higher poverty rates, Cultural and social norms surrounding health behaviours, Low health literacy levels and incomplete perceptions of health, Linguistic and educational disparities, Limited affordable, reliable, or public transportation options, unemployment, Lower population densities in certain areas for program economies of scale coverage, and effective program operation, Lack of access to nutritional food, Safe Drinking water, proper Sanitation Facilities are some of the many barriers.

According to Lancet India Group for Universal Healthcare, "To sustain the positive economic trajectory that India has had during the past decade, and to honour the fundamental right of all citizens to adequate health care, the health of all Indian people has to be given the highest priority in public policy. We propose the creation of the Integrated National Health System in India through provision of universal health insurance, establishment of autonomous organisations to enable accountable and evidence-based good-quality health-care practices and development of appropriately trained human resources, the restructuring of health governance to make it coordinated and decentralised, and legislation of health entitlement for all Indian people. The key characteristics of our proposal are to strengthen the public health system as the primary provider of promotive, preventive, and curative health services in India, to improve quality and reduce the out-of-pocket expenditure on health care through a well regulated integration of the private sector within the national health-care system. Dialogue and consensus building among the stakeholders in the government, civil society, and private sector are the next steps to formalise the actions needed and to monitor their achievement"[5].

Hitherto we have showcased a genre of problems which strangulate the rural health infrastructure but finding ways out of it should also be a part of the discussion. Some possible ways out are discussed as below.

Various experts and practitioners, based on their own experience and global evidence, made the following recommendations that would have relevance for strengthening primary healthcare in rural India.

Investments in Primary Healthcare :

The policy commitment to invest 2.5% of GDP on healthcare and 70% of this expenditure on primary healthcare should be tracked periodically.

States that provide lower allocations on healthcare should be encouraged and supported to provide higher allocations.

Primary healthcare :

PHCs and Health and Wellness Clinics should retain the gatekeeping function:

This would help in increasing utilization of PHCs and maintain the primacy of primary healthcare. It would also help in reducing expenditure by reducing unnecessary referrals

There must be universal coverage for primary healthcare, in addition to the secondary and tertiary care:

Promoting access to primary healthcare will reduce the overall expenditure on healthcare, by reducing unnecessary referrals, by preventing illnesses, and by treating diseases at an earlier stage.

PHC team for health and wellness :

Responsibility (and accountability) for care of a defined population should be entrusted to the entire primary healthcare team:

The team would consist of the PHC staff (including the primary care physician), and H and WC staff (consisting of the mid-level provider, auxiliary nurse midwife (ANMs), multipurpose worker (MPWs), and accredited social health activists (ASHAs). Such a team is likely to provide comprehensive and continued care. Primary care physician should be trained in family medicine, and nurses (and other mid-level providers) should be trained in equivalent generalist care

Primary care team should be adequately supported through regular skilling, incentives, and supervision. Appropriate technological solutions should be provided to help them deliver quality healthcare. These teams should have functional linkages with higher levels of healthcare.

Creating and retaining healthcare professionals for rural primary healthcare (PHCs and H and WCs)

Revise undergraduate medical and nursing curriculum to align with rural priorities:

The training of MBBS should be aligned toward producing rural family physicians, and of nursing graduates, to produce rural primary care nurses

Currently, the graduate training of nurses and doctors has a heavy urban and tertiary healthcare bias

Allocate a large proportion of postgraduate seats for family-centered care with rural immersion:

In recent years, there has been a huge increase in postgraduate seats (MD/MS) for medical graduates. Allocating them to family medicine, with appropriate training in rural health care settings, will bring about the change in focus from tertiary care to primary care, and from urban bias to rural focus. It would require setting up family medicine programs in medical colleges, with strong rural focus

A similar shift can happen if large numbers of postgraduate seats for nurses are allocated to community health nursing, or nurse-practitioner program.

Make newly setup rural medical colleges responsible for district healthcare:

A large number of state-funded medical colleges are being set up in district hospitals, most of which are rural. Entrusting them with healthcare of their respective districts, focusing on sourcing rural students, adapting their training curricula to meet local needs, and helping them place within the districts would help them fulfil their social accountability. In such colleges, focus should be on primary and secondary care rather than tertiary care

Identify and accredit rural training sites for rural health professionals:

It would ensure sustained and high-quality training of a large number of professionals required for managing PHCs and H and WCs. The staff of these training sites should be accorded a faculty status.

Set up an empowered group to define improvements in training, living, and working conditions for rural healthcare professionals:

Such a group should be constituted of medical and nursing educationists from institutes that have a long experience of training doctors and nurses for rural areas, and practicing rural physicians and nurses[6].

To conclude, we have to traverse a lot of ragged terrain before we reach the zenith of success equating the standard of health care available both in rural and urban sector. Indomitable zeal and incessant and conjoined efforts on behalf of the government as well as the health care professionals can slowly yet surely bring about the coveted sun rise in the comparatively darker valley of rural health care.

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