Rural Health Care System in India

Rural Health Care System – the structure and current scenario

The health care infrastructure in rural areas has been developed as a three tier system (see *Chart 1*) and is based on the following population norms:

Table 1.

Centre	Population Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Sub-Centres (SCs)

1.2. The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker/ MPW(M) (for details of staffing pattern, see ***Box 1***). One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centres are 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, diarrhea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Ministry of Health & Family Welfare is providing 100% Central assistance to all the Sub-Centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Worker is borne by the State Governments. Under the Swap Scheme, the Government of India has taken over an additional 39,554 Sub Centres from State Governments / Union Territories since April, 2002 in lieu of 5,434 number of Rural Family Welfare Centres transferred to the State Governments / Union Territories. There are 1,45,272 Sub Centres functioning in the country as on March 2007.

Primary Health Centres (PHCs)

1.3. PHC is the first contact point between village community and the Medical Officer. The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). At present, a PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. The activities of PHC involve curative, preventive, primitive and Family Welfare Services. There are 22,370 PHCs functioning as on March 2007 in the country.

Chart 1.


RURAL HEALTH CARE SYSTEM
IN INDIA
Community Health Centre (CHC)
A 30 beded Hospital/Referal Unit for 4 PHCs with Specialised services
Primary Health Centre (PHC)
A Referal Unit for 6 Sub Centres 4-6 beded manned with a Medical Officer Incharge and 14 subordinate paramedifcal staff
Sub Centre (SC)
Most peripheral contact point between Primary Health Care System & Community manned with one MPW(F)/ANM & one MPW(M)

Box 1.

STAFFING PATTERN

A.	STAFF FOR SUB - CENTRE:	Number of Posts
1.	Health Worker (Female)/ANM	1
2.	Health Worker (Male)	1
3.	Voluntary Worker (Paid @ Rs.100/- p.m. as honorarium)	1
	Total:	3
B.	STAFF FOR NEW PRIMARY HEALTH CENTRE	
1.	Medical Officer	1
2.	Pharmacist	1
3.	Nurse Mid-wife (Staff Nurse)	1
4.	Health Worker (Female)/ANM	1
5.	Health Educator	1
6.	Health Assistant (Male)	1
7.	Health Assistant (Female)/LHV	1
8.	Upper Division Clerk	1
9.	Lower Division Clerk	1
10.	Laboratory Technician	1
11.	Driver (Subject to availability of Vehicle)	1
12.	Class IV	4
	Total:	15
C.	STAFF FOR COMMUNITY HEALTH CENTRE:	
1.	Medical Officer #	4
2.	Nurse Mid– Wife(staff Nurse)	7
3.	Dresser	1
4.	Pharmacist/Compounder	1
5.	Laboratory Technician	1
6.	Radiographer	1
7.	Ward Boys	2
8.	Dhobi	1
9.	Sweepers	3
10.	Mali	1
11.	Chowkidar	1
12.	Aya	1
13.	Peon	1
	Total:	25

:Either qualified or specially trained to work as Surgeon, Obstetrician, Physician and Pediatrician. One of the existing Medical Officers similarly should be either qualified or specially trained in Public Health).

Box 2.

RURAL HEALTH INFRASTRUCTURE - NORMS AND LEVEL OF ACHIEVEMENTS (ALL INDIA)				
S.No.	Indicator	National Norms		Achievements
1	**Rural Population (2001) covered by a:**	General	Tribal/Hilly/Desert	
	Sub Centre	5000	3000	5111
	Primary Health Centre (PHC)	30000	20000	33191
	Community Health Centre (CHC)	120000	80000	1.83 lakhs
2	Number of Sub Centres per PHC	6		6
3	Number of PHCs per CHC	4		6
4	**Rural Population (2001) covered by a:**			
	HW (F)	5000	3000	5035
	HW (M)	5000	3000	11808
5	Ratio of HA (M) to HW (M)	1:6		1:3
6	Ratio of HA (F) to HW (F)	1:6		1:9
7	**Average Rural Area (Sq. Km) covered by a:**			
	Sub Centre	--		21.47
	PHC	--		139.40
	CHC	--		770.90
8	**Average Radial Distance (Kms) covered by a:**			
	Sub Centre	--		2.61
	PHC	--		6.66
	CHC	--		15.66
9	**Average Number of Villages covered by a:**			
	Sub Centre	--		4
	PHC	--		29
	CHC	--		158

Community Health Centres (CHCs)

1.4. CHCs are being established and maintained by the State Government under MNP/BMS programme . It is manned by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. As on March, 2007, there are 4,045 CHCs functioning in the country.

