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Rural Health Care System in India: A Critical Analysis

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ABSTRACT

India is a country with a diverse population, culture, and geography. Despite recent improvements in the healthcare system, there is still a significant gap in the quality of healthcare between urban and rural areas. The rural healthcare system in India faces several challenges that hinder its ability to provide effective and timely healthcare services to the rural population. These challenges include inadequate healthcare facilities, a shortage of healthcare professionals, and poor healthcare infrastructure. The lack of basic amenities such as clean water, electricity, and sanitation, as well as the limited transportation infrastructure, makes it difficult for patients to access healthcare facilities located far away from their homes. The government has taken significant steps to improve the rural healthcare system. One of the most significant initiatives taken by the government is the National Rural Health Mission (NRHM), launched in 2005, which aims to provide accessible, affordable, and quality healthcare to the rural population. Moreover, different judicial pronouncements have declared Right to Health as a fundamental right.

A three-tiered scheme has been created for the health care facilities in rural regions that include- Sub-Centres(SCs), Primary Health Centres(PHCs) and Community Health Centres(CHCs) which work at different levels to facilitate good health to the rural population.

To address the challenges faced by rural healthcare in India, a comprehensive approach is needed that addresses the root causes of the challenges. This approach must include improving healthcare infrastructure, increasing access to healthcare services, improving sanitation and hygiene, increasing the availability of essential medicines, raising health awareness, and increasing funding for rural healthcare. This research paper deals with all of the above mentioned aspects and reaches to a rational conclusion.

***Keywords**: Rural, Fundamental Right, National Rural Health Mission, Sub-Centres, Primary Health Centres, Community Health Centres.*

I. INTRODUCTION

India is a country that is known for its diverse culture, population, and geographical features.

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Despite the advancements made in the healthcare system in recent years, there is still a significant disparity between the quality of healthcare in urban and rural areas. The rural health care system in India is plagued with several challenges that hinder its ability to provide effective and timely healthcare services to the rural population. The rural population in India constitutes a significant portion of the total population, and the lack of adequate healthcare services in these areas can have a severe impact on the overall health and well-being of the population. According to a report by the World Health Organization (WHO), the rural population in India faces several challenges related to healthcare access, including inadequate healthcare facilities, a shortage of healthcare professionals, and poor healthcare infrastructure.

The healthcare infrastructure in rural areas is underdeveloped and lacks the necessary facilities and equipment required to provide quality healthcare services. Many rural healthcare facilities do not have basic amenities such as clean water, electricity, and sanitation facilities. In addition, the lack of transportation infrastructure makes it difficult for patients to access healthcare facilities located far away from their homes. Moreover, many healthcare professionals prefer to work in urban areas due to better job opportunities, higher salaries, and better living conditions. This has resulted in a severe shortage of doctors, nurses, and other healthcare professionals in rural areas. The lack of adequate healthcare professionals makes it difficult for rural healthcare facilities to provide quality healthcare services to the rural population. Many people in rural areas are not aware of the importance of maintaining good health and seeking medical attention when required. This lack of awareness results in people not seeking medical attention until their condition becomes severe, making it difficult for healthcare professionals to provide effective treatment.

The government has taken several steps to improve the rural healthcare system in India. One of the most significant initiatives taken by the government is the National Rural Health Mission (NRHM), which was launched in 2005 which aims to provide accessible, affordable, and quality healthcare to the rural population. Under this mission, the government has taken several steps to improve the healthcare infrastructure in rural areas, including the construction of new healthcare facilities, upgrading existing facilities, and providing necessary equipment and supplies. The government has also taken steps to address the shortage of healthcare professionals in rural areas. The NRHM provides incentives and benefits to healthcare professionals who work in rural areas, including higher salaries, better living conditions, and opportunities for career advancement.

In addition, the government has launched several initiatives to improve the education and training of healthcare professionals in rural areas. The government has also launched several

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initiatives to improve the awareness and education regarding healthcare in rural areas. These initiatives include the dissemination of information regarding healthcare through various mediums such as television, radio, and newspapers. The government has also launched several programs to educate people regarding the importance of maintaining good health and seeking medical attention when required.

However, there is still a long way to go in improving the healthcare infrastructure, addressing the shortage of healthcare professionals, and improving the awareness and education regarding healthcare in rural areas. A concerted effort is required by the government, healthcare professionals, and civil society to ensure that the rural population in India receives quality healthcare services.

