HEALTHCARE MANAGEMENT IN RURAL INDIA

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Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. ~World Health Organization, 1948

As the say goes, "*The greatest wealth is health. ~Virgil*" the wealth has to be preserved. The target in Indian context is the rural class as they are devoid of basic needs. The basic health care delivery system in India in rural sector is implemented through the Primary Health Centers (PHC). Each PHC has a group of female health assistants called ANM (Auxiliary Nurse Midwife) associated to cover a population of 5000 by each of them. There are Doctors attached to each Primary Health Centre whose job is to cater maximum number of patients in and around the area where it is situated. The basic health needs of the rural villages typically are safe water, hygiene, and protection from communicable diseases, healthcare for mother and child, among others. The social divide of rich and poor makes the Doctor's & ANM even more significant in providing the needy with health care at minimal cost. In providing these services the Doctor's & ANMs are made to maintain a number of records in registers.

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The components of Health services quality is mentioned below -

COMPONENTS OF HEALTH SERVICES QUALITY

	Structure	**Process**	**Outcome**
Technical	Equipment staff (numbers, qualifications, expertise) Training Teaching affiliation size, volume, ownership Governing board	Accuracy of diagnosis Appropriateness of treatment Skills Plans and sequencing Practice guidelines	Morbidity, mortality Health status Palliation Frequency of adverse incidents Malpractices Donations
Interpersonal	Technology – impact on roles and relationships Building design Presence of patient Advocates, social Workers, translators, Ethics committees	Collegiality Communication Honesty with Patients and families Sensitivity and compassion In delivery of care	Patient satisfaction Family satisfaction Referrals Compliance Returns for future care Malpractice Donations
Amenities	Cleanliness Presence of conveniences Ease of access Appearance of staff	Efficiency in patient flow Short waiting periods	Patient satisfaction Family satisfaction Referrals Donations

Primary Health Centers are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-centres for curative, preventive and promote health care. A typical Primary Health Centre covers a population of 20,000 in hilly, tribal, or difficult areas and 30,000 populations in plain areas with 4-6 indoor/observation beds. It acts as a referral unit for 6 sub-centres and refer out cases to CHC (30 bedded hospital) and higher order public hospitals located at sub-district and district level.

Standards are the main driver for continuous improvements in quality. The performance of

Primary Health Centres can be assessed against the set standards. In order to provide optimal level of quality health care, a set of standards are being recommended for Primary Health Centre to be called Indian Public Health Standards (IPHS) for PHCs. The launching of National Rural Health Mission (NRHM) has provided this opportunity.

The standards prescribed in this document are for a PHC covering 20,000 to 30,000 populations with 6 beds.

Setting standards is a dynamic process. Currently the IPHS for Primary Health Centres has been prepared keeping in view the resources available with respect to functional requirement for Primary Health Centre with minimum standards such as building manpower, instruments, and equipments, drugs and other facilities etc.

The overall objective of IPHS for PHC is to provide health care that is quality oriented and sensitive to the needs of the community. These standards would help monitor and improve the functioning of the PHCs.

SERVICE DELIVERY

- All "Assured Services" as envisaged in the PHC should be available, which includes routine, preventive, promotive, curative and emergency care in addition to all the national health programmes.
- Appropriate guidelines for each National Programme for management of routine and emergency cases are being provided to the PHC.
- All the support services to fulfil the above objectives will be strengthened at the PHC level.

MINIMUM REQUIREMENT FOR DELIVERY OF THE ABOVE-MENTIONED SERVICES:

The following requirements are being projected based on the basis of 40 patients per doctor per day, the expected number of beneficiaries for maternal and child health care and family planning and about 60% utilization of the available indoor/observation beds (6 beds). It would be a dynamic process in the sense that if the utilization goes up, the standards would be further upgraded. As regards, manpower, one more Medical Officer (may be from AYUSH or a lady doctor) and two more staff nurses are added to the existing total staff strength of 15 in the PHC to make it 24x7 services delivery centre.

