

The Challenges and innovative solutions to rural health dilemma

The six decades of Indian independence have witnessed too many plans, papers and proposals giving top priority to the health issues in India. Unfortunately, despite huge economic growth, health continues to be the greatest predicament. Even the WHO slogans 'Health for All', 'Millennium Development Goals and more recently 'universal health care have not translated into meaningful action on ground. The accessibility of healthcare as well as utilization of available healthcare facilities, especially in rural areas, continue to be poor in India.

Problems as opportunities

While I am not undermining some improvisation indicated by better health indices, corporate participation, available resources through the National Rural Health Mission, but it has been too little and too late. The present health scenario is a toxic combination of uneven quality, high cost, frequent errors and limited access for marginalized population. It is observed that 70% of population has no access to specialist care as 80% of specialists live in urban areas. Only 13% of rural population have access to primary health centers, 33% to sub-center and 9.6% to a hospital (NFHS-II). Poor quality services at state-run hospitals force many people to visit private facilities. The overall health care utilization is also low, only half of (52%) of Indian mothers receive three or more ante natal checkups; Only 43.5% of children in India receive all vaccinations {(NFHS-3, 2005-06)}. At one side our peripheral health centres are underutilized whereas on other side our tertiary and secondary (District) level facilities are often argued as overloaded with the work that could have been done at lower centres, resulting in compromise of quality. Others continue to argue that even these centres have not successfully exploited the skills of its specialists with only 2–3 OPDs/OTs per week per physician. The underutilization of peripheral centres is attributed to varied factors related to accessibility, quality, affordability, deficient human resource, poor monitoring, lack of community participation and ownership. Vast and diverse geographical locations of India inhibits proper penetration of health care delivery in such areas. Further, health care personnel are reluctant to work at block or below level areas, as they have to face two challenges,

first the absence of reasonable living conditions (eg. proper housing, 24 hour electricity supply, good school for their children, social isolation etc) and second, the under functioning of majority of health care facilities in such areas and hence no opportunity to translate their technical skills. Absence of stringent transfer policy leads to frustration among staff. Posting of surgeons at under functioning facilities at the beginning of their career erodes their surgical skills and make them non-functional forever. The absence of accessible quality primary care services leads many poor people to either forgo medical care altogether or choose to seek expensive and unregulated care in the private sector. Lack of adequate quality data on burden of disease and trauma for proper planning along with poor public health awareness are a few more issues. MCI and Nursing council of India in their current shape are inert to some extent as their main focus is only on quantitative assessment of staff, infrastructure, material and equipments rather than quality or treatment audit. The qualitative assessment e.g. professional skills of staff, managerial skills of administrators, quality of health care provided, quality of students trained at these institutes are totally missing. Deep rooted corruption is prohibiting the smooth flow of system, especially the prompt purchase of medical equipments and diagnostics. Directorate of Medical and Health, the apex administrative and regulatory body for Medical and Health in India lacks the technical expertise and needs overhauling. The middle level managers of health system e.g. CMHOs, BMOs are unable to accomplish tasks at their own level. They act as a weak link between higher authority and periphery. System has taken away their self-esteem.

Raising the bar

Inequality in health care delivery and changing pattern of disease in India are adding to the basic deficiencies in healthcare delivery. This has pushed India facing the characteristic parallel dual burden of communicable and non communicable diseases. Surge of coronary heart disease(CAD), diabetes and stress along with old age infections and malnutrition have become conspicuous by this change. Emergence of Scrub typhus, Dengue, Swine flu further enhances the

burden of diseases. While policy makers say that health is a priority yet this is not reflected in their budget allocation. This needs to be strengthened either by continuous collaboration with lawmakers or inclusion of these stakeholders through formation of interdisciplinary regulatory bodies. Out of the overall spending of 5.1% of GDP (compared to 8–10% in developing countries), the major share (4.2%) comes from private sector. The negligible 0.9% public share has recently increased to 2% but remains far below the desired level. Increase in population constantly exceeds the increase in spending. High out of pocket expenses i.e. almost 70% of the per capita expenses is uncalled for. Another gap is a huge cut of money spent on curative medical care compared to insignificant spending on preventive health.