1.5. The details of the norms for each level of rural health infrastructure and current status against these norms are given in ***Box 2***.

2. Strengthening of Rural Health Infrastructure Under National Rural Health Mission

2.1. Under the mandate of National Common Minimum Programme (NCMP) of UPA Government, health care is one of the seven thrust areas of NCMP, wherein it is proposed to increase the expenditure in health sector from current 0.9 % of GDP to 2-3% of GDP over the next five years, with main focus on Primary Health Care. The National Rural Health Mission (NRHM) has been conceptualized and the same is being operationalised from April, 2005 throughout the country, with special focus on 18 states which includes 8 Empowered Action Group States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttaranchal, Orissa and Rajasthan), 8 North East States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura) Himachal Pradesh and Jammu & Kashmir.

2.2. The main aim of NRHM is to provide accessible, affordable, accountable, effective and reliable primary health care, especially to poor and vulnerable sections of the population. It also aims at bridging the gap in Rural Health Care through creation of a cadre of Accredited Social Health Activists (ASHA) and improve hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources. The NRHM further aims to provide overarching umbrella to the existing programmes of Health and Family Welfare including RCH-II, Malaria, Blindness, Iodine Deficiency, Filaria, Kala Azar T.B., Leprosy and Integrated Disease Surveillance. Further, it addresses the issue of health in the context of sector-wise approach addressing sanitation and hygiene, nutrition and safe drinking water as basic determinants of good health in order to have greater convergence among the related social sector Departments i.e. AYUSH, Women & Child Development, Sanitation, Elementary Education, Panchayati Raj and Rural Development.

2.3. The Mission further seeks to build greater ownership of the programme among the community through involvement of Panchayati Raj Institutions, NGOs and other stakeholders at National, State, District and Sub District levels to achieve the goals of National Population Policy 2000 and National Health Policy.

2.4. Under the strategy of NRHM, in order to fill the gaps in the existing rural health care infrastructure available in the country, the key components, inter-alia, of the Mission are as given below:

(i) Creation of a cadre of Accredited Social Health Activists (ASHA) in 2.5 lakh villages in four years – 8 EAG States, J&K and Assam.

(ii) Creation of village health scheme and preparation of village health plan – 18+ states.

(iii) Strengthening sub centres with untied funds of Rs. 10,000/- per annum – 10+8+States.
(iv) Raising 2000+CHCs to the level of IPHS.
(v) Codification of Indian Public health Standards (IPHS) – 18+states.
(vi) Integrating vertical health and family welfare programmes under NRHM at National, State and District level – all states.
(vii) Strengthening Programme Management Capacities at National State and District level – 10+8+states.
(viii) Institutionalising district level management of health – all districts.
(ix) Supply of generic drugs (both Allopathic and AYUSH) – 18+States.
(x) School health check up programme – 18+States
(xi) Promotion of multiple health insurance model – all states.
(xii) Supplementing Vitamin 'A' and Iron Folic Acid to deficient children at Anganwadi level – 18+states.
(xiii) Promotion of private sector for achieving public health goals – all states.
(xiv) Setting up of comprehensive Health and Family Welfare clinics – 5 States+select districts.
(xv) Services of ANM and medical officers, PHCs to be ensured at fixed days at Anganwadi levels.
(xvi) Mainstreaming ISM. Exploring new Health Financing Mechanism, Policy reforms in Medical Education and Public Health Management.
(xvii) The mission shall focus on rural areas since bulk of the strategic interventions are aimed at improvement of primary health care in rural areas.

