

# PUBLIC HEALTH CARE DELIVERY SYSTEM: CURRENT STATUS OF SUB-CENTERS, PHCs, AND CHCs IN KEYLONG BLOCK OF LAHAUL-SPITI DISTRICT OF HIMACHAL PRADESH

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**ABSTRACT:** *The present study describes the status of the health care delivery in the remote district of Lahaul-Spiti. This is the first of its own kind of study being done in Keylong block. Health care facility is the right of every individual so it is well required to have quality infrastructure, qualified medical personnel, and easy access to basic medicines and medical facilities to reach out to 60% of population in India. A majority of 700 million people lives in rural areas where the condition of medical facility is very poor. Considering the picture of harsh facts there is a dire need of new practices and procedures to ensure that quality and timely healthcare reaches the deprived corners of the Indian villages specially the remote ones. Although lots of policies and programs are being run by the Government but the success and effectiveness of these programs is questionable due to poor implementation. Situation of rural India's health delivery system is not very good as 8% of the PHCs do not have doctors or medical staff, 39% do not have lab technicians and 18% do not even have a pharmacist. In this study researcher will look at the standards of public health care facility/services provided and most importantly the no of doctors, nurses, and other staffs appointed versus the services and personnel available at sub-centers, PHCs, CHCs, and district hospitals in Keylong block. Himalayan region is already a remote hilly area with scattered population, and public health care facility centers are the only medical help that is available to the people of this region.*

**Keywords:** *Health Care, Public Health Care Delivery System, Himalayan Region, Lahaul-Spiti*

## INTRODUCTION

Indian health care delivery system is one of the biggest and most complex public healthcare delivery system in the world. The public health care infrastructure in rural areas has been developed as a three-tier system based on the population norms (which varies with plain areas and tribal/hilly/remote areas). Indian healthcare delivery system comprises of 15236 Sub-Centers (SCs), 25020 Primary Health Center (PHCs), 5363 community health centers (CHCs), 1024 (sub-district hospitals), and 755 District hospitals.

Access to primary health care is the top-ranking health priority for rural areas in India. And across the health sector, primary care is highly valued as the key mechanism for meeting the majority of health care needs of most individuals. Primary care practices provide essential care for a wide range of health problems; guide patient through the health system, including referrals; support disease prevention, management, and health promotion.

A report on the Health Survey and Development Committee, commonly referred to as the Bhore Committee Report (1946), has been a landmark report for India, from which the current health policy and systems have evolved. The recommendation for three tiered health-care system to provide preventive and curative health care in rural and urban areas placing health workers on government payrolls and limiting the need for private practitioners became the principles on which the current public healthcare systems were founded. This was done to ensure that access to primary care is independent of individual socioeconomic conditions. India has a mixed health-care system, inclusive of public and private health-care service providers.<sup>6</sup> However; most of the private healthcare providers concentrated in urban India, providing secondary and tertiary care health-care services. The public health-care infrastructure in rural areas has been developed as a three-tier system based on the population norms.<sup>7</sup>

## Sub- Center

Sub-Centers are the most basic unit of the health care delivering system, which meant to provide preventive and primitive care with some curative services for minor ailments such as fever, acute respiratory illness, diarrhea, etc. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker MPW (M). One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub Centers. Sub-Centers 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 programs. The Sub-Centers are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Department of Family Welfare is providing 100% Central assistance to all the Sub-Centers 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 39554 Sub Centers from State Governments / Union Territories since April, 2002 in lieu of 5434 number of Rural Family Welfare Centers transferred to the State Governments / Union Territories. There are 146026 Sub Centers functioning in the country as on September, 2005 as compared to 142655 in September, 2004. And the services at the Sub-centers are being provided by Auxiliary Nurse Midwives (ANM) and Community Health Workers (HW).

### Primary Health Centers (PHC)

The next important basic health center of this complex health care delivery system is the PHC. So PHCs are the referral centers for the Sub-Centers and are the first contact point between community and the qualified medical doctors in India. As per the Indian Public Health Standards (IPHS), a PHC serves to a population of around 20000 in Hilly, tribal, and desert areas, while 30000 in plain area with better accessibility. A PHC consists of medical officer, staff nurses, health supervisors like Female health workers/Male health workers, head staff nurse and other supporting staffs to provide out patients and in patients care. The activities of Primary Health Centers involve curative, preventive, primitive and Family Welfare Services.

