PRIMARY HEALTH CENTRES: POLICY AND PROGRAMME IN HARYANA

[1]Bhupender*, [2]Dr. Mahender Singh

1Research Scholar, 2Supervisor (Associate Professor)
Department of Public Administration
NIILM University, Kaithal (Haryana), India

Email ID: bhupenersingh.aug@gmail.com

Accepted: 03.07.2022 **Published**: 01.08.2022

Keywords: Primary Health Centres.

Abstract

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 . an integrated curative and preventive health 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, 24855 PHCs have been established in the country (March,2019). In this paper, we illuminate challenges posed by contexts to the implementation of the Primary Health Centres (PHC) approach, using the example of primary health centres (rural peripheral health units) in India and Haryana. We first present a historical review of 'written' policies in India—to understand macro contextual influences on primary health centres. Then we highlight micro level issues at primary health centres using a contemporary case study of Haryana with health care infrastructure. The Indian Health Care System is presently facing several challenges. For attaining the goal of Health for All, India requires not only logical pulling of existing Strategies in education but also training of medical education is necessary. This paper highlights some contextual complexities of implementing PHC—considering macro and micro level issues. The Strengthening of Primary Health Care system has to be attained through the participation of the people.

Paper Identification

**Corresponding Author*

INTRODUCTION

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 . 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, 24855 PHCs have been established in the country (March,2019). Global rhetoric on health has recently showed a renewed interest in the values and practices of comprehensive Primary Health Care (PHC). The adoption of the Sustainable Development Goal of ‘healthy lives’ and ‘wellbeing for all’ marks a change towards more holistic considerations of health; in line with the sociopolitical ideas of PHC heralded 40 years ago at the Alma-Ata conference.Some of these ideas have been reaffirmed recently in global forums. However, there is an urgent need for these ideas on PHC to take roots within country contexts—for past experience has shown that implementation of PHC is not straightforward. At a macro level, a whole range of factors in a country’s health system context-competing ideologies to the PHC approach (global and country-specific), fiscal priorities and development aid mechanisms that favour vertical programs— along with broader sociopolitical and epidemiological factors—influence the uptake of PHC interventions. Further, these macro issues interact with the ‘everyday politics’ of the health system —more specifically, frontline actors’ values, past experiences and expectations. All this together influences what happens to PHC on the ground.

Context-competing ideologies to the PHC approach (global and country-specific), fiscal priorities and development aid mechanisms that favour vertical programs— along with broader sociopolitical and epidemiological factors—influence the uptake of PHC interventions. Further, these macro issues interact with the ‘everyday politics’ of the health system —more specifically, frontline actors’ values, past experiences and expectations. All this together influences what happens to PHC on the ground.

OBJECTIVE OF THE STUDY:-To study the current status of Primary health Infrastructure Development & various innovative of Primary health centres in Haryana.Main focus to provide the best health care facilities at ground level.

Methods :-Policy implementation processes have been recognized as being shaped by complex interactions between actors, processes and contexts. Multiple notions of ‘context’ exist in literature. Context has been considered as factors beyond the health sector, as having distinct dimensions—situational, structural, cultural and external, and as a source of ‘power’ that underpins policy-makers choices. In this study, context mainly refers to factors— at macro levels and micro levels of the health system— that have influenced primary health centres.

Examining macro contexts:- By macro contexts, we refer to ideologies and fiscal choices (mainly national, but these reverberate with global issues) that have shaped primary health centres in India. We focus on factors that contributed to the originally envisaged model of primary health centres—and subsequent policy choices—influenced by competing ideologies and fiscal priorities—that attenuated this model. To examine macro contexts, we conducted a historical literature review of 13 national-level policy documents , 5-year national economic plans since independence in 1947 and some supporting literature on the development of Indian health policies .The account of the macro context of primary healthcentres presented in this paper has been derived from a literature review of key policy documents in India, supported by global literature and research on history of public health in India.

