

Primary Health Care Resources in India

2.1 Infrastructure

The health care infrastructure in rural areas in India has been developed as a three tier system and is based on the population norms as shown in Table 2.1.

Table 2.1 : Primary Health Structures and their Population Norms

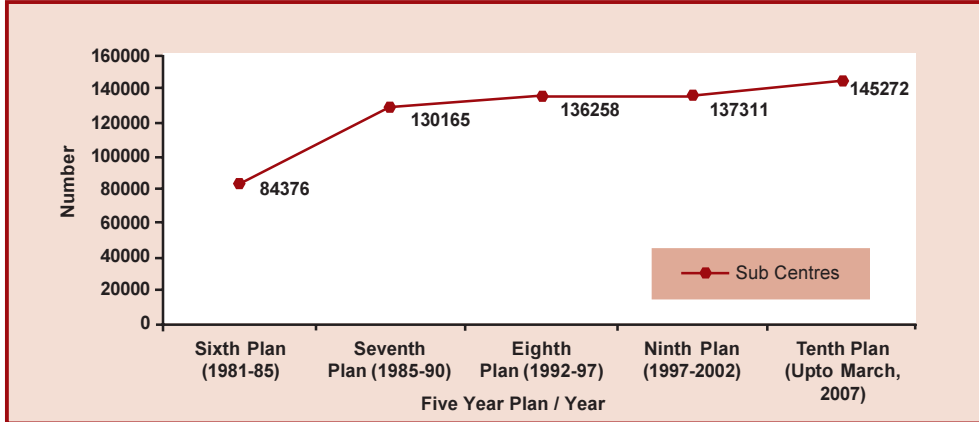
Centre	Prpulatio Norms	
	Plain Area	Hilly/Tribal/Difficult Area
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Source: Rural Health Statistics, MOHFW, GOI, 2007

Sub-Centres (SCs)

The Sub-centre is the most peripheral health unit and first contact point between the primary health care system and the community. Each sub-centre has one Female Health Worker / ANM (Auxiliary Nurse Midwife) and one Male Health Worker. One Female Health Assistant (Lady Health Visitor LHV) and one male health assistant supervise six sub centers. Sub-centres are assigned to perform tasks related to components of primary health care. They are provided with basic drugs for minor ailments needed for taking care of essential health needs of population. The Government of India is providing 100% central assistance to all sub-centres in the country since April 2002 in the form of salaries of ANMs and LHVs and rent of buildings. There are

Figure 2.1 : Progress of Primary Health Care System (Sub-Centres)



Source: Rural Health Statistics, MOHFW, GOI, 2007

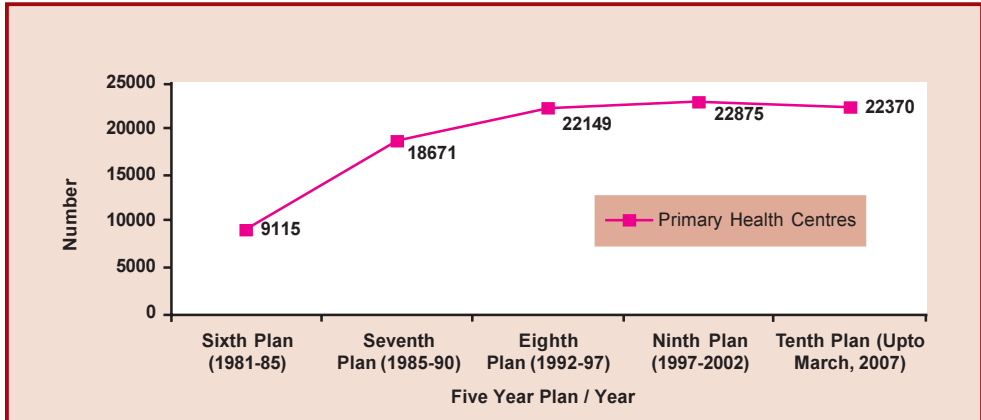
1, 45,272 sub-centres functioning in the country as on March 2007. The progress in number of existing sub-centres is shown in Figure 2.1.

NRHM has proposed strengthening of sub-centres in the form of provision of untied fund of Rs10,000 per annum. This fund to be utilized for local needs and maintenance of subcentres. The units will also be provided with essential drugs, both allopathic and AYUSH. Upgradation of subcentres is planned with provision of additional manpower in vacant positions.