### Community Health Centers (CHC)

Patients who require further specialist care are referred to next higher level of health service delivery center called CHCs. Community health centers (CHCs) are established and maintained by the State Government under the MNP (Minimum needs programme) & BMS (Basic minimum services programme) program in an area with a population of 120000 people and in hilly/difficult to reach/ tribal areas with a population of 80000. As per minimum norms, a CHC is required to be staffed by four medical specialists, that is, surgeon, physician, gynecologist/obstetrician and pediatrician supported by 21 paramedical and other staff. It has 30 beds with an operating theater, X-ray, labor room and laboratory facilities. It serves as a referral center for PHCs within the block and also provides facilities for obstetric care and specialist consultations.

### LITERATURE REVIEWS

This section highlights some of the studies related to public health care delivery system in foreign and Indian context.

The quality of the rural health care delivery system is determined by the availability of providers and health care facilities to rural residents and the ability of those providers and organizations to give care that is needed and effective in generating positive health outcomes. (Gregg and muscovite, 2003, Rosenblatt 2002).

NRHM, launched in 2005, was a watershed for the health sector in India. With its core focus to reduce maternal and child mortality, it aimed at increased public expenditure on health care, decreased inequity, decentralization and community participation in operationalization of health-care facilities based on IPHS norms. It was also an articulation of the commitment of the government to raise public spending on health from 0.9% to 2-3% of GDP.

As per a World Bank funded research it was found that in 2011-2012 there were 2.5 million health workers (density of 20.9 workers per 10000 populations) in India. However 56.4% of all health workers were unqualified, including 42.3% of Allopathic doctors, 56.1% of AYUSH practitioners, 27.5% of Dentists, 58.4% of nurses and midwives and 69.2% of health associates. By cadre there were 3.3 qualified allopathic doctors and 3.1 nurses and midwives per 10000 populations, this is around one fourth of the World Health Organization's benchmark of 22.8 doctors, nurses, and midwives per 10000. Research shows that 77.4% of qualified health professionals are located in urban India, while population of urban India is only 31% Of the total population. This urban- rural difference was higher for allopathic doctors (density 11.4 times higher in urban areas) compared to nurses and midwives (5.5 times higher in urban areas) (Shahrawat and Bhatnagar 2016).

### METHOD OF INVESTIGATION

#### Objective

- (1) To compare the overall present condition of the public health care system of Keylong block with the National norms of the rural health care infrastructure(as per the Ministry of Health and Family Welfare)

#### Research Design and Sample

The researcher has adopted qualitative research method using interview method and secondary data. This study has been conducted with a sample of 14 PHCs, 19 Sub-centers, and 2 CHCs in Keylong block of Lahaul-Spiti district in Himachal Pradesh. Data was collected on the basis of the National Norms of the Rural Health Infrastructure given by the Ministry of Health and Family Welfare, Government of India. Name of the Health centers has not been disclosed.

### RESULTS AND DISCUSSION

**Table 1 Rural Health Infrastructure – National Norms**

|            | Population Coverage                          | No Of Beds | Staffs   | Total Number                   |
|------------|--|------------|--|--------------------------------|
| Sub-Center | General- 5000<br>Tribal/Hilly/Desert- 3000   | 0          | Health Worker<br>(Female)/ANM<br>Health Worker (Male)<br>Voluntary Worker                          | 1<br>1<br>1                    |
| PHC        | General- 30000<br>Tribal/Hilly/Desert- 20000 | 4-6        | Medical Officer<br>Pharmacist<br>Nurse Mid-wife (Staff Nurse)<br><br>Health Worker<br>(Female)/ANM | 1<br>1<br>1<br><br>1<br>1<br>1 |

|     |   |    |   |   |
|-----|---|----|---|---|
|     |   |    | Health Educator<br>Health Assistant (Male).<br>Health Assistant(Female)/LHV<br><br>Upper Division Clerk<br>Lower Division Clerk<br>Laboratory Technician<br>Driver (Subject to availability of Vehicle)<br><br>Class IV | 1<br>1<br>1<br>1<br>1<br><br>1  |
| CHC | General- 120000<br>Tribal/Hilly/Desert- 80000 | 30 | Medical Officer<br>Nurse Mid- Wife (staff Nurse)<br><br>Dresser<br>Pharmacist/Compounder<br>Laboratory Technician<br>Radiographer<br>Ward Boys<br>Dhobi<br>Sweepers<br>Mali<br>Chowkidar<br>Aya<br>Peon<br>Total        | 4<br>7<br><br>1<br>1<br>1<br>1<br>1<br>2<br>1<br>3<br>1<br>1<br>1<br>25 |

