

UTILIZATION OF PRIMARY HEALTH CENTRE SERVICES IN RURAL AREAS IN THE INTEREST OF PUBLIC HEALTH AND HUMAN RIGHTS

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I. INTRODUCTION :-

Human rights are moral principles or norms that describe certain standards of human behaviour, and are regularly protected as legal rights in national and international law. They are commonly understood as inalienable fundamental rights "to which a person is inherently entitled simply because she or he is a human being," and which are "inherent in all human beings" regardless of their nation, location, language, religion, ethnic origin or any other status. They are applicable everywhere and at every time in the sense of being universal, and they are egalitarian in the sense of being the same for everyone. They require empathy and the rule of law and impose an obligation on persons to respect the human rights of others. They should not be taken away except as a result of due process based on specific circumstances, and require freedom from unlawful imprisonment, torture, and execution.

The doctrine of human rights has been highly influential within international law, global and regional institutions. Actions by states and non-governmental organizations form a basis of public policy worldwide. The idea of human rights suggests that "if the public discourse of peacetime global society can be said to have a common moral language, it is that of human rights." The strong claims made by the doctrine of human rights continue to provoke considerable skepticism and debates about the content, nature and justifications of human rights to this day. The precise meaning of the term right is controversial and is the subject of continued philosophical debate; while there is consensus that human rights encompasses a wide variety of rights such as the right to a fair trial, protection against enslavement, prohibition of genocide, free speech, or a right to education, there is disagreement about which of these particular rights should be included within the general framework of human rights; some thinkers suggest that human rights should be a minimum requirement to avoid the worst-case abuses, while others see it as a higher standard.

Primary Health Care is the first level of contact of the individuals, the family and the community with the public health system, which brings health care as close as possible to where the common people live and work. The experience and concern in health development and primary health care in India dates back to the Indus valley civilization as early as 3000 B.C. In the modern time, the basis for organisation of health services in India through primary health care was laid by the recommendations of the Bhole committee in 1946. Later, based on the proposal of first integrated All round Development programme (the community development programme) primary health centres were set up for each community development block. With the passage of time extensive changes have taken place in the Indian health system in the backdrop of Alma Ata declaration (1978), Health for all and off late the Millennium development goals. The Governments both at central and state level have started playing an effective role in providing health care services to the poorest of the poor.

Government of India (GOI) has launched various Health schemes under National Rural Health Mission (NRHM, sub mission under National Health Mission) in 2005, provided health insurance coverage to the poor and the unorganised workers (Rashtriya Swasthya Bima Yojna, Yashaswini and Vajpayee Arogyasri in Karnataka state), established numerous primary health centres both in rural and urban areas (2346 as per May 2012 in Karnataka), Community health centres (146 as per May 2012) to include all in the web of health care system. Recently the GOI, has launched a new health programme named National Urban Health Mission (NUHM) under Ministry of Health and Family Welfare with an intention to upgrade the health status of the urban population in general and disadvantaged sections of the society in particular. Under NUHM the government plans to establish more PHCs in rural areas. In this regard, it becomes essential to crosscheck the success of the existing health care centres especially Primary Health Centres as they are bridge (referral) between Community Health Centre and Sub Centres and first tier health care units. As the success of Primary Health Centres lies in the maximum utilisation of its services by the people, there is a need for intensive research in this field. And, as the government is trying to address the health issues of rural and urban areas through separate programmes (NRHM and NUHM), there is need to examine is there any differences exists in the accessibility of PHC services in these areas.

Further, available literature confirmed that a number of studies were done in the area of accessibility and utilisation of health care services at national level as well as at state levels irrespective of type of health care centre. However, very few studies attempted to compare the health care service utilisation between rural and urban areas especially in Indian context; where disparity between rural and urban is a serious issue in all the fields i.e., in development, infrastructure, socio economic status so on. In this background, the present study made an attempt to compare the utilization of PHC services in rural and urban areas by identifying significant determinants.