Primary Health Centres (PHCs)

PHCs remain the first contact between village community and Medical Officer. They are 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. There are 22,370 PHCs functioning as on March 2007 in the country. The progress in number of existing PHCs is shown in Figure 2.2.

Figure 2.2 : Progress of Primary Health Care System (PHCs)



Note : Under Tenth Five Year Plan (2002-07), some of the PHCs have been up graded as CHCs.

Source: Rural Health Statistics, MOHFW, GOI, 2007

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

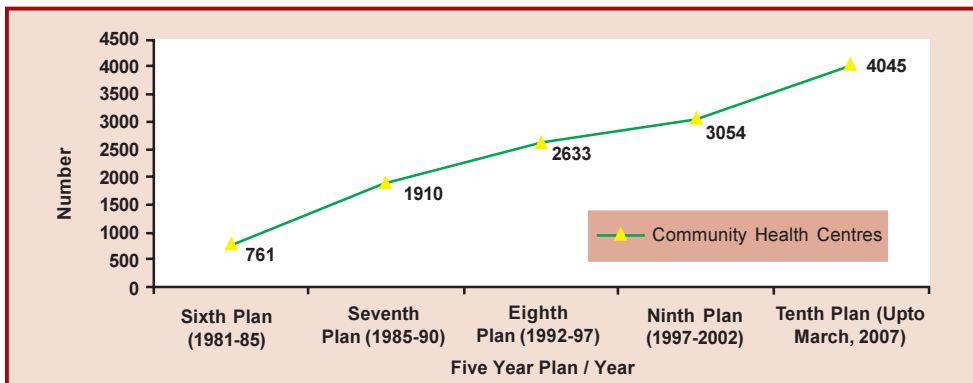
1. Adequate and regular supply of essential quality drugs and equipment to PHCs
2. Provision of 24 hour service in atleast 50% PHCs by addressing shortage of doctors, especially in high focus states, through mainstreaming AYUSH manpower.
3. Observance of standard treatment guidelines and protocols.
4. Intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, upgradation of 100% PHCs for 24 hour referral service, and provision of second doctor at PHC level (1 male, 1 female) to be undertaken on the basis of felt need.

Community Health Centres (CHCs)

CHCs are manned by four medical specialists i.e. Surgeon, Physician, Gynaecologist 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.

NRHM aims to strengthen services at CHCs by operationalising 100% CHCs as 24 hour First Referral Units (FRUs), including posting of anesthetists. New Public Health standards have been formulated for all cadres of primary health care functioning units including CHCs. The objectives of these public health standards are essentially to provide optimal expert care to the community; 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. A set of assured service package is provided to population. An additional public health programme manager posting is recommended on contractual basis at all CHCs for supervising surveillance operations; coordination of national health programmes; management of ASHAs etc. A standard set of essential drugs and equipment is enlisted at CHCs level. Quality assurance is envisaged in delivery of health care and is recommended that every CHC to have the charter of patient rights prominently displayed at entrance of CHCs. The progress in number of existing CHCs is shown in Figure 2.3.

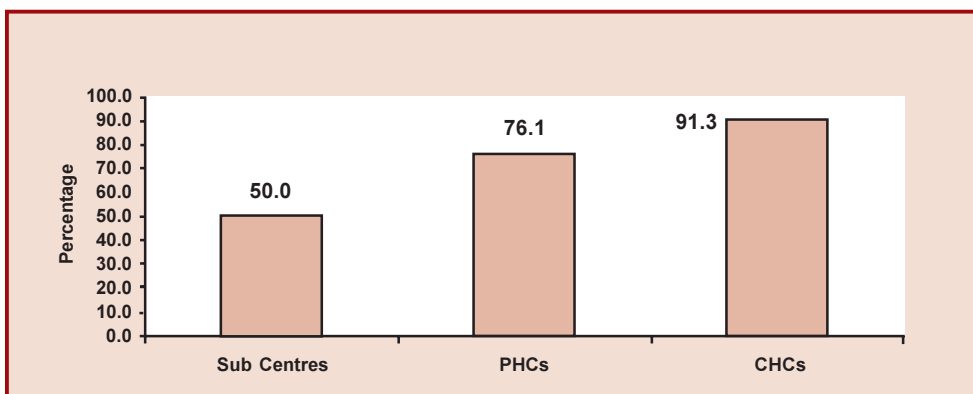
Figure 2.3 : Progress of Primary Health Care System (CHCs)



Source: Rural Health Statistics, MOHFW, GOI, 2007

The number of these centres has shown an increasing trend over the last years on continuous basis. According to the figures of population based on 2001 population census, the shortfall in the rural health infrastructure comes out to be of 20855 subcentres, 4883 PHCs and 2525 CHCs. About 50% of sub-centres, 76% of PHCs and 91% of CHCs are located in the Government buildings (Figure 2.4).