2.5. Overview of NRHM

(i) The National Rural Health Mission is being launched for a period of seven years (2005-2012) i.e. 2 years of Tenth Plan and full Eleventh Plan.
(ii) The Mission shall cover entire country, with focus attention on 18 states having weak demographic indicators/ infrastructure.
(iii) NRHM is an omni-bus broad band programme, and all other programmes would be sub-components, retaining the sub-budget heads wherever required for vertical programmes.
(iv) The emphasis under NRHM is to improve primary health care, decentralization, intra and inter-sectoral convergence and community ownership.
(v) NRHM provides broad policy guidelines – states have flexibility to draw their action plans to attain the goals of NRHM
(vi) RCH-II, including National Family Welfare Programme (NFWP) and Empowered Action Group (EAG) are subsumed into NRHM.
(vii) Operational phase of the Mission is from April, 2005.
(viii) MOUs being entered into, with the State Governments for RCH-II, will be broad based for NRHM, to ensure their commitments to the systemic reform and new financial pattern of performance based funding under NRHM.

2.6. Funding

The budget outlay for National Rural Health Mission for 2005-06 is Rs. 6731.16 Crores.

2.7. Mission Outcome

The following are anticipated Mission outcomes likely to be achieved after its implementation:

- Provision of village level health provider (ASHA) in under served villages
- Strengthening Sub- centers /PHCs
- Raising CHCs to the level of IPHS
- Institutionalizing District level Management of Health (all districts)
- Prevention and control of communicable and non communicable diseases including locally endemic diseases
- Increase utilization of First Referral Units from less than 20% (2002) to more than 75 % by 2010
- Reduction in communicable diseases, MMR, IMR and would help in attaining population stabilization.

2.8. NRHM Plan of Action for Infrastructure Strengthening

2.8.1 **Component (A): Accredited Social Health Activists**

- Every village/large habitat will have a female Accredited Social Health Activist (ASHA) -chosen by and accountable to the panchayat- to act as the interface between the community and the public health system. States to choose State specific models.

- ASHA would act as a bridge between the ANM and the village and be accountable to the Panchayat.

- She will be an honorary volunteer, receiving performance-based compensation for promoting universal immunisation, referral and escort services for RCH, construction of household toilets, and other healthcare delivery programmes.

- She will be trained on a pedagogy of public health developed and mentored through a Standing Mentoring Group at National level incorporating best practices and implemented through active involvement of community health resource organisations.

- She will facilitate preparation and implementation of the Village Health Plan along with Anganwadi worker, ANM, functionaries of other Departments, and Self-Help Group members, under the leadership of the Village Health Committee of the Panchayat.

- She will be promoted all over the country, with special emphasis on the 18 high focus States. The Government of India will bear the cost of training, incentives and medical kits. The remaining components will be funded under Financial Envelope given to the States under the programme.

- She will be given a Drug Kit containing generic AYUSH and allopathic formulations for common ailments. The drug kit would be replenished from time to time.

- Induction training of ASHA to be of 23 days in all, spread over 12 months. On the job training would continue throughout the year.

- Prototype training material to be developed at National level subject to State level modifications.

- Cascade model of training proposed through Training of Trainers including contract plus distance learning model.

- Training would require partnership with NGOs/ICDS Training Centres and State Health Institutes.

2.8.2 **Component (B): Strengthening Sub-Centres (SC)**

- Each sub-centre will have an Untied Fund for local action @ Rs. 10,000 per annum. This Fund will be deposited in a joint Bank Account of the ANM & Sarpanch and operated by the ANM, in consultation with the Village Health Committee.

- Supply of essential drugs, both allopathic and AYUSH, to the Sub-centres.

- In case of additional Outlays, Multipurpose Workers (Male)/ Additional ANMs wherever needed, sanction of new Sub-centres as per 2001 population norm, and upgrading existing Sub-centres, including buildings for Sub-centres functioning in rented premises will be considered.

2.8.3 **Component (C): Strengthening Primary Health Centres (PHCs)**

Mission aims at strengthening PHCs for quality preventive, promotive, curative, supervisory and outreach services, through:

- Adequate and regular supply of essential quality drugs and equipment (including Supply of Auto Disabled Syringes for immunisation) to PHCs

- Provision of 24 hour service in at least 50% PHCs by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower.