The million dollar question is that despite the available resources, generated from higher economic growth, nothing has worked. The lack of clear vision, absence of inclusive strategies, lack of motivation, zeal and enthusiasm combined with failure of bureaucratic leadership are some of the reasons impairing rural health care delivery. The pride and status of medical professional of all cadres is waning. There is an utter disregard for the attempts to provide basic amenities to employees in rural areas by the state. Apathetic attitude of management for their staff and lack of professional protection during health care delivery further aggravates the problem. This holds back health care providers to take innovative steps suitable to local needs. There is an absence of reward for excellence or punishment for failures in the system. Introduction of a mechanism to measure accountability of health care workers and quality of work done by them as well as to reward the star performers can result in raising the bar of quality. Some important elements of NABH's guidelines have been proposed as a means to improve the management of health care delivery in both urban and rural regions. Outbreaks of Malaria, Dengue, swine flu and other seasonal diseases, requiring urgent attention, depletes major share of resources which could be addressed by provision for supplementary funds. There is a gross disconnect between primary, secondary and tertiary care facilities. Likewise private sector has its own concerns of massive

treatment cost, lack of sensitivity and absence of Corporate Social Responsibility (CSR) schemes. While the Govt hospitals need to learn from efficient utilization of manpower from management practices of private hospitals, the private hospitals need to reduce their costs of treatment.

This is high time that we redefine healthcare and make a determined effort, as an interdisciplinary team, allowing the technocrats to implement innovative programs. In democracy, the remedial approach needs to be innovative, pragmatic and actionable that can resurrect the system, bypassing corruption, overcoming complacency and inefficiency. There is a need to incorporate "cooperative thinking" in the system by diverting efforts towards provision of universal basic care i.e. "Good for most rather than best for few". This is a huge task with an inherently contradictory objective, but essentially requires a planned trial. System now requires a radical surgery, no palliation. We need to bring the authority of public sector and efficiency and energy of private sector together.

The current national agenda calls for an immediate focus on the rural health delivery systems including tribal and inaccessible areas, which constitute nearly 70% of the population hitherto deprived of the advancements in health and disease management.

Models of governance of rural healthcare delivery

The RURBAN initiative of developing villages can be gainfully used for innovative medical manpower management in primary healthcare. Thus, the concept of Model Group Housing at block level/PHC level should be considered where government employees of all the departments eg. Medical and Health, PWD, School Education, Police, Electricity, Bank, Jaldaya Vibhag, BDO, Road & Transport, Post & Telegraph etc. could be provided accommodation where required. Facilities like school, playground, community centre, supermarket etc. could be provided in the neighbourhood. This would take care of the "Doctors Deficiency" argument very often put forward as an excuse for non-availability of medical and health facilities. This concept would allow holding, retaining and recruiting fresh talent by facilitating their stay and improvising their quality of life comparable with their counterparts in the city. Thus, the feeling of being deprived and frustrated could be compensated.

The critics might argue that it is a very optimistic project and shall require long time to complete while consuming a lot of resources. While one has waited for solutions including conditional provisions of rural posting, increased allowances or even making the rural services compulsory to doctors or other skilled workers, for more than several decades, the project looks worth serious consideration. The resources under RURBAN model, the funds from Prime Minister exchequer, Member of Parliament, Village Development Project and those under the National Rural Health Mission with low cost housing along with several other projects could be merged to give impetus to the newer solutions.