The main issue being addressed is primary health care. Only up to 20 % of rural people have access to quality health care that is available 24 hours, accessible and affordable. The sheer size and extent of the Government health care infrastructure make it the most effective delivery mechanism for primary health care. Moreover, partnering with the Government and taking over the complete management of non-performing and remote primary health centres in tribal areas is the basis for this model. The main beneficiaries are rural people. The goal is to provide quality primary health care – curative, preventive, primitive and rehabilitative aspects along with innovations in primary care.

II. ROLE OF INFRASTRUCTURE

The healthcare services are divided under State list and Concurrent list in India. While some items such as public health and hospitals fall in the State list, others such as population control and family welfare, medical education, and quality control of drugs are included in the Concurrent list. The Union Ministry of Health and Family Welfare (UMHFW) is the central authority responsible for implementation of various programmes and schemes in areas of family welfare, prevention, and control of major diseases. In the case of health the term infrastructure takes on a wider role than mere physical infrastructure. Healthcare centres, dispensaries, or hospitals need to be manned by well trained staff with a service perspective. In this chapter we include medical staff in our ambit of discussion on rural health infrastructure.

The current conditions of physical infrastructure, staff, access, and usage are laid out here before identifying critical gaps and requirements in infrastructure and services. Issues related to institutions, financing, and policy are discussed in the context of these critical need gaps and the potential role of the private sector in healthcare provisioning in villages is explored.

About 49.7 per cent of the sub-centres, 78.0 per cent of the PHCs and 91.5 per cent of CHCs are located in the government buildings. The rest are located either in rented buildings or rent free Panchayat/Voluntary Society buildings. As on September 2005, overall 60,762 buildings are required to be constructed to house sub-centres. Similarly, for PHCs 2948 and for CHCs 205 additional buildings are still required. Data on facilities within these centres are not available. Most reports and evaluation studies point to the lack of equipment, poor or absence of repairs, improper functioning, or lack of complementary facilities such as 24-hour running water, electricity back-ups, and so on. But conditions being what they are, unreliable electricity and water supplies also take their toll on the performance of these centres.

III. ENCOURAGING MEASURES TOWARDS COMMITMENT OF STAFF'S:-

1. Promote NYS Association for Rural Health.
2. Increased use/access to technology in clinics.
3. Smaller ? housing for the elderly .
4. Address regulatory issues for elderly homes – make it easier.
5. National health care system with prescription .
6. Lower health care premiums.
7. Reach populations through schools.
8. Better food shopping and education.
9. Stable rural hospitals.
10. School based health clinics . . . use in rural areas (full range of services)
11. Tele health: Replication VA System.
12. Use pools of organizations to find ways to cause volunteer insurance.
13. Access to alternate trainings for EMTs (expand programs)
14. Increase reimbursement and compensation for travel and time (must travel long distances to serve clients in rural areas) .
15. Shift to more tele-home care (tele-medicine) internet access to information.
16. Need actual hospital beds (acute care only)
17. Public-private partnership to create practice enhancement concept – invertible charge.
18. Increase incentives to attract nurses and physicians – state funded.
19. Increase community recruitment of professionals “health service core”
20. Need a physician office in every community .
21. Explore tele-medicine as an option .
22. Need quality and affordable housing to attract healthcare professionals .
23. Policy for insurance companies to pay for preventative care.
24. Get rid of Medicare D .
25. Small business and self-employed need access to insurance .
26. Access, to dental, preventative care for kids.
27. Unfunded mandates for emergencies, terrorism – drain resources from existing programs .
28. A system that is more proactive – preventative oriented, rather than reactive.
29. Universal healthcare – increase corporate pressure on government to achieve. universal healthcare .
30. Increased awareness of coverage.
31. Increased coordination between agencies.
32. Decrease unfunded mandates for hospitals and community health centers.
33. AHEC – Area Health Education Center – develop pipeline – engage kids starting in elementary schools.
34. Increase funding for IT capacity and access to tele-medicine.