- Observance of Standard treatment guidelines & protocols.

- In case of additional Outlays, intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, upgradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need.

2.8.4 **Component (D): Strengthening Community Health Centres (CHCs) for First Referral Care**

A key strategy of the Mission is:

- Operationalising 3,222 existing Community Health Centres (30-50 beds) as 24 hour First Referral Units, including posting of anaesthetists.

- Codification of new Indian Public Health Standards" setting norms for infrastructure, staff, equipment, management etc. for CHCs.

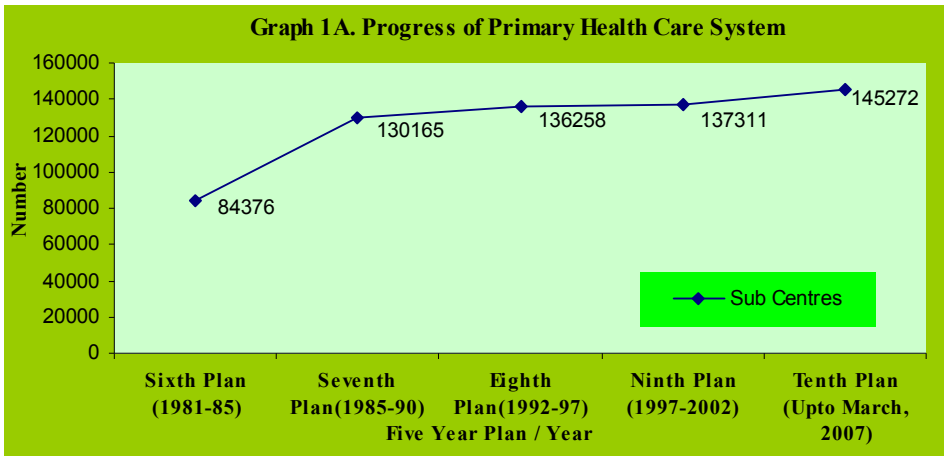
- Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.
- Developing standards of services and costs in hospital care.
- Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.
- In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.

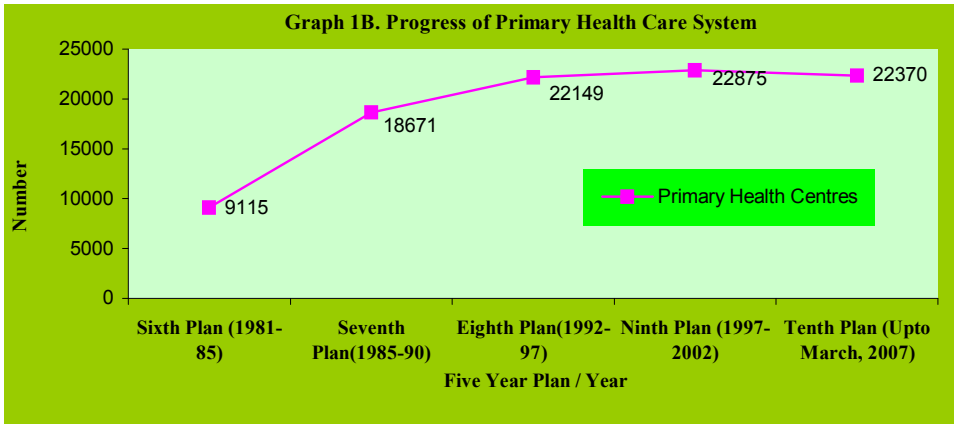
Another important intervention under NRHM is the provision of a Mobile Medical Unit at District level for improved outreach services.

