

Evaluating the Functioning of Primary Health Centres in India - An Empirical Study

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Abstract: Given the importance of public health centres in India in the environment of increasing utilisation of the private health services, an attempt has been made to assess the causes and determinants of using the services of the primary health centres in the rural areas. The findings of the study show that people are obsessed with the private medical practitioners because of huge treatment costs and ineffective treatment and are now increasingly utilising the services of the primary health centres.

Key words: health, primary health centres, public health, rural areas, medical practitioners.

Introduction: In the developing countries like India, the health care delivery hardly reaches to every nook and corner of the country. After gaining the political freedom, there emerged a national commitment to improve the health of people. The first step in this direction was comprehensive health care approach given by Bhole committee in 1946. This Committee suggested an integration of preventive, promotive and curative health services from womb to tomb, to every individual irrespective of sex, caste, creed, colour and geographical location. This laid the foundation for establishment of network of PHCs and the Sub Centres in India. In 1978 a new approach to healthcare came into existence at Alma Ata (USSR), known as “Primary Health Care”. It defined primary healthcare as, “essential health care made universally accessible to individuals and acceptable to them, through their full participation and at a cost that community could afford” thereby differentiating it from the concepts like basic health services, easily accessible care and services provided by general practitioners which were treated as being synonymous with primary healthcare. The primary health care approach as envisaged in Alma-Ata declaration is based on principles of social equity, national coverage, self-reliance, inter sectoral co-ordination and involvement of people in the planning and implementation of health programs in pursuit of pre-designed common health goals.

Significance of Primary Health Care: The importance given to primary health care is because of underlying five ideas. First, it is the recognition of the importance of intersectoral action for development of health. This emerged because economic growth did not necessarily “trickle down” to the poor as economists had assumed. The nucleus of development was how to uplift the standard of life of the poor people. Second reason was the experience of earlier programmes that the key infectious diseases could not be successfully combated by specific and intensive isolated programmes, controlled and coordinated from the Centre. The third underlying idea was that preventive and promotive actions should not be separated from curative action, because for attaining the desired results proper integration of these is important. Fourth was the evidence that there was a range of health activities which were relatively cheap and very effective but did not reach millions of people throughout the world. Finally, it represented a strong action against

authoritarian attempt of the health professionals to impose health on people guided by their vested interests.

Design of the study: The current study adopted a cross sectional research design, because it is useful in obtaining an overall picture as it stands at the time of study. The multi stage purposive sampling technique was used for the analysis. In the first stage five Primary Health Centres were selected and information about the physical and human infrastructure was obtained from the concerned medical officers, then from each Primary Health Centre six outpatients were selected and information was obtained from them about the quality of services delivered by these Primary Health Centres.

Results: On an average, the OPD attendance per PHC is 30 patients per day. In 40% of the PHCs average OPD attendance is greater than 40 patients. It shows that in the rural areas significant percentage of people seek treatment from the public health facilities and hence strengthen the argument that people trust the public health providers. In the surveyed PHCs the number of inpatients is very low the possible reasons for this could be inadequate infrastructural facilities to provide a complete package of treatment, hesitation of people to come for treatment for complicated ailments and the casual attitude of the PHC staff towards inpatients. Among the patients seeking treatment from PHCs, 46 % came for maternal and child care services. This significant percentage can be attributed to the fact that these health centres have been strongly connected to the NRHM, which mainly deals with improving the maternal and child health. An important finding of the study is that the major beneficiaries of the services of PHCs are the most vulnerable and illiterate sections of our society. Hence these health centres need to play more proactive role in healthcare delivery.

On an average, each PHC receives 22.5% of its required medicine supply. This shortage of required medicine has immense forward linkages in the determination of healthcare delivery of these health centres. Out of this meagre supply of medicines, it is not expected that PHCs can serve the interests of patients better. This shortage of required medicine supply draws a thick line between the people and their usage of services of these health centres.

People opt for PHCs as a source of treatment if located at nearest possible distance. In the remote areas, people prefer the local medical practitioner. It shows that people have good faith in PHCs wherever these are present. On an average the duration of waiting period for the patients was 12 minutes. This short duration of waiting period can be attributed to low patient rush and rather simple nature of ailments, for which people come to these health centres. Time given by a doctor to the patient is very powerful factor in determining the faith of people in these health centres. As many as 65% patients were satisfied from the consultation with the doctor. This shows that majority of the respondents have faith in the doctors present in these health centres.

On an average those patients who require laboratory tests got 68% of these tests done in the concerned PHCs. It means that as far as basic laboratory tests are concerned, PHCs are well equipped with adequate laboratory manpower and medical equipment. PHCs receive 22.5% of their required medicine supply. Patients received only 6% of the medicines from these health centres. It shows that there are significant leakages w.r.t. availability of medicines in these health centres. The leakages in medicine supplies from these PHCs were also confirmed by the 20% village heads. Only 20% patients were satisfied with the availability of medicines in the PHCs. This low percentage is expected because these health centres receive less quantity of required medicine supply and as such, with this insufficient supply they could not please every patient.

On an average each PHC has to cover villages within the range of 6kms, because in the study area the average distance between the far off villages from the nearest PHC is 6kms. Wherever PHCs are present, people have strong faith in them because PHCs as first preference of treatment of

people for common ailments is supported by 33.3% village heads; these are mostly the village heads of the PHC villages.

In aggregate, 15% of the sanctioned staff is deficient in the PHCs. Out of total staff; the deficiency of doctors is 27%. In the 40% of the surveyed PHCs, gynaecologist is absent; ironically these PHCs are in the periphery regions. It is a testimony to the fact that still the far flung areas lack the facilities for maternal healthcare service. Out of the PHCs where gynaecologist is present, 66.7% have the monthly average of deliveries below five and 33.3% PHCs have the monthly average of five to ten deliveries. This average is much below the recommended average of 20 deliveries per month per PHC as supported by IPHS, 2012.

Almost 60 % PHCs close after 4pm, hence even for the emergency care rural areas have to depend upon the already congested urban health institutions. Particularly during the accidents in the rural areas, lack of emergency service facility nearby proves fatal.

School health is neglected by 40% of the Primary Health Centres; it is the significant weak link of preventive care in the health system. Preventive healthcare is also neglected by the Public Health Engineering (PHE) department also because PHE officials visited only 26.7% villages during last year to look into the sanitation of the villages and their water sources. .

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Schools which are located in the PHC village receive diverse facilities from the PHCs whereas the schools located in the vicinity and farther areas receive only a few services that too for formality purposes. As distance of schools increase from the nearby PHC, the school health activities of the PHC faint. There by, cementing the argument that remote schools are neglected from the purview of health activities of the PHCs.

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