(A) Gram Swaraj

Mahatma Gandhi believed that India lived in its villages as significant number of population lives in villages. Gandhi's idea of Gram Swaraj, also known as Village Self-Rule, was a concept that revolved around the decentralization of power, resources, and decision-making to the village level. The concept of Gram Swaraj was based on the principle of self-reliance and self-sufficiency. Gandhi believed that every village in India had the potential to be self-sufficient and self-governed. According to him, Gram Swaraj meant that every village in India should have access to basic amenities such as clean water, sanitation facilities, and healthcare.

All in all Gandhi promoted the idea that; the rural population should not have to travel to the urban areas for the healthcare benefits. The villages should be self-efficient to cater to the healthy lifestyle where all the amenities required for the maintenance of healthcare of the rural population is made available.

II. RIGHT TO HEALTH

State and population health are of utmost significance in a welfare state. It assumes that the government will make sure that there are favourable circumstances for health. Public health upkeep and development must come first because they are essential elements of any contemporary state. Both the wealthy and the impoverished must have the right to health. Numerous aspects of the right to health are addressed, including shelter, food, water, sanitation, and the atmosphere. Human development is a key indicator of health, and human development is the foundational element of economic and societal growth. Since ancient times, India has recognised that everyone has the right to health care and security. Independent India addressed the public as the right's bearer and the state as the main supplier of health for all, as is its responsibility. As a founding member of the UN, our nation has approved a number of

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international agreements that guarantee the right to healthcare for all members of society. The basic right to health is not explicitly recognised in the Indian Constitution.[2]

However, a basic right to life and personal autonomy is guaranteed by Article 21 of the Indian Constitution. The word "life" in this text refers to a human life, not just a life of survival or animal presence. It has a much broader definition that includes the right to a living wage, a higher standard of living, and sanitary working and recreational conditions. A life of honour is inextricably linked to the freedom to health. The fundamental ideas and components of the right to health, the right to health in other nations, the right to health as guaranteed by the Indian Constitution, and the application of the right to health in India will all be covered in this essay. In addition, we will discuss a current problem in light of the epidemic scenario.

The Supreme Court has stated time and again that the term "life" in Article 21 refers to a life with human respect, not just subsistence or an animal existence. (Francis Coralie Mullin vs The Administrator, Union Territory of Delhi[3] AIR 1981 746). The term "right to life" encompasses a wide range of rights, including the right to a living wage, a higher standard of living, sanitary working circumstances, and the right to recreation. Therefore, a right to health is an essential component of living a life of dignity. To fully comprehend the nature of the duties of the state in this regard, Article 21 should also be considered in conjunction with the preceding directive principles of state policy.

The Supreme Court ruled in Bandhua Mukti Morcha v. Union of India[4] that the DPSP should be properly enacted by the State even though they are not legally enforceable and only have persuasive value. The Court further declared that Article 21's definition of life and liberty includes one's honour and physical well-being.

The scope of Article 21 was further expanded in the case of Paschim Banga Khet Mazoor Samity v. State of West Bengal[5], where the court ruled that it is the duty of the government to ensure that each individual receives adequate medical care and to work for the welfare of the general public.

In addition, the Supreme Court ruled in Parmanand Katara v. Union of India[6] that every doctor, whether practising in a government hospital or elsewhere, has a duty to expand his professional services with the necessary expertise to safeguard a patient's life.

[2] Sanjay Nikaash, Right To Health And Health Care, https://www.legalserviceindia.com/legal/article-6107-right-to-health-and-health-care.html
[3] Francis Coralie Mullin vs The Administrator, Union Territory of Delhi AIR 1981 746
[4] Bandhua Mukti Morcha v. Union of India AIR 1984 SC 812
[5] Paschim Banga Khet Mazoor Samity v. State of West Bengal (1996) 4 SCC 37
[6] in Parmanand Katara v. Union of India, AIR 1989 S.C. 2039

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In the ensuing case of Consumer Education and Research Centre v. Union of India[7] AIR 1995 SC 922, it was determined that Article 21's basic rights to health and medical assistance to safeguard a worker's health and vitality, both during employment and after retirement, apply.