FACILITIES

The document includes a suggested layout of PHC indicating the space for the building and other infrastructure facilities. A list of equipment, furniture and drugs needed for providing

the assured services at the PHC has been incorporated in the document. A Charter of Patients' Rights for appropriate information to the beneficiaries, grievance redressal and constitution of Rogi Kalyan Samiti/Primary Health Centre Management Committee for better management and improvement of PHC services with involvement of PRI has also been made as a part of the Indian Public Health Standards. The monitoring process and quality assurance mechanism is also included.

The concept of Primary Health Centre (PHC) 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-Centres (SCs) 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. Increasingly, these centres came under criticism, as they were not able to provide adequate health coverage, partly, because they were poorly staffed and equipped and lacked basic amenities.

The 6th Five year Plan (1983-88) proposed reorganization of PHCs on the basis of one PHC for every 30,000 rural population in the plains and one PHC for every 20,000 population in hilly, tribal and backward areas for more effective coverage. Since then, 23,109 PHCs have been established in the country (as of September 2004).

PHCs are the cornerstone of rural health services- a first port of call to a qualified doctor of the public sector in rural areas for the sick and those who directly report or referred from Sub-centres for curative, preventive and promotive health care. It acts as a referral unit for 6 sub-centres and refer out cases to Community Health Centres (CHCs-30 bedded hospital) and higher order public hospitals at sub-district and district hospitals. It has 4-6 indoor beds for patients.

PHCs are not spared from issues such as the inability to perform up to the expectation due to (i) non-availability of doctors at PHCs; (ii) even if posted, doctors do not stay at the PHC HQ; (iii) inadequate physical infrastructure and facilities; (iv) insufficient quantities of drugs; (v) lack of accountability to the public and lack of community participation; (vi) lack of set standards for monitoring quality care etc.

Standards are a means of describing the level of quality that health care organizations are expected to meet or aspire to. Key aim of these standards is to underpin the delivery of quality services which are fair and responsive to client's needs, which should be provided equitably and which deliver improvements in the health and wellbeing of the population. Standards are the main driver for continuous improvements in quality. The performance of health care delivery organizations can be assessed against the set standards. The National Rural Health Mission (NRHM) has provided the opportunity to set Indian Public Health Standards (IPHS) for Health Centres functioning in rural areas.

There are Standards prescribed for a 30 bedded hospital by Bureau of Indian Standards (BIS). Recently, under NRHM, Indian Public Health Standards have been framed for Community Health Centre as the BIS is considered as very resource-intensive at the present scenario. But no such standards have been laid down for Primary Health Care Institutions. In order to provide optimal level of quality health care, a set of standards are being recommended for Primary Health Centre to **be called Indian Public Health Standards (IPHS) for PHCs**.

The nomenclature of a PHC varies from State to State that include a Block level PHCs (located at block HQ and covering about 100,000 population and with varying number of indoor beds) and additional PHCs/New PHCs covering a population of 20,000-30,000 etc. **The standards prescribed in this document are for a PHC covering 20,000 to 30,000 populations with 6 beds,** as all the block level PHCs are ultimately going to be upgraded as Community Health Centres with 30 beds for providing specialized services.

Setting standards is a dynamic process. Currently the IPHS for Primary Health Centres has been prepared keeping in view the resources available with respect to functional requirement for PHCs with minimum standards such as building manpower, instruments, and equipments, drugs and other facilities etc.

OBJECTIVES OF INDIAN PUBLIC HEALTH STANDARDS (IPHS) FOR PRIMARY HEALTH CENTRES -

The overall objective of IPHS is to provide health care that is quality oriented and sensitive to the needs of the community.

The objectives of IPHS for PHCs are:

- To provide comprehensive primary health care to the community through the Primary Health Centres.
- To achieve and maintain an acceptable standard of quality of care
- To make the services more responsive and sensitive to the needs of the community.