Figure 2.4 : Percentage of Sub Centres, PHCs and CHCs functioning in Government buildings

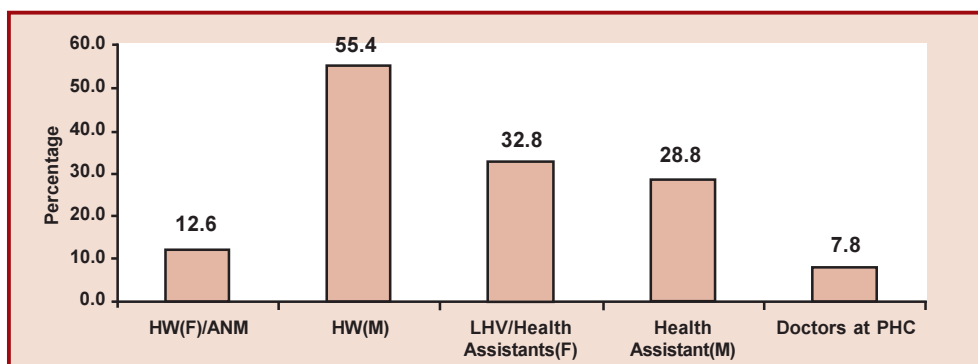


Source: Rural Health Statistics, MOHFW, GOI, 2007

2.2 Manpower

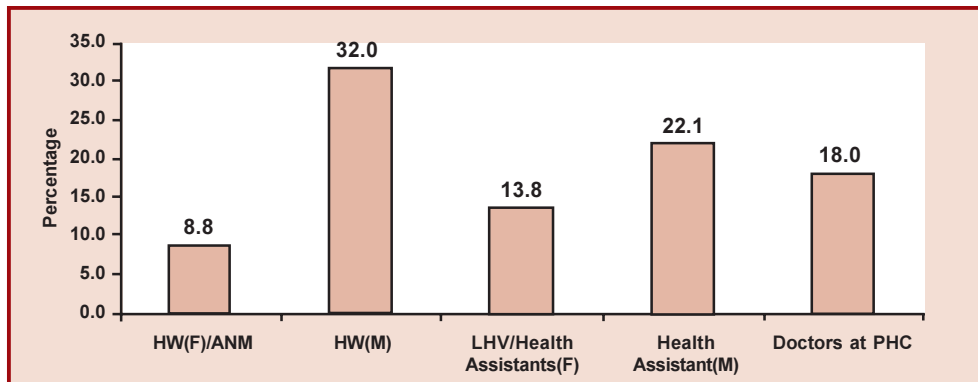
The existing manpower is an important prerequisite for the efficient functioning of the Rural Health Infrastructure. Despite significant progress made in terms of creating manpower over the years, there remains a huge gap in terms of human resources at primary care level, which is realized by the government of India, and the process is underway to bridge the gap. The graphs beneath represent the shortfall in these primary care manpower resources (Figure 2.5 to 2.9).

Figure 2.5 : Shortfall - Percentage of shortfall as compared to requirement based on existing infrastructure



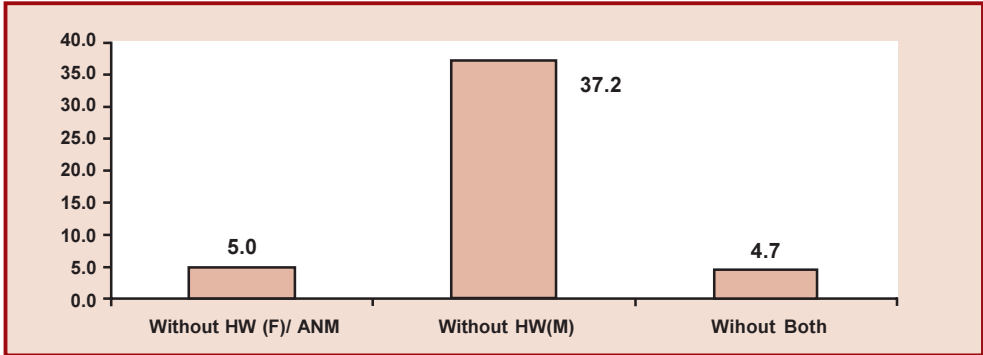
Source: Rural Health Statistics, MOHFW, GOI, 2007

