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# Progress of Rural Health Care System in India

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***Abstract***
*This study attempts to examine the progress of rural health care in India during the period between 2004-05 and 2011-12 in terms of increase in the total number of health centre functioning, number of health centre functioning at government buildings and number of availability of manpower at health centre. At the national level there is an increase of 2340 SCs, 813 PHCs and 1487 CHCs in 2011-12 as compared to those existing in 2004-05. This implies an increase of about 44.4% in the number of CHCs, about 3.5% in the number of PHCs and about 1.6% in the number of SCs in 2012 as compared to 2005. The study shows that 64% of total sub-centre, 83% of PHCs and 97% of CHCs are functioning at government buildings as on March 2012. The rest are located either in rented buildings or rent free Panchayat/ voluntary society buildings. The availability of manpower is one of the important prerequisite for the efficient functioning of rural health services. When we compare the manpower position of major categories in 2012 with that in 2005, it is observed that there are significant improvements in terms of the number in all the categories.*
***Keywords****: Sub-centre, primary health centre, community health centre and their progress.*

## Introduction

Rural health care system in India has been developed as a three tier system with Sub Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of primary health care system. The Minimum Needs Programme (MNP) was introduced in the country in the first year of the fifth five – year plan (1974-79) with objective to provide certain basic minimum needs and thereby improve living standards of the people. In the field of rural health, the objective was to establish one sub-centre for a population 5000 people in the plain and for 3000 in tribal and hilly areas, one primary health centre for 30000 populations in plain area and 20000 populations in tribal and hilly areas and one community health centre for population of one lakh. However, as the population density in the country is not uniform, it shall also depend upon the case load of the facility and distance of the village / habitations which comprise the sub-centre.

The objective of this paper is to examine the progress of rural health care system in India during the period between 2004-05 and 2011-12 in terms of total number of health centre functioning, number of health centre functioning at government buildings and availability of manpower (ANM/HW (F), HW (M), Doctors Specialists, Radiographers, Pharmacists, Laboratory technicians and Nursing staff) in the health centre. The necessary data and information required for the study have been collected from Ministry of health and family welfare, Government of India. Simple average and percentage analysis have been used to analyze the data.

**Sub- Centres (SCs)**

The Sub- Centre is the most peripheral and first point of contact between the primary health care system and the community. A sub-centre provides interface with the community at the grass- root level, providing all the primary health care services. It is the lowest rung of a referral pyramid of health facilities consisting of the sub-centre, primary health centre, community health centre, sub-divisional / sub-district hospitals and district hospitals. The purpose of the health sub- centre is largely preventive and promotive, but it is also provides a basic level of curative care. As per population norms, there shall be one sub-centre established for every 5000 population in plain areas and for every 3000 population in hilly/tribal/ desert areas. Each sub-centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM)/ Female Health Worker HW (F) and one Male Health Worker HW (M). Under National Rural Health Mission (NRHM), there is a provision for one additional second ANM on contract basis. One Lady Health Visitor (LHV) is entrusted with the task of supervision of six sub-centres.

Sub-centre is assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. The sub-centre is provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. Ministry of health and family welfare is providing 100% central assistance to all the sub-centre in the country since April 2002 in the form of salary of ANMs and LHVs. In order to provide quality care in sub-centre, Indian Public Health standards (IPHS) is being prescribed to provide basic primary health care services to the community and achieve and maintain an acceptable standard of quality of care. These standards would help monitor and improve functioning of the sub-centre. Currently the IPHS for sub-centre has been prepared keeping in view the resources available with respect to functional requirement of sub-centre with minimum standards, such as building, manpower, instruments and equipment, drugs and other facilities and desirable standards which represent the ideal situation. The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of community.