At state level the Central Server at commissioner's office receives data from all districts in the state. The data here is compiled and the reports from village level to state level can be viewed on these computers. Also this integrated data can be extended to inter-departmental usage by the government.

The percentage of time saved by the ANM, improved accuracy of collected data in the family encounters and number of timely responses to emergency problems and accuracy of reports at all the levels in the health care system will be the indicators for improved health. When usage builds up the Basic Health indicators, Infant Mortality Rate (IMR), Maternal Mortality Rate (MMR) will show improvement. The average weight of new born children, percentage reduction of ANM time in data capture and reporting percentage increase in the population coverage, total number of family planning operations done on the eligible couples, etc will also form the indicators to the effectiveness of the solution.

For the common man in rural villages, the use of PDA by the ANM helps his family members prevent health disasters. This is possible because the ANM, who is giving service to his family members in treating a high-risk pregnant woman or immunization to a child, has all the history of the cases stored in her PDA. The ANM can access anytime the history data in PDA and take necessary steps for providing appropriate treatment in time. This pre-preparedness of ANM helps the common man not only protect his family members from preventable fatalities, but also heavy financial losses through spending on treatment, irrecoverable health disasters, and loss of life. When applied to large-scale population, the above health-care system can lead to poverty elimination at the village level as the common man's expenditure on medical treatment comes down drastically.

In the other districts where the computerization is not in place in the health sector, the statistics is number based. The main benefit to the Government through the PDA aided project is that the system is name based and can track the complete record of every citizen level at any time. This helps the Government in strategic planning such as maintaining optimal stock of medicines, infrastructure facilities and so on.

Lessons learned during the implementation of the project have been deliberated at a workshop where delegates from the Ministry of Health of the Government of India, health administrators, academicians, doctors, ANMs, and para-medical professionals participated. Key lessons are listed below:

1. Building up of reliable citizen's database in rural villages helps the common man to get multiple services from a single point of source that the Government wants to facilitate.
2. Monitoring at all levels and usage of the systems and reports is vital as it is key to optimal resource planning in terms of inventory maintenance of drugs and infrastructure facilities.
3. Before taking IT to the rural villages, the key factors like telecommunications, power supply, connectivity to villages are essential.
4. Schedules and automatic report generation has resulted in considerable timesaving for the ANMs, which could be utilized for providing better service.
5. Use of IT in facilitation of name based service at individual level is a paradigm shift from the way health services were provided earlier.
6. Use of common citizen database can facilitate other Government Departments as well.

The innovative use of information technology by ANMs in delivering the rural health care services with a PDA has been successful. The cost of these devices will become affordable by the Governments as the volumes of demand increases reflecting in decreased prices. Computerization helped the department in evaluating and improving the health parameter indices like MMR, IMR and monitor the couple production rate, birth rate etc.

Awareness of the benefits of IT at all levels, increases professional knowledge and new methods of treatment to improve the health care and in-turn enhance the quality of health of rural population.

PROJECT ACTIVITIES OF INDIA HEALTH CARE

- Kodhaki (Nagpur District), May 1 (ANI): A mysterious fever, identified as Chicken Gunia, has afflicted about 450 persons in about 17 villages of Nagpur District.
- Similar in symptoms to dengue fever, Chicken Gunia leaves individuals complaining of high fever, body ache, joint pains and spells of nausea.
- Several patients with symptoms of chicken gunia are undergoing treatment at the Primary Health Centre (PHC).
- I suffered high fever. My body became stiff suddenly. I had severe pain in the joints and I find difficulty in walking. I took medicines but it is not helping me. I am still under treatment, said Ramdas, a patient.