Figure 2.6 : Vacancy Position - Percentage of Sanctioned Post Vacant



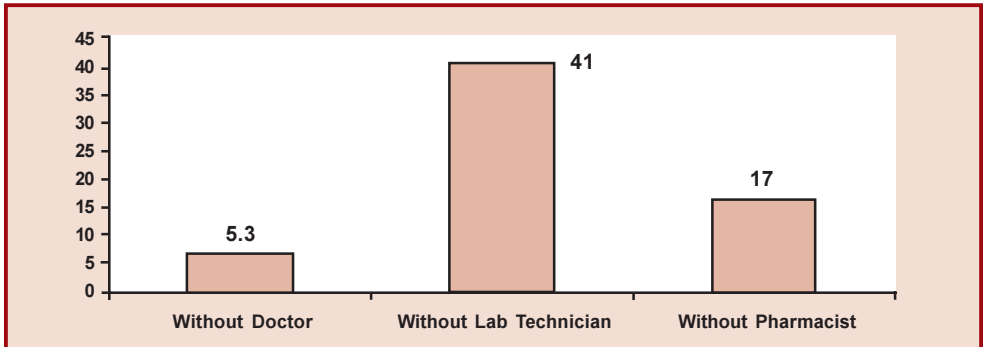
Source: Rural Health Statistics, MOHFW, GOI, 2007

Figure 2.7 : Percentage of Sub Centres functioning without ANMs or/and HW(M)



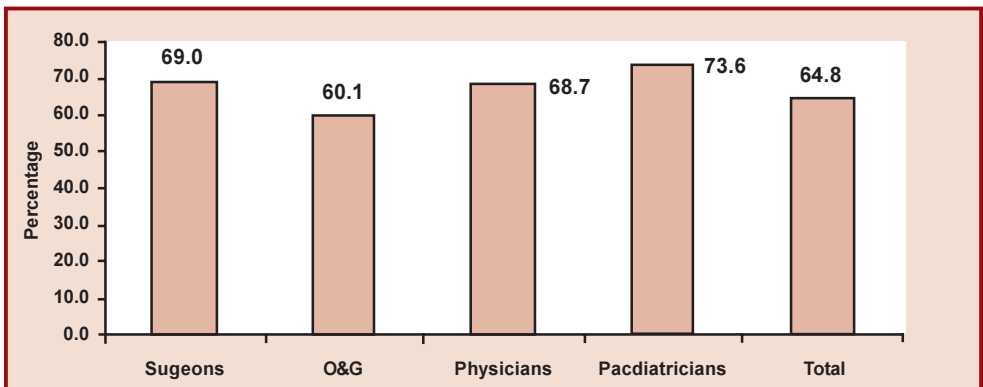
Source: Rural Health Statistics, MOHFW, GOI, 2007

Figure 2.8 : Percentage of PHCs without Doctor, Lab Tech., Pharmacist



Source: Rural Health Statistics, MOHFW, GOI, 2007

Figure 2.9 : Percentage shortfall of Specialists as compared to requirement based on existing infrastructure



Source : Rural Health Statistics, MOHFW, GOI, 2007

NRHM realizes the deficiencies and gaps currently existing in the human resources at health facilities. It aims strongly in bridging these gaps and urges to effectively utilize the manpower by developing multiskilling and multitasking capacities in existing manpower. Scope of strengthening services at primary health care facilities is well envisaged and currently steps are underway to build primary health care resources in the country. Some of the efforts made in this regard are depicted in Box 2.1.

Box 2.1 : Role of NRHM in strengthening of quality services at these centres

Sub-centres

By engagement of contractual ANMs wherever required and by provision of Rs. 10,000 annual untied grant, nearly all Sub-Centres have been made functional. Sub Centres have judiciously used the untied funds as per need, from buying B.P. equipment, weighing machine, to repairing the examination table, cleaning the Sub Centre, etc. Early evidence suggests that deliveries have started taking place in a few Sub Centres because of the untied grants. A second ANM is in place in 7699 Sub Centres.

Primary Health Centres

2230 PHCs have been made round the clock functional with a provision of two additional Nurses. Of these 600 have been made round the clock functional in Tamil Nadu this year. Rs.50,000 Annual Maintenance Grant and Rs.25,000 as untied grant for PHCs have been sanctioned all PHCs.