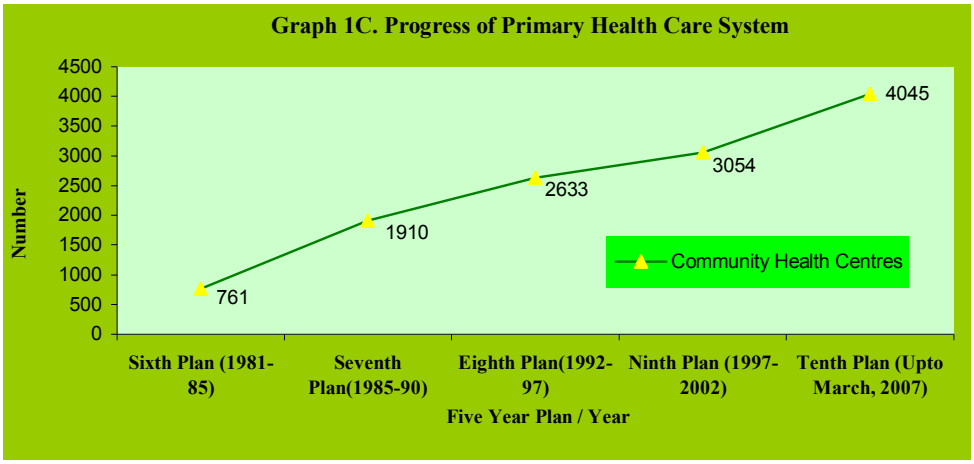
3. Rural Health Infrastructure - a statistical overview

The Centres Functioning

3.1. The entire family welfare programme is being implemented through Primary Health Care system. The Primary Health Care Infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System. Progress of Sub Centres, which is the most peripheral contact point between the Primary Health Care System and the community, is a prerequisite for the overall progress of the entire system. A look at the number of Sub Centres functioning over the years reveal that at the end of the Sixth Plan (1981-85) there were 84,376 Sub Centres. The figure rose to 1,30,165 at the end of Seventh Plan (1985-90) and to 1,36,258 at the end of Eighth Plan (1992-97). At present, as on March, 2007, 1,45,272 Sub Centres are functioning in the country.



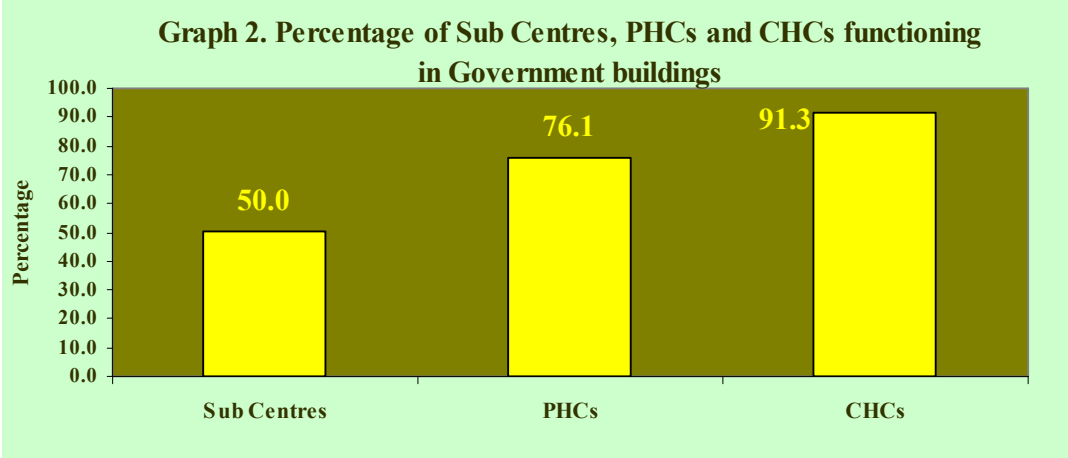




Similar progress can be seen in the number of PHCs which was 9115 at the end of sixth plan (1981-85) and the figure almost doubled to 18671 at the end of Seventh Plan (1985-90) and rose to 22149 at the end of Eighth Plan (1992-97). As on March, 2007, there are 22370 PHCs functioning in the country. In accordance with the progress in the number of SCs and PHCs, the number of CHCs has also increased from 761 at the end of Sixth Plan (1981-85) to 1910 at the end of Seventh Plan (1985-90) and 2633 at the end of Eighth Plan (1992-97). As on March, 2007, 4045 CHCs are functioning. According to the figures of population based on 2001 Population Census, the shortfall in the rural health infrastructure comes out to be of 20855 Sub Centres, 4883 PHCs and 2525 CHCs.