- Fahim Akhtar, the medical officer at the Kodhaki Primary Health Centre, said that blood samples of some of the patients have been sent to the National Institute of Virology in Pune to confirm the presence of the disease.
- Chicken Gunia is caused by mosquito bites and at present, no vaccine exists to counter it. (ANI)

MARKETING STRATEGY

(HEALTHCARE MANAGEMENT)

- Do individuals really want health care?
- Understanding preferences
- Stated and revealed preferences
- Measuring preference
  - Qualitative analysis
  - Conjoint analysis
  - Willingness to pay
- A Conjoint analysis example – Ryan (1999)
- Problems with preferences

Do individuals want health?

- Yes they do, but that is not all they want
- Individuals want many things (unlimited wants) and have limited ability to pay for it (scarce resources)
- One problem of focusing just on health outcomes is that we may be forcing some types of trade-offs that lowers welfare.
- We need to take into account the patients preferences – i.e. their own welfare

What are preferences?

- The majority of economics is built on the concept of preferences. These describe what individuals like and dislike.
- Economists use preferences as a measure of benefit to the individual or society.
- If an individual has to choose between to bundles A and B, then either
  - A is preferred to B,
  - B is preferred to A
  - Or the individual is indifferent between A and B.
- Preferences are assumed to be
  - Complete (we have preferences over everything)

  - Reflexive (any outcome is at least as good as itself)
  - Transitive (If x is preferred to y and y preferred to z, then it must be the case that x is preferred to z

Example: What do patients want?

- Ryan (1999) aimed at studying patient preferences for in vitro fertilization.
- Focuses on the trade-off between health outcomes and non-health outcomes (processes)
- Aims at estimating a utility function through a stated preference technique known as conjoint analysis (discrete choice analysis)
- Conjoint analysis:
  - Forced choice between two systematically different options (which is better, profile A or profile B)
  - Options vary over specific attributes
  - Attributes vary over specific ranges

The attributes

- Attitudes of the staff towards the patient:
  - Uncaring/unsympathetic; caring/sympathetic
- Continuity of contact with same staff
  - See same staff; see many different staff
- Time on waiting list first IVF attempts
  - 1, 3, 6, 18, 36 months
- Cost to you per attempt
  - 0, 750, 1500, 2500, 3000
- Chance of taking home a baby
  - 5, 10, 15, 25, 35 percent
- Follow up support
  - Yes; no

Quality of service is the watchword in the Health Care Market. Measuring quality involves complications especially in health care services; it is difficult to clearly define an ‘output’ of a firm – hospital. Two decades ago, though quality services might have been provided, terms like consumerism and efficiency measurement were not familiar in the health care market. Increase in competition, increase in cost and changes in the attitudes of the consumers had strongly influenced the health care providers towards consumerism.

In India, the health care system consists of three types of providers, government organization, private and voluntary organizations. The government spends a substantial amount on health infrastructure. It also provides services at no cost or at subsidized rates. A higher utilization of private health services, in spite of heavy government expenditure poses import questions. Are government institutions operating inefficiently? Are the patients willing to pay higher cost for quality of services? Is it true that the quality of services is better in private health care institutions? In India, there is no published information on quality of services of different type of health care institutions.

Planning for an efficient health care system requires information on the existing facilities and the change in health infrastructure over a period and the areas requiring improvement. The availability of institutions has a major impact on the quality of services provided. Over a period there has been a growth of institutions in India, especially after 1980.

Table – 1 **GROWTH OF HOSPITALS AND PHCS IN INDIA**

	India		
	Hospitals		PHCs
	Public	Private and Voluntary	
1984	3835	3256	7210
1985	4027	3342	7250
1986	4093	3381	8496
1987	4215	3549	14145
1989	4504	5641	16756
1990	4526	5646	20531
Sept 2004	7008	12000	23109

The mere existence of institutions does not guarantee quality services. The institutions should be equipped with adequate manpower and facilities. Increase in the institutions should also be in correspondence with an increase in population. Rural areas suffer from inadequate manpower. The Government of India in its various health plans stresses on the provision of primary health care services to rural poor.