The model housing township should also harbor the first referral unit (FRU) consisting of a gynecologist, anesthesiologist, pediatrician and surgeon with facility of ICU. Such team effort would provide cohesive and coordinated medical services. The primary health centre physicians could also stay at the model township and may be allowed to run the OPDs and the National health programmes or other specific responsibilities by a 'to and fro' movement every day. The initial phase of populating such hospitals in such model villages (or townships) can happen by way of temporary deployment of skilled manpower from larger govt hospitals or tertiary care centres that feed such rural areas. Emergencies at the PHCs can be either handled through ambulance 108, or the mobile surgical services stationed at the model township which can periodically conduct camps and handle necessary medical, surgical, emergency and blindness control programme. The sub centres could remain connected to FRU by the ASHA worker or the incharge, who could be from the AYUSH staff. The proposal to effectively mainstream AYUSH in present rural health delivery systems would go a long way and also pave way for looking into the deep rooted indigenous system of medicine well accepted among people. There could be value addition of services by AYUSH staff if they are trained for national health programmes, identifying emergencies in facilitating a decrease in IMR, MMR and IFR. Needless to state, the huge work force of AYUSH is available with majority of the states in India. Further, to reduce the out of pocket expenses, innovative insurance model combining the RSBY with "TOP UP" Scheme created by UNICEF and is proposed by the author as means to bring change under his leadership.

The instant health advice 'electronically' proposed by NIDAN would add to the quality healthcare. Similarly, either outsourcing the diagnostics based on the Rajasthan CT/MR PPP Model could not only add to the quality results and management but would also provide public awareness in the rural areas for early diagnosis and planned preventive strategies. The PPP diagnostic model along with the innovative insurance scheme can generate huge financial resources (the State Government being partner) for the development both at primary and secondary care services. Further, the model townships could be connected through telemedicine to the tertiary care centres for availability of speciality/superspeciality consultation and also continuing medical education. The health managers could be made administrative incharge for procurement and maintenance of equipment and on a day to day basis could also organize financial planning systems of accountability thereby relieving the medical professionals for delivering their professional services at ease. Paramedic training and orientation could be a periodic phenomena with the Health managers sustaining efficient health delivery system.

Alternatively, measures like pooling of locally available private specialist doctors or sharing specialist from one PHC to another or if there is a lack of manpower at the FRU outsource the overall health services either to the local nursing homes or private cooperative of doctors or the corporate hospitals could be mobilized. The NABH or JCI implementation with regional modifications could improve the quality of services.

Administrative reforms

To give the impetus to the whole new concept the administrative machinery needs to be integrated and reorganized. The Medical, Health and Education Department need to work in synergy to achieve the objective of overall enhancement of health. It is, therefore, possible for three Departments to be supervised by a singular Principal Secretary. The convergence link for primary, secondary and tertiary level health services should be Director General of Health Services. There could be five Directors under DG namely Director Infectious diseases and Epidemiology (including statistics); Director Non communicable and life style based diseases (including Nutrition); Director, Mother and Child health and Family Welfare; Director, Training, continuous medical education, School health & IEC; Director,

Mobile health unit, Transport, communication and Information Technology. These could cohesively interact with other supportive departments like PHED and Science & Technology. To give impetus to research on endemic and perennial diseases, the establishment of "Model Rural Township" concept of ICMR could be very useful. The State Medical Councils (presently inert) could assert their authority in pushing and updating the professional's knowledge by using the human resources at tertiary and secondary care. The tertiary care should be given the task of conducting epidemiological surveys to identify regional rural health issues. All these efforts could create a healthy milieu for rural health practices.

Affordable health care by research

Finally, provision of healthcare for rural areas hinge on the affordability of

treatment and diagnostic costs. In order to propel the indigenous production of medical devices, drugs, surgicals and diagnostics, the biomedical scientists in the hospitals, research institutions and elsewhere can come together and translate their knowledge into affordable medical products. By instituting 'innovation clinics', the consulting scientists and doctors could join hands in order to translate their respective knowledge useful for bedside of patient around the Model Rural Research Centre of ICMR. This will be important in fulfilling the PM's concept of 'make in India' thereby saving both the costs of import thereby enabling affordable health care.

Thus, while the innovative solutions are available within the existing financial

and human resource systems, one would look forward to the grand initiative from the determined Prime Minister to act as a radical plastic surgeon rather than the cosmetic one to make the life beautiful for poor, deprived sick and ailing population in the rural areas. He is the man of the hour, only time will tell whether this "Iron Man" can solve the irony of rural health care delivery.

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Ashok Panagariya,

Member, State Planning Board on Health Issues (Rajasthan) INDIA