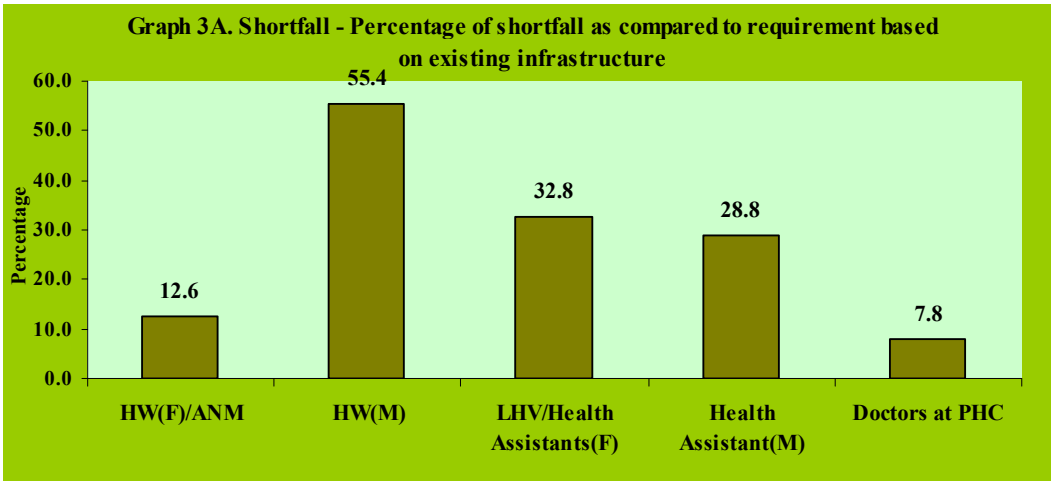
Building Status

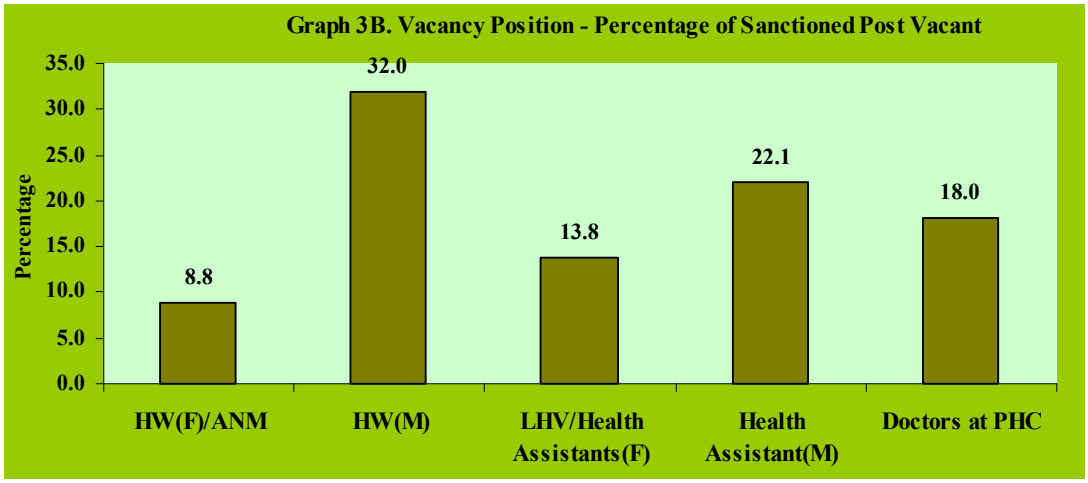
3.2. About 50% of Sub Centres, 76% of PHCs and 91% of CHCs are located in the Government buildings. The rest are located either in rented building or rent free Panchayat/ Voluntary Society buildings. As on March, 2007, in case of Sub Centres, overall 66382 buildings are required to be constructed. Similarly, for PHCs 3618 and for CHCs 199 buildings are required to be constructed.