III. NATIONAL RURAL HEALTH MISSION

The National Rural Health Mission and the National Urban Health Mission were merged into the National Health Mission (NHM), which was introduced by the Indian government in 2005. It was prolonged once more in March 2018 to run through March 2020. It is run by a mission director, and Indian government-appointed national level monitors keep an eye on it.National Urban Health Mission (NUHM) and the Rural Health Mission (NRHM) (NUHM). Strengthening the Health System (RMNCH+A) in Rural and Urban Areas, Reproductive, Maternal, Neonatal, Child and Adolescent Health, and Communicable and Non-Communicable Diseases are the main programme components. The NHM envisions achieving universal access to just, reasonable, high-quality healthcare services that are accountable to the public and sensitive to their requirements.[8]

(A) Initiatives:

1. Accredited Social Health Activists

Accredited Social Health Activists (ASHAs), community health workers, have been hired to build a bridge between the community and the healthcare system. Poorer segments of the population, particularly women and children who have a hard time accessing healthcare in remote regions, turn to ASHA first for any health-related needs. The ASHA Program is spreading throughout the States and has proven especially effective at re-engaging people in the public health system. It has also increased the use of outpatient services, diagnostic centers, hospital births, and inpatient care. One ASHA serves every 1000 people.

2. Rogi Kalyan Samiti (Patient Welfare Committee) / Hospital Management Society

An administrative organisation known as the Rogi Kalyan Samiti (Patient Welfare Committee) or Hospital Management Society serves as a board of directors for hospitals to oversee their operations. These Committees receive funding through an untied fund to carry out patient care initiatives.

3. Untied Grants to Sub-Centres

Untied Grants to Sub-Centers have supported grassroots medical advancements. Some

[7] Consumer Education and Research Centre v. Union of India AIR 1995 SC 922
[8] https://en.wikipedia.org/wiki/National_Health_Mission

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examples include:

- ANMs' (Auxiliary Nurse Midwives) effectiveness in the field has increased, enabling them to provide improved prenatal care and other medical services.
- Untied funds have helped Village Health Sanitation and Nutrition Committees (VHSNC) become more involved in their local communities and better serve the requirements of low-income families and children.

4. Health care contractors

In addition to providing health care providers to neglected areas, NRHM has been engaged in training to broaden physicians' skill sets at institutions that have been recognised by the states as being strategically situated. Similar to this, the development of nursing staff and support personnel like ANMs is given the appropriate significance. Additionally, NHM is in favour of AYUSH services being offered concurrently in PHCs, CHCs, and district hospitals.

5. Janani Suraksha Yojana

The Government of India has initiated the Janani Suraksha Yojana (JSY), a programme to promote safe parenting. On April 12, 2005, the Indian Prime Minister officially unveiled it. Its objectives include promoting hospital birth among low-income expectant mothers and lowering maternal and neonatal fatalities. As a component of the National Rural Health Mission, it is run by the Ministry of Health and Family Welfare. In states with poor rates of institutional birth, the Scheme combines cash support with labour and delivery, as well as postpartum care**.**

10,438,000 women took advantage of the programme's advantages in 2014–15. The percentage of hospital deliveries in India nearly quadrupled between 2005 and 2016, from 18% to 52%, according to the World Health Organization.

6. Janani Shishu Suraksha Karyakram (JSSK)

Janani Shishu Suraksha Karyakarm (JSSK) was established to offer free to and from transportation, free medications, free diagnostics, free blood, and free nutrition to expectant mothers who visit public health facilities for delivery and sick infants up to one year olds as part of recent initiatives and to advance the cause of universal healthcare.

7. Rashtriya Bal Swasthya Karyakram (RBSK)

In order to detect childhood-specific illnesses, developmental delays, impairments, birth abnormalities, and deficits, a Child Health Screening and Early Intervention Services programme was introduced in February 2013. The programme will provide complimentary care, including surgery, for health issues identified through this programme for approximately

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27 crore children aged 0 to 18.

8. District hospital and knowledge center (DHKC)

As part of a new plan, district hospitals are being improved to offer multi-specialty medical care, such as dialysis, advanced cardiac care, cancer treatment, mental health treatment, emergency medical and trauma care, etc. Through a telemedicine centre housed in the district headquarters and established as centres for paramedic and nurse training, these institutions would serve as the knowledge base for clinical treatment in facilities below them.

IV. RURAL HEALTH CARE SYSTEM – THE STRUCTURE AND CURRENT SCENARIO

A three-tiered scheme has been created for the health care facilities in rural regions:

1. Sub-Centres (SCs)

The Sub-Centre is the initial and most distant point of interaction between the community and the basic healthcare system. A minimum of one Auxiliary Nurse Midwife (ANM) / Female Health Worker and one Male Health Worker must staff each Sub-Centre. One extra second ANM is allowed under NRHM on a contract basis. In charge of overseeing six Sub-Centres is one Lady Health Visitor (LHV). In order to affect behavioural change and provide services related to mother and child health, family welfare, nourishment, vaccination, diarrhoea control, and control of communicable diseases programs, sub-Centres are given human communication-related duties.