IV. QUALITY OF SERVICES PROVIDED AND CHALLENGES:-

1. Rural healthcare identified the need for an inter-related health care system – networking health and human services to increase cost-effectiveness and efficiency. Current methods are not working; there is inadequate funding and re-imburement methods are unattractive to professional health care providers. A change in technology is necessary, but assistance is required in this area; it can be facilitated through increasing public-private partnerships and information sharing. Tele-home care is an important mechanism that is needed in rural communities that requires adequate internet access, often lacking in rural communities. Rural healthcare should focus on problems prevalent in their communities, such as, obesity and diabetes, and greater emphasis should be placed on risk prevention such as, drug-use and mental care for adolescents.
2. Opposing goals create conflict for health care in the region. For example, Crystal Run offers competent healthcare services but does not accept Medicaid which bars poor people from access. Also, the positive aspects of hospitals that have been able to stay open are offset by clinic closures, reduced access to primary services, and required travel that reduces poor people's access to specialty services. Health clinics in schools and mobile dental clinics to schools are positive, but greater access to preventative dental care for kids and insurance is needed. CCE, and local hospitals, among other agencies offer health education resources for community members, but home rehab services are inadequate or non-existent. In addition to access, another primary issue appears to be the lack of nurses, EMT volunteers and physicians in rural areas. State funded incentives are desired to attract professionals, such as, quality affordable housing and incentives to retain and attract volunteers. Simplification of the billing process equitable billing is needed. Unfunded mandates to cope with emergencies and terrorist threats, as well as meeting needs of summer visitors pose a great burden on communities and drain funds from existing programs. Tele-medicine is an option that needs to be further explored.
3. Rural communities are greatly burdened by unfunded mandates in the area of health care, in addition to struggling with shortages of healthcare workers and an aging workforce that could intensify this shortage. The health care system is dysfunctional, insurance, even subsidized insurance, is too expensive, hospitals are inadequately reimbursed, they bear the costs of uninsured, and engage in reactive practices, as opposed to proactive practices that could save money and promote better health in the long-run. Medicaid creates a large gap among those receiving services as they have poorer access to primary care due to lack of transportation and little to no access to specialty services. The community desires a system that is more proactive and oriented toward prevention; it desires universal health care and better coordination between agencies in both research and practice. While BOCES, AHEC, community colleges, Upstate Med were all identified as positive resources for training health care professionals, greater integration with the community is needed, such as sending students to work in the rural communities, engaging kids in the community from an early age, and creating new visions in the medical profession through education. Development of tele-medicine and internet access is needed and a decrease in unfunded mandates is necessary to establish a sustainable system.
4. Health care service availability, public health care coverage and eligibility are not clearly understood or fully utilized by the clientele they are meant to serve. Many are unaware of benefits and don't take advantage of services, while there is also recognition that the Medicaid system is cumbersome and difficult to manage from both provider and customer perspectives. There are limitations on coverage, lack of carriers, time consuming and complicated application process, as well as transportation requirements for the application process. Government regulations of the Medicaid system are difficult for providers to follow and the poor reimbursement process heavily burdens service providers. The paperwork process needs to be easier to manage and better incentives created for providers to locate in rural areas. Expansion of the mental healthcare system is necessary and transportation to services is highly important. Workforce development is

necessary to fill community needs for nurses, EMTs, and encourage schooling (including funding) and youth participation in the medical field.

5. The primary problem facing rural health care is the problem of access. Distance and transportation prevent many from having access to specialists or treatment facilities while the

working poor often fall between the cracks of Medicaid assistance and have no access to health care. It is also difficult to attract and keep health care professionals in rural areas. The Healthy NY program and the Rural Health Care Network help the situation, as does the work already implemented with assistance to the working poor, but much is needed. Ideally, a national healthcare system that is completely inclusive would be implemented, but for now, communities must adapt the facilitated enrollment program so that healthcare access is more inclusive.