Community Health Centres

Rupees twenty lakhs have been provided to all the CHCs as first installment to move towards Indian Public Health Standards. 1554 CHCs have carried out Facility Surveys to plan for the gaps as per IPHS. Rs. Twenty Lakhs have been provided to all CHCs as first installment to move towards IPHS.

Source : NRHM Progress made so far, NRHM, MOHFW, GOI

Apart from Government directly providing primary care resources in terms of manpower and health systems, civil bodies, NGOs, private sector is also involved in provision of primary care in India. Private sector as a whole constitutes biggest care provider in India. States have utilized the contribution of private sector by outsourcing some of the primary health care

service provision either partially or totally. The involvement of private sector in this form is increasing to large extent and such kind of involvement is adding dimensions of care that have been successfully provided at primary care level. One such successful case study is illustrated in the Box 2.2.

Box 2.2 : Out Sourcing of Primary Health Care to NGOs



Karuna Trust, Non Governmental Organization, Managing 25 Primary Health Centres in Karnataka and 9 PHCs in Arunchal Pradesh.

Features of PHC at Karnataka managed by Karuna Trust:

- The MO, ANM, Male Health worker, Staff Nurse, Pharmacist, Lab Technician , stay in PHC headquarter
- 24 X 7 PHCs
- Availability of essential drugs through out the year.
- Taking total responsibility of the PHC population: No duplication
- People oriented community based, cost-effective, culture & region specific primary health care.
- Effective implementation of Reproductive Child Health - New Born care and Essential Obstetric Care and other National Health Programmes
- Specialist services at PHC: Obstretician & Gynaecologist, Ophthalmologist, Physician, Pediatrician
- Good Referral System: Transport for emergencies - One of the staff accompa nies the patient
- Mainstreaming of HIV/AIDS in PHC
- Addressing Specific problems: Sickle Cell Anemia & Hot Water Epilepsy.
- PHC Waste Management
- Community-based rehabilitation of people with disability

- Training house surgeons in Primary Health Care.
- True Community Needs Assessment by PRA/PLA and Micro-plan for every village - formation of Village Health Committees (VHCs), Sub-center & PHC Committees.
- Accountability of PHCs to people through Community Monitoring
- Promoting SHGs & MSSs - micro-credit & income generation, anti-liquor & anti smoking movement
- Convergence of health, nutrition, drinking water & sanitation.
- Involvement of PRIs: Gram Sabha, & Gram Panchayats
- Medical & social audit of Maternal & Infant deaths
- Women friendly environment in the PHC & HMIS - Gender desegregated

Innovations brought out in Primary Health Centres at Karnataka:

- ❖ **Tribal ANMs** program: Training tribal girls as ANMs and posting them in the Tribal Sub-centers. Now 18 months course for 10th standard pass girls.
- ❖ Introduced **Dental Health & Cancer** Control Program in PHC - ANMs trained to take Pap Smears.
- ❖ Integration of **Rehabilitation** into Primary Health Care in addition to preventive, promotive & curative health care.
- ❖ **Telemedicine** in Primary health Care
- ❖ Community Herbal Gardens - for common ailments
- ❖ SHGs - Micro-credit for out-patient care
- ❖ **Community Health Financing/ Insurance**
 - Premium Rs.22 (1 Year Rs. 30/-) per person per year , Premium costs shared by community, Milk Co-operatives, SHGs,UNDP and GPs,
 - No exclusions - all age groups - hospitalization due to any illness, Rs. 50/- paid to patient for daily wages lost and Rs. 50/- to the hospital for extra drugs per day of hospitalization
 - Ambulance services and referrals - diagnosis & treatment are also covered
 - Maximum of 25 days of Hospitalization
 - Amount paid to patients every day through the revolving fund at each hospital
 - For Above Poverty Line, the Janarogya Policy for Rs.70/-, with exclusions - Private hospitals included
- ❖ Promotion of **Traditional Medicine** - 20 herbs for Primary Health Care. Integration of Ayurveda & Homeopathy (**AYUSH**).