Medical care services have expanded rapidly during recent past and the expectations of people have risen greatly. The cost of services has also increased and what the customer expects from the hospital is qualitatively better and timely services. Medical services are entering a ‘buyers market’ situation from hitherto ‘sellers market. India probably has the

largest private health sector in the world. But we do not have adequate information on the services provided by private sector.

The marketing strategy consists of 7 P's – a common marketing term and analysis. The 7 P's are –

1. Product
2. Price
3. Place
4. Promotion
5. People
6. Process
7. Physical evidence

The 7 P's are also known as the 'Marketing Mix'. The 7 P's allow you to analyse and get thinking about how you operate your business. Many sellers do not do this and this is the difference from those who become successful and those who do not.

PRODUCT

The Healthcare belongs to Service Marketing rather than a product selling. Here your product is your services provided to your customer. The services have to be provided on the basis of the customer's needs and wants. When a patient enters a hospital the first and foremost need is that he wants to get well as soon as possible. So the moment he meets a Doctor he should be welcomed in a fashion that he gets easily adapted to the environment. In this aspect the following things play a major role –

a) Duties of Physicians to their Patients
   - Obligations to the sick.
   - Patience, delicacy and secrecy.
   - Proper and specific diagnosis.
   - The patient must not be neglected.

b) Duties of the Physician to the Profession at large
   - Upholding the honour of the Profession.
   - Membership of Medical Societies.
   - Safeguarding the Profession.
   - Exposure of unethical conduct.

c) Patients Rights (Approved by American Hospital Association, 1973)
   - A patient has the right to considerate and respectful care

- The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment and prognosis in terms the patient can be reasonably expected to understand.
- The patient has the right to refuse treatment to the extent permitted by law and be informed of the medical consequences of his action.
- The patient has the right to receive from the physician, information necessary to give informed consent prior to the start of any procedure and/or treatment.
- The patient has the right to every consideration of his privacy concerning his own medical care programme.
- The patient has the right to expect that all communications and records pertaining to his case should be treated as confidential.
- The patient has the right to expect that within its capacity a hospital must make reasonable response to the request of the patient for services.
- The patient has the right to obtain information as to any relationship of his hospital to other health care and educational institutions in so far as his care is concerned.
- The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation affecting his care of treatment.
- The patient has the right to expect reasonable continuity of care.
- The patient has the right to examine and receive an explanation of his bill regardless of the source of payment.
- The patient has the right to know what hospital rules and regulations apply to his conduct as a patient.

Source – Health Action, December 1990

PRICE

A product is only worth what a customer is prepared to pay for it!

In service marketing, the price you choose needs to be competitive, but this does not mean it needs to be the cheapest. Many small businesses are able to compete with larger ones by offering extra value services, better value for money. Your pricing must to able to provide you with a profit!

PLACE

In healthcare sector place plays a major role since the place where the hospital is located will attract the customers.

PROMOTION

This is the way in which you communicate to the customers about your hospital and services that you are providing. This can be done in a number of ways that includes making brand image, advertising, special offers etc. Promotion must get the customers attention, it must be appealing to them, and it must inform them of a constant message and above all give the customer a reason to come to your hospital.

PEOPLE

The manpower plays a major role as far as service marketing is concerned. If you take special reference of hospitals the people who work there catches the attention of the customers as compared to the management that runs the hospital. So recruitment and selection of people must be totally professional and target based.

PROCESS

The procedure of giving services also acts as an impetus in getting more customers. If the procedure of getting nurse or ward boy or stretcher for the patient is quick and accurate the customers will be attracted to the hospital. Similarly, during the discharge of the patient if the procedure of clearing the bill is quick the patient as well as his relatives is very happy.

PHYSICAL EVIDENCE

In services physical evidence can not be touched like a product can be. Hence the evidence will be only your services and the promotion will be mouth to mouth publicity of these services by the visiting patient.

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