In terms of what is needed to improve access to rural health, the main component is education. Through programs at community colleges and distance learning, more local individuals can become health professionals and more youths will stay in the local area. The intersection of technology and medicine must also be explored, as tele-medicine has great potential in rural areas.

6. The health care sector is highest paying employer, providing stable employment year round. However, it is still difficult to recruit and retain well trained employees and EMT shortages are especially problematic. One way to address this problem is by ensuring affordability of professional health-care education to encourage youth to enter this field. A very important concern highlighted is limited accessibility to services both because of transportation and lack of insurance, in addition to limited services and lack of specialist care. School-base health care systems are needed, universal access to preventative care, such as dental, optic (Medicaid does not reimburse for these services), and transportation to service providers. Telemedicine should be expanded, especially for the elderly, and home-based health care should be promoted throughout the community. The health care system is fragmented and many organizational changes are needed, e.g. reimbursement system, health record structure, home-based care, and collaboration between hospitals, all of which would greatly benefit care recipients through cost – effective, efficient practices. Fort Drum should be seen as an opportunity for expansion of the medical field in this region.
7. The major issues facing rural healthcare are accessibility, lack of specialty services and lack of personnel. Rural areas do not have the needed specialists to satisfy the population. There is a lack of prenatal and psychological care services in rural areas and no OBGYN delivery service exists in Essex County. Transportation is a major barrier to many residents who lack the needed means to get to specialists and health centers. Exacerbating the problem is the fact that it also remains difficult to retain and recruit doctors into rural areas. More funding is needed for preventative medicine and rural residents need to be better educated about annual exams, basic healthcare and overall wellbeing. A broader array of services must be available to rural residents, including dental, psychiatric and prenatal care. Transportation must also be improved in order to allow rural poor to access healthcare providers. Also, health insurance must be made more affordable and accessible for small businesses, not just individual employees, because small businesses which provide insurance are more likely to attract employees and flourish.
8. Rural health care is a source of economic development; it provides jobs and local practitioners are often dedicated to the community. The problems faced in this area are inaccessibility due to lack of transportation, inadequate cell phone access in some areas, inadequate insurance that doesn't cover dental and other preventative services, and difficulty in retaining physicians and volunteer EMS personnel. In addition, Medicaid presents a challenge, as local attitudes prevent people from applying to the program and the reimbursement system puts a heavy financial burden on local providers. More focus should be placed on preventative medicine, greater state assistance is needed to alleviate burden on counties, Medicaid reimbursement process should be simplified,

greater collaboration between urban and rural providers promoted, especially for training purposes, and healthcare needs should be considered in initial infrastructural planning stage.

V. CONCLUSIONS :-

Government health services the study recommends that the government should provide subsidized services, such as bus services to and from the centre or to provide 24*7 mobile clinic services in both the areas, particularly in rural areas where influence of distance is more on utilisation of services. Awareness about Government health schemes and facilities is found statistically significant in determining the utilisation rates in rural area. Hence much needs to be done on increasing awareness of people on public health care services.

Finally it is proper to remember that health is at bottom an issue in justice. It is in this context that we should ask the question as to how far and in what way has politics been engaged in health care? The record is disappointing. Most health sector issues figuring in political debate are those that affect interest groups and seldom central to choices in health care policy. For instance conditions of service and reward systems for Government doctors have drawn much attention often based on inter service comparison of no wider interest. Inter-system problems of our plural medical care have drawn more attention from courts than from politics. Hospital management and strikes, poor working of the MCI and corruption in recognition of colleges, dramatic cases of spurious drug supply etc have been debated but there has been no sustained attention on such issues as why malaria recrudescence is so common in some parts of India or why complaints about absence of informed consent or frequent in testing on women, or on the variations in prices and availability of essential drugs or for combating epidemic attacks in deprived areas seldom draw attention.

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