- ❖ Promotion of Generic drugs and **Rational drug use**
- ❖ Introduced **Mental Health** Program including Low cost management of Epilepsy.
 - MANASA - A comprehensive system of care for homeless mentally ill people
 - Transit Centre
 - Helpline
 - Rehabilitation and reintegration with families

Some of the Indicators of these PHCs at Karnataka

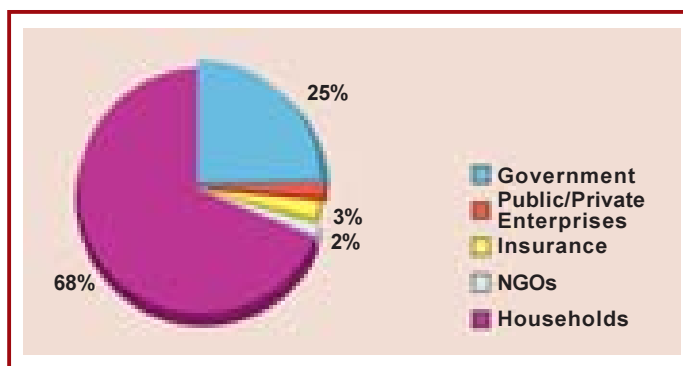
- ❖ Crude Birth Rate- 13/ per 1,000 population
- ❖ Crude Death Rate: 5.8/ per 1,000 population
- ❖ Infant Mortality Rate: 23.8/ 1000 live births
- ❖ Perinatal Mortality Rate: 17/ 1000 live births
- ❖ Neonatal Mortality Rate: 10.2/ 1000 live births
- ❖ Under five Mortality Rate: 26.8/ 1000 live births

Source : www.mohfw.nic.in/nrhm/presentations/multidimensional_workshop/ppp_karunatrust.zip

2.3 Financial resources for Primary Health Care

India's estimated health expenditure for the year 2001-02 was 4.8% of the GDP. Out of this, central, state, and local governments spent one fourth of the total expenditure (Figure 2.10).

Figure 2.10 : Share in Healthcare Spending



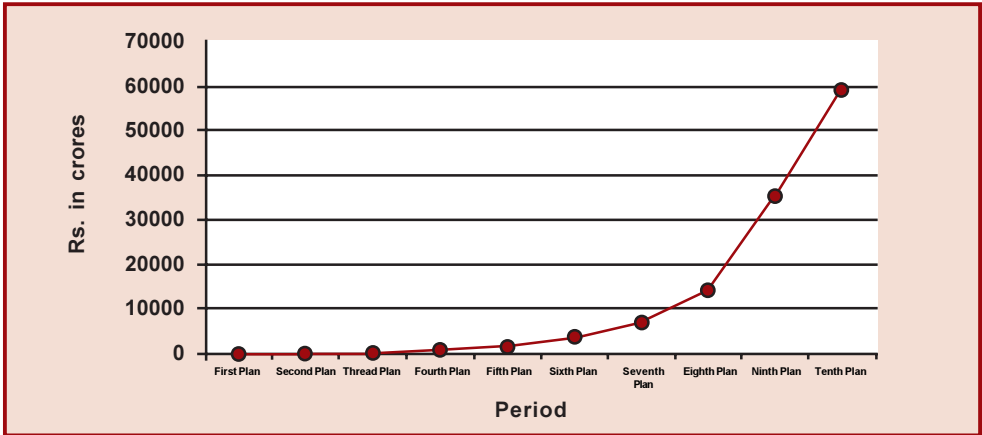
Source : NCMH, 2005

Households (out of pocket expenditure) contribute maximum share in health spending. In per capita terms, household expenditure measured in nominal prices has almost tripled from Rs 364 in 1995-96 to Rs 905 in 2003-04, while real per capita household expenditure is expected to only marginally increase from Rs 265 to Rs 367 respectively.


Public spending on health in India has increased from 0.22% of GDP in 1950-51 to 1.05% of GDP during the mid-1980s, and stagnated at around 0.9% of the GDP during the later years. In terms of per capita expenditure, it increased significantly from less than Re 1/- in 1950-51 to about Rs 215 in 2003-04. However in real terms, for 2003-04 this is around Rs 120. This is considered far below what is recommended for low-income countries.

The allocation under five year plans is on continuous rise since 1985-90 Seventh Five Year Plan (Figure 2.11).

Figure 2.11 : Five Year Plan Outlays



Source: Planning Commission of India



The Government of India is committed to increase the allocation of funds to raise the public spending on health to 2%. NRHM envisages an additionality of 30% over existing annual budgetary outlays. The state governments are expected to raise their contributions to public health budget by minimum 10% per annum to support the mission activities.

The allocation of funds for health and family welfare activities during eleventh five year plan (2007-2012) is on steep rise (227%) as against financial outlays and expenditure for health and family welfare for the 2002-07 Tenth Five Year Plan. (Annual Report, MOHFW, GOI, 2007-08)