Manpower

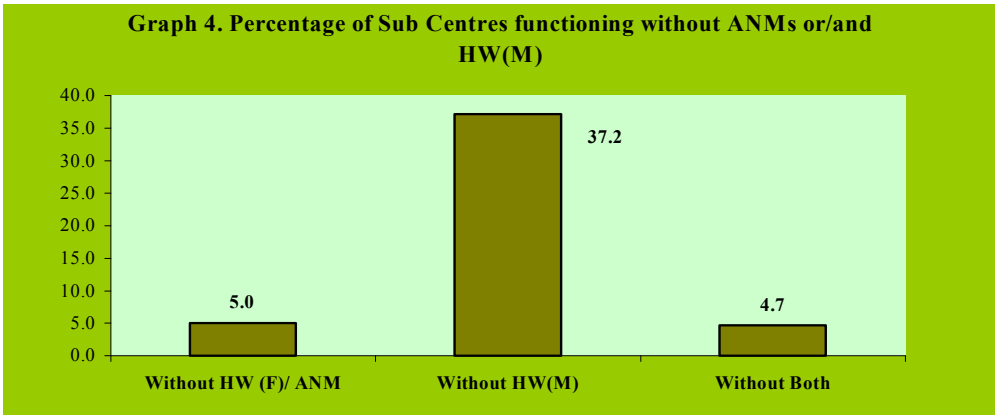
3.3. The existing manpower is an important prerequisite for the efficient functioning of the Rural Health Infrastructure. As on March, 2007 the overall shortfall (which excludes the existing surplus in some of the states) in the posts of HW(F) / ANM was 12.6% of the total requirement. Similarly, in case of HW(M), there was a shortfall of 55.4% of the requirement. In case of Health Assistant (Female)/LHV, the shortfall was 32.8% and that of Health Assistant (Male) was 28.8%. For Doctors at PHCs, there was a shortfall of 7.8% of the total requirement.



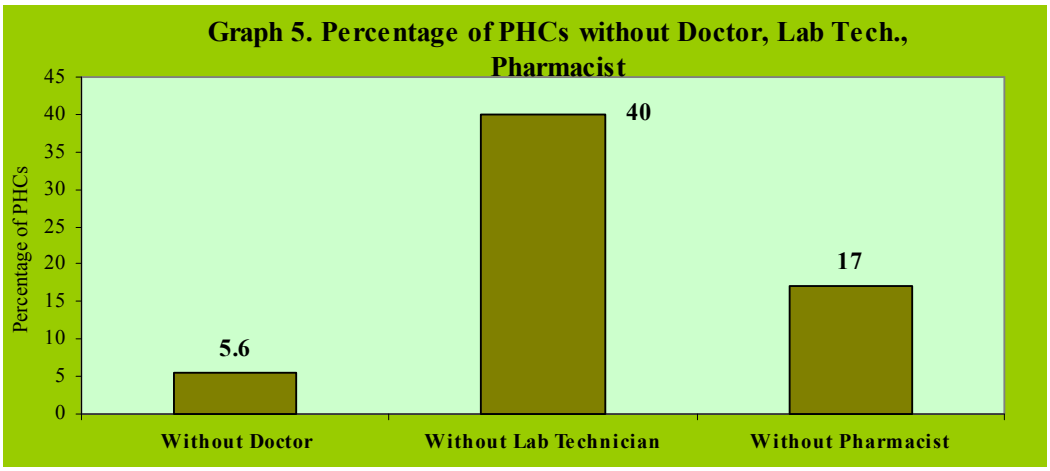


Even out of the sanctioned posts, a significant percentage of posts are vacant at all the levels. For instance, about 8.8% of the sanctioned posts of HW(Female)/ ANM were vacant as compared to about 32% of the sanctioned posts of MPW(Male)/Male Health Worker. At PHC, about 13.8% of the sanctioned posts of Female Health Assistant/ LHV, 22.1% of Male Health Assistant and 18% of the sanctioned posts of doctors were vacant.

3.4. At the Sub Centre level the extent of existing manpower can be assessed from the fact that about 5% of the Sub Centres were without a Female Health Worker / ANM, about 37.2% Sub Centres were without a Male Health Worker and about 4.7% Sub Centres were without both Female Health Worker / ANM as well as Male Health Worker. This indicates a large shortfall in Male Health Workers, resulting in poor male participation in Family Welfare and other health programmes and overburdening of the ANMs.