According to a glance at the number of Sub Centres operating over the years, there were 84,376 Sub Centres at the end of the Sixth Plan (1981–85), 1,30,165 at the end of the Seventh Plan (1985–90), and 1,45,272 at the end of the Tenth Plan. (2002-2007). There are 1,48,124 active Sub Centers in the nation as of March 2011.

2. Primary Health Centres (PHCs)

Between the village population and the medical officer, PHC serves as their initial point of interaction. The PHCs were designed to offer the rural people combined curative and preventive healthcare, with a focus on the preventive and promotional elements of healthcare. Under the Minimum Needs Programme (MNP)/Basic Minimum Services (BMS) Program, the State Governments construct and manage PHCs. A PHC must have a Medical Officer and 14 paramedics and other staff members as per the minimal criteria. Two extra Staff Nurses may be hired on a retainer basis by PHCs under NRHM. With 4 to 6 patient spaces, it serves as a referral centre for six Sub Centers. Curative, preventive, promotional, and family welfare services are all a part of PHC's operations.

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PHCs increased from 9115 at the conclusion of the Sixth Plan (1981–1985) to almost 18671 at the end of the Seventh Plan. (1985-90).At the conclusion of the Tenth Plan, there were 22370 PHCs. (2002-2007). There were 23887 PHCs operating in the nation as of March 2011. In many States, a handful of PHCs have been raised to the status of CHCs.

3. Community Health Centres (CHCs)

Under the MNP/BMS initiative, the State Government creates and maintains CHCs. According to minimal standards, a CHC must be staffed with four medical specialists, including a surgeon, physician, gynecologist, and pediatrician, as well as 21 paramedical and support personnel. It has 30 indoor bedrooms as well as an OT, an X-ray, a labour room, and lab amenities. It offers accommodations for obstetric treatment and expert consultations in addition to acting as a referral facility for four PHCs.

The number of CHCs has grown from 761 at the end of the Sixth Plan (1981–85) to 1910 at the end of the Seventh Plan (1985–90), and to 4045 at the end of the Tenth Plan, in line with the growth in the number of Sub Centers and PHCs. (2002-2007). There are 4809 CHCs operating in the nation as of March 2011.

Indian Public Health Standards (IPHS) in rural regions have established population norms for public health centres as mentioned below in order to guarantee access to healthcare services:

Sl.No.	Public Health Facilities	Plain Area	Hilly/ Tribal/ Difficult Area
1	SC	5000	3000
2	PHC	30,000	20,000
3	CHC	1,20,000	80,000

Table 1.1

According to Rural Health Statistics, 2019–20, there are 155404 rural sub-centers, 18610 ayushman bharat health & wellness centres - sub centres (AB-HWC-SCs), 24918 rural primary health centres (PHCs), 16635 ayushman bharat health & wellness centres – primary health centres (AB-HWC-PHCs), and 5183 rural community health centres. (CHCs).[9]

The current Sub-Health Centers (SHCs) and Primary Health Centers (PHCs) are being converted into AB-HWCs under Ayushman Bharat to deliver twelve packages of

[9] https://pib.gov.in/PressReleasePage.aspx?PRID=1777642

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Comprehensive Primary Health Care (CPHC), which includes universal, free, and nearby preventative in nature, promotive, therapeutic, palliative, and rehabilitation amenities.[10]

Additionally, with a budget of Rs. 64,180 crores until 2025–2026, the PM Ayushman Bharat Health Infrastructure Mission (PM–ABHIM) envisions greater expenditures in public health and other health changes to improve access to healthcare in remote areas by:

- Establishing health and wellness institutions in towns and communities for illness detection at an early stage.
- Additional beds for urgent care are being added to local hospitals.
- Block Public Health Units (BPHU) Assistance in 11 States with High Priority
- district-wide comprehensive public health labs

V. CHALLENGES TO RURAL HEALTH

a. **Inadequate healthcare infrastructure:** Rural areas in India often have inadequate healthcare infrastructure, including a shortage of healthcare facilities, medical equipment, and healthcare professionals. The few healthcare facilities available in rural areas are often poorly equipped and understaffed, making it challenging to provide quality healthcare services to the rural population. This issue is exacerbated by the concentration of healthcare facilities in urban areas, leading to a significant healthcare disparity between urban and rural populations.