**Primary Health Centres (PHCs)**

The concept of primary health centre is not new to India. The Bhore committee in 1946 gave the concept of a PHC as a basic health unit to provide as close to the people as possible, an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The health planners in India have visualized the PHC and its sub centre as the proper infrastructure to provide health services to the rural population. The central council of health at its first meeting held in January 1953 had recommended the establishment of PHCs in community development

blocks to provide comprehensive health care to the rural population. These centres were functioning as peripheral health service institutions with little or no community involvement. A typical primary health centre covers a population of 20000 in hilly, tribal, or difficult areas and 30000 populations in plain areas with 6 indoor/ observation beds. The PHCs are established and maintained by the state government under the minimum needs programme/ Basic minimum services. As per minimum requirement, a PHC is to be manned by a Medical Officer supported by 14 paramedical and other staff. Under NRHM, there is a provision for 2 additional staff nurses at PHCs on contract basis. It acts as a referral unit for 6 sub-centre and refer out cases to CHC (30 bedded hospitals) and higher order public hospitals located at sub-district and district level. The activities of PHC involve curative, preventive, promotive and family welfare services.

Standards are the main driver for continuous improvements in quality. The performance of primary health centre can be assessed against the set standards. Currently the IPHS for primary health centre has been revised keeping in view the resources available with respect to functional requirements of primary health centre with minimum standards such as buildings, manpower, instruments and equipment, drugs and other facilities etc. The revised IPHS has incorporated the changed protocols of the existing health programmes and new programmes and initiatives especially in respect of non-communicable diseases.

**Community Health Centres (CHCs)**

The community health centre is designed to provide referral health care for cases from the primary health centre level and for cases in need of specialist care approaching the centre directly. 4 PHCs are included under each CHC thus catering to approximately 80000 populations in tribal/ hilly/ desert areas and 120000 populations for plain areas. CHC is a 30 bedded hospital providing specialist care in Medicine, Obstetrics and Gynecology, Surgery, Pediatrics, Dental and AYUSH. CHCs are being established and maintained by the state government under MNP/BMS programme. As per minimum norms, a CHC is required to be manned by 4 Medical specialists i.e., Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff.

IPHS for CHCs have been prescribed National Rural Health Mission (NRHM) since early 2007 to provide optimal specialized care to the community and achieve and maintain an acceptable standard of quality of care. A setting standard is a dynamic process, the need was felt to update the IPHS keeping in view the changing protocols of existing national health programmes, development of new programmes especially for non-communicable diseases and prevailing epidemiological situation in the country and different states /UTs of the country, accordingly the revision has been carried out. These standards would act as benchmarks and help monitor and improve the functioning of the CHCs.

**Progress of rural health care in India**

This study attempts to examine the progress of rural health care in India during the period between 2004-05 and 2011-12 in terms of increase in the total number of health centre functioning, number of health centre functioning at government buildings and number of availability of manpower at health centre. The table No.1 shows the number of SCs, PHCs and CHCs existing as on March 2012 compared to those reported existing as on March 2005. As may be seen from the table, at the national level there is an increase of 2340 SCs, 813 PHCs and 1487 CHCs in 2011-12 as compared to those existing in 2004-05. This implies an increase of about 44.4% in the number of CHCs, about 3.5% in the number of PHCs and about 1.6% in the number of SCs in 2012 as compared to 2005.

The study shows that 64% of total sub-centre, 83% of PHCs and 97% of CHCs are functioning at government buildings as on March 2012. The rest are located either in rented buildings or rent free Panchayat/ voluntary society buildings. The comparative picture of the building status of health centre shows that the number of SCs functioning in the government buildings has increased by 47.7% during the period between 2005 and 2012. This is mainly due to substantial increase in the government buildings in the states of Andhra Pradesh, Assam, Chhattisgarh, Haryana, Karnataka, Madhya Pradesh, Maharashtra, Manipur, Orissa, Punjab, Rajasthan, Sikkim, Tripura, Uttar Pradesh, West Bengal and Puducherry. Similarly, number of PHCs functioning in government buildings has also increased by 24% during the same period. This is mainly due to increase in the government buildings in the states of Assam, Chhattisgarh, Gujarat, Haryana, Himachal Pradesh, Karnataka, Madhya Pradesh, Maharashtra, Nagaland, Madhya Pradesh, Rajasthan and Uttar Pradesh. Numbers of CHCs functioning in government buildings have increased appreciable in 2012 as compared to 2005. The number of CHCs functioning in government buildings has significantly increased by 66.12% during the year between 2005 and 2012.