The researcher has covered 19 sub-centers, 14 PHCs, and 2 CHCs to complete the study. There is no private hospital in Keylong. Researcher has found out that there is not even a single public health care delivery centers in Keylong block which are equipped with all the necessary staffs and other medical facilities (compare to the national norms given by the Ministry of health and Family welfare). As shown in table 2 the current scenario of rural health infrastructure of Keylong, it is evident that all parts of the three tier system of health care infrastructure in Keylong is far behind the national norms in terms of No of doctors, supporting staffs, operation theatre, ambulance etc. all the Sub-Centers are having only 50% of qualified workforce. National norms are 15 staffs per PHC but in Keylong out of 14 PHCs none are having full strength. Two PHCs are having only 20% workforce, Six PHCs are having only 13.3 workforce, three PHCs are having less than 10% workforce, one PHC do not have doctor and health worker, and two PHCs have only doctors (each one has two doctors). Coming to CHCs (there are total two CHCs in Keylong block-one in Shansha and another one in Udaipur) but none are satisfying the national norms, instead of having 4 Medical officers; one CHC is having 2 and second one is having 3 Medical officers only. Total number of staffs required is 25/CHC but in Keylong one CHC is having total 4 staffs (including Doctors), and 2<sup>nd</sup> one is having total six staffs (including Doctors).

**Table 2 - Rural Health Infrastructures – Current Scenario of Keylong Block**

| Health Center | No Of Centers Equipped With All The Facilities As Per The National Norms | No of Staffs Required In One Center As Per The National Norms | No Of Staff Available In Keylong Block           | No Of Center Without Doctor | No Of Center Without Staff Nurse | No Of Center Without Pharmacist | No Of Centers With Operation Theatre And Labour Room | No Of Centers With Ambulance Facility |
|---------------|--|---|--|-----------------------------|----------------------------------|---------------------------------|--|---------------------------------------|
| SUB CENTER    | 0  | 3   | All the sub centers have maximum one staff only. | not applicable              | 0                                | not applicable                  | not applicable                                       | not applicable                        |

|     |   |    |  |   |   |   |  |  |
|-----|---|----|--|---|---|---|--|--|
| PHC | 0 | 15 | 6 PHCs has 2 staffs(including 1 doctor)<br>2 PHCs has 3 staffs(including 1 doctor)<br>1 PHC has 4 staffs(including 1 doctor)<br>3 PHCs has 1 staff(i.e. only Doctor)<br>1 PHC has no Doctor and only one staff.<br>2 PHC has 2 doctors but without other staffs. | 1 | 4 | 8 | Out of 14 PHCs only 6 has labour room. There are 8 PHCs which do not have either operation theatre or labour room. | Only 4 PHCs have their own Ambulance facility. |
| CHC | 0 | 25 | 1 <sup>st</sup> CHC has 4 staffs(including 2 doctors and 2 supporting staffs)<br>2 <sup>nd</sup> CHC has 6 staffs(including 3 doctors and 3 supporting staffs)   | 0 | 0 | 2 | Both the CHCs have operation theatre and labour room.  | Well equipped.                                 |

## CONCLUSION

As India is having the federal system of government so the areas of governance and operations of health system in India have been divided between the union and the state governments. Main responsible entity is the Union ministry of health and Family Welfare for implementation of various programs on a national scale (Tuberculosis program, Malaria prevention programs, AIDS control etc to name a few). In addition the Ministry assists states in preventing and epidemics through technical assistance. On the other hand the areas of public health, hospitals, sanitation and so on come under the purview of the state, making health a state subject. And the areas which are having broader ramification at the national level, such as family welfare and population control, drug distribution, are governed jointly by the Union and the state government. So we can see that although we have very basic health care infrastructure; a three tier system of rural health care but in most of the cases these infrastructures are not up to the mark. There is serious dearth of qualified medical professional in rural areas, especially in tribal/Hilly areas. While interviewing PHC doctors they told that they don't want to continue in this remote area because there is lack of transport, telecommunication service, market, limited choices in food intake, good residential facility, etc. In urban areas there is mixed health care system, i.e. a network of private and public health service providers, but in tribal/hilly part only choice with the people is public health care facility; so there is a dire need to attract qualified doctors to these hilly areas.

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