b. **Limited access to healthcare**: Rural populations in India often face numerous barriers in accessing healthcare. These barriers include poor transportation infrastructure, long distances to healthcare facilities, and a lack of healthcare professionals in rural areas. Rural populations are often unable to afford the cost of transportation to urban areas to seek medical care, which limits their access to healthcare services.

c. **Poor sanitation and hygiene**: Poor sanitation and hygiene are significant challenges in rural areas in India. Many rural areas lack basic sanitation infrastructure, such as toilets and clean drinking water, leading to the spread of communicable diseases such as diarrhea, typhoid, and cholera. Lack of hygiene awareness among the rural population further exacerbates this issue.

d. **Limited availability of medicines**: The availability of essential medicines is often limited in rural areas in India. This can lead to inadequate treatment for common

[10] ibid

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diseases and illnesses, which can have severe health consequences for rural populations. Even when medicines are available, rural populations often lack awareness of the importance of taking medicines as prescribed.

e. **Low levels of health awareness**: Many rural populations in India have low levels of health awareness, leading to poor health-seeking behaviour, delayed diagnosis, and treatment, and a lack of preventive measures. This issue is compounded by the lack of healthcare professionals in rural areas who can provide health education and awareness programs.

f. **Inadequate funding for rural healthcare**: Despite the significant healthcare needs of rural populations, healthcare funding in India is often focused on urban areas, leaving rural areas with insufficient resources to address health challenges effectively. As a result, many rural healthcare facilities lack the necessary resources to provide quality healthcare services to the rural population. This lack of funding also impacts the recruitment and retention of healthcare professionals in rural areas.

VI. CONCLUSION AND SUGGESTIONS

India has made significant strides in improving healthcare services over the years, but there is still a significant gap in healthcare access and outcomes between urban and rural areas. Addressing the challenges faced by rural healthcare in India is critical to bridging this gap and ensuring that all citizens have access to quality healthcare services, regardless of their location or economic status. By prioritizing the healthcare needs of rural populations, India can achieve its goal of providing universal healthcare to all its citizens.

To address the challenges faced by rural healthcare in India, a comprehensive approach is needed that addresses the root causes of these challenges. This approach must include improving healthcare infrastructure, increasing access to healthcare services, improving sanitation and hygiene, increasing the availability of essential medicines, raising health awareness, and increasing funding for rural healthcare.

Improving healthcare infrastructure in rural areas is critical to providing quality healthcare services to rural populations. This can include the construction of new healthcare facilities, the upgrading of existing facilities, and the deployment of medical equipment and technology to rural areas. Additionally, increasing the number of healthcare professionals in rural areas can help to address the shortage of healthcare professionals in these areas.

Increasing access to healthcare services is another critical component of addressing the

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challenges faced by rural healthcare in India. This can include improving transportation infrastructure to rural areas, providing mobile healthcare services to remote areas, and increasing the number of healthcare professionals in rural areas. Additionally, the use of telemedicine and other digital healthcare technologies can help to bridge the gap in healthcare access between rural and urban populations.

Improving sanitation and hygiene in rural areas is also critical to improving health outcomes for rural populations. This can include the construction of basic sanitation infrastructure such as toilets and clean drinking water sources, as well as education campaigns to raise awareness of the importance of hygiene and sanitation practices.

Increasing the availability of essential medicines in rural areas is critical to providing adequate treatment for common diseases and illnesses. This can include the deployment of mobile medical vans and the establishment of rural pharmacies to ensure that essential medicines are available to rural populations.

Raising health awareness among rural populations is also critical to improving health outcomes. This can include health education campaigns to raise awareness of common health issues and how to prevent them, as well as the promotion of healthy behaviours and lifestyles.

Finally, increasing funding for rural healthcare is critical to ensuring that rural populations have access to quality healthcare services. This can include increased government funding for rural healthcare facilities and programs, as well as the promotion of public-private partnerships to help fill the gap in healthcare funding.

In conclusion, addressing the challenges faced by rural healthcare in India requires a comprehensive approach that addresses the root causes of these challenges. Improving healthcare infrastructure, increasing access to healthcare services, improving sanitation and hygiene, increasing the availability of essential medicines, raising health awareness, and increasing funding for rural healthcare are all critical components of this approach. By prioritizing the healthcare needs of rural populations, India can ensure that all citizens have access to quality healthcare services, regardless of their location or economic status.

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