**Table – 1: Progress of rural health care in India**

| S.No. | Particular | 2004-05 | 2011-12 | Increase in percentage |
|---|---|---|---|---|
| 1 | **Total number of health centre functioning** | | | |
| | SCs | 146026 | 148366 | 1.60 |
| | PHCs | 23236 | 24049 | 3.50 |
| | CHCs | 3346 | 4833 | 44.44 |
| 2 | **Number of health centre functioning at government buildings** | | | |
| | SCs | 63901 (43.76) | 94380 (63.61) | 47.70 |
| | PHCs | 16023 (68.96) | 20015 (83.23) | 24.91 |
| | CHCs | 2822 (84.34) | 4688 (97.00) | 66.12 |
| 3 | **Manpower in health centre (In position)** | | | |
| | HW (F) /ANM at SCs and PHCs | 133194 | 207578 | 55.85 |
| | Doctors at PHCs | 20308 | 28984 | 42.72 |
| | Specialists at CHCs | 3550 | 5858 | 65.01 |
| | Radiographers at CHCs | 1337 | 2314 | 73.07 |
| | Pharmacists at PHCs and CHCs | 17708 | 26219 | 48.06 |
| | Laboratory Technicians at PHCs and CHCs | 12284 | 17525 | 42.66 |
| | Nursing staff at PHCs and CHCs | 28930 | 66424 | 129.60 |

Source: Rural health statistics, Ministry of health and family welfare, Government of India.
Note: Figure in parenthesis indicates percentage to total.

The availability of manpower is one of the important prerequisite for the efficient functioning of rural health services. When we compare the manpower position of major categories in 2012 with that in 2005, as shown in the table No.1, it is observed that there are significant improvements in terms of the number in all the categories. For instance, the number of HW (F) /ANM at sub-centre and PHCs has increased from 133194 in 2005 to 207578 in 2012 which accounts to an increase of about 56%. Similarly the allopathic doctors at PHCs have increased from 20308 in 2005 to 28984 in 2012, showing an increase of 43% during the period. Moreover specialists and Radiographers at CHCs have increased by 65% and 73% respectively during the period between 2005 and 2012. Pharmacists, laboratory technicians and nursing staff at PHCs and CHCs have also increased by 48%, 43% and 130% respectively during the same period.

**Conclusion**

The total number of health centre (SCs, PHCs and CHCs) functioning, number of health centre functioning at government buildings and availability of manpower in health centre in rural India have increased remarkably during the period between 2005 and 2012.

The National Rural Health Mission (NRHM) (2005-12) seeks to provide effective health care to rural population throught the country. The Mission is an articulation of the commitment of the government to raise public spending on health from 0.9% of GDP to 2-3% of GDP. NRHM aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum programme and promote policies that strengthen public health management and service delivery in the country. It has as its key components provision of a female health activist in each village; a village health plan prepared through a local team headed by the health and sanitation committee of the Panchayat, strengthening of rural hospital for effective curative care and made measurable and accountable to the community through Indian public Health standard integration of vertical health and family welfare programmes, optimal utilization of funds and infrastructure, and strengthening delivery of primary healthcare. It seeks to revitalize local health traditions and mainstream AYUSH into the public health system. It further aims at effective integration of health like sanitation and hygiene, nutrition and safe drinking water through a district plan for health. It seeks decentralization of programmes for district management of health and to address the inter-state and inter-district disparities among the states including unmet needs for public health infrastructure. It also seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary health care.

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