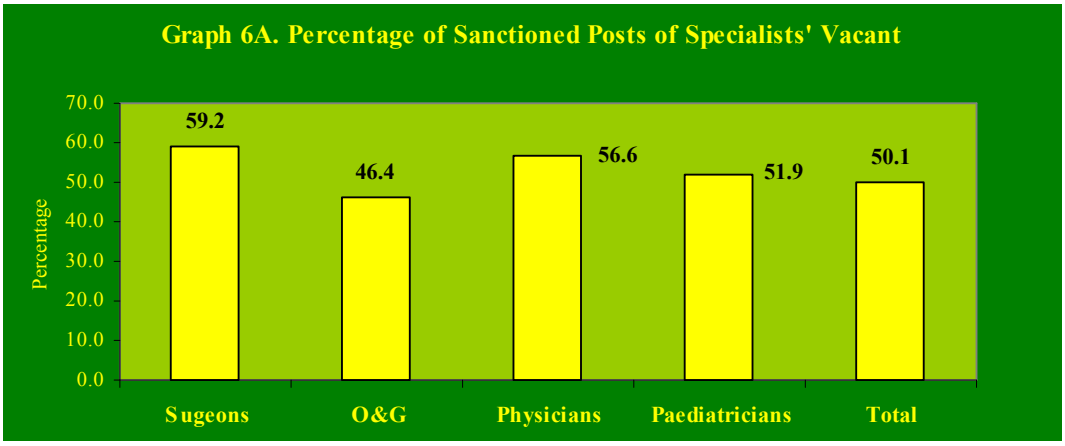


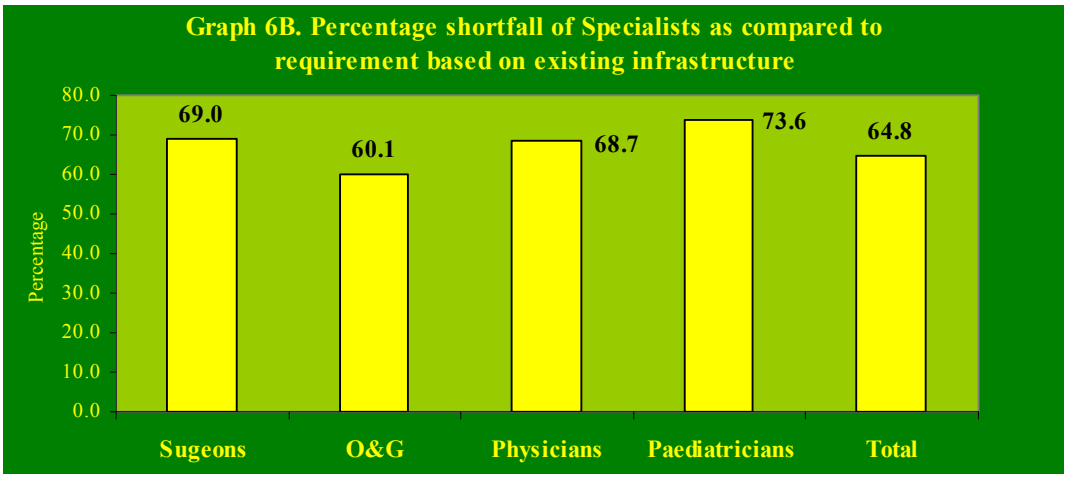
3.5. PHC is the first contact point between village community and the Medical Officer. Manpower in PHC include a Medical Officer supported by paramedical and other staff.



As on March, 2007, about 5.6% of the PHCs were without a doctor, about 40% were without a Lab technician and about 17% were without a Pharmacist

3.6. The Community Health Centres provide specialized medical care in the form of facilities of Surgeons, Obstetricians & Gynaecologists, Physicians and Paediatricians.





The current position of specialists manpower at CHCs reveal that out of the sanctioned posts, about 59.2% of Surgeons, 46.4% of Obstetricians & Gynaecologists, 56.6% of Physicians and about 51.9% of Paediatricians were vacant. Overall about 50% of the sanctioned posts of specialists at CHCs were vacant. Moreover, there was a shortfall of 64.8% specialists at the CHCs as compared to the requirement for existing infrastructure on the basis of existing norms.