Examining the micro context :-Micro-level contexts, in our study, encompass local actors’ values, expectations and practices. By actors, we refer to both community and health system actors. Frontline workers use their discretion to understand, cope and fit a policy idea into their routine behaviours (termed as ‘practices’); and it is these practices of frontline workers that the community ultimately experiences as policy. This, in turn, affects community expectations

from primary health centres and their utilisation. In other words, how local actors interact with a policy idea can be considered as the 'pragmatic context' of policy implementation .We conducted Illustrative quotes from Indian policy documents.

Sample quotes from Indian policy documents

Pre -Independence :-While the word PHC is not mentioned, many broad elements of the approach are justified in India's original vision of the health system Global influences: National Health Service, UK 1.'The closer the health service can be brought to the people whom it serves, the fuller will be the benefit it can confer on the community. The scheme must therefore provide for the creation of a large number of units……' (Govt. of India, 1946)

2.'Suitable housing, sanitary surroundings and a safe drinking water supply are the primary conditions for securing such a measure of environmental hygiene as it is essential to ensure the prerequisites of a healthy life. Without these, our towns and villages will continue to be factories of disease which will help to maintain undiminished the demands on the curative side of the medical services.' (Govt. of India, 1946).

Independence to 1970.:-1. Originally proposed approach diluted. Ideologies shift to promoting verticalised interventions as 'interim' solutions.

Global influences: Rockefeller-focused techno managerial intervention against malaria, ford foundation-family planning perspectives and funding.

1.The Bhore Committee drew attention to the implications of the trends of population growth and suggested action to be taken on this behalf, the full-blooded 'National Family Planning Programme' today is a far cry from the faltering and half-hearted recommendations of that Committee in regard to population control.' (Govt. of India, 1961).

Late 1970s to 1980s:-Revival of PHC approach. Selective PHC ethos adopted in India.

Global influences: WHO: Alma Ata 1978, Unicef—focus on GOBI-FFF

1.'We realise that the need for medical relief is so great in our country that to make medical officers concentrate so largely on preventive work may be met with criticism. We have however made this recommendation after careful consideration. Our view is that with the limited staff and funds at disposal of the country, our health programme will show more effective and lasting results if the effort is directed towards the creation of conditions conducive to healthy living instead of concentrating too largely on the administration of medical relief.'(ICSSR and ICMR, 1981).

Late 1980s to 2005:-Documents argue that to bring equity with limited resources, there is need to focus on issues not covered otherwise by the private sector. The revised health policy NHP 2002 does not mention comprehensive PHC.

Global influences: World Bank, Global Health Initiatives, Millennium Development Goals.

1. NHP-1983, in a spirit of optimistic empathy for the health needs of the people, particularly the poor and under-privileged, had hoped to provide 'Health for All by the year 2000 AD', through the universal provision of comprehensive primary healthcare services. In retrospect, it is observed that the financial resources and public health administrative capacity which it was possible to marshal, was far short of that necessary to achieve such an ambitious and holistic goal' (National Health Policy 2002).

2005 to current:-

Documents argue for strengthening health systems by increasing investments; and providing financial protection. Comprehensive PHC is referred to in terms of service coverage.

Global influences: New Global Health Initiatives. Debates on vertical programme versus horizontal strengthening, Universal Health Coverage.

1. The key features of the mission include making public health delivery system fully functional and accountable to the community, human resource management, community involvement, decentralisation, rigorous monitoring and evaluation against standards, convergence of health and related program from village level upwards, innovations and flexible financing and also interventions for improving health indicators (NRHM 2005–12)

2. Now 14 years after the last health policy, the context has changed in four major ways. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases (National Health Policy2017).

Results:- Primary health centres were originally envisaged as 'social models' of service delivery; front-line institutions that delivered integrated care close to people's homes. However, macro issues of chronic underfunding and verticalisation have resulted in health centres with poor infrastructure, that mainly deliver vertical programmes. At micro levels, service provision at primary health centres is affected by doctors' disinterest in primary care roles and an institutional context that promotes risk-averseness and disregard of outpatientcare. Primary health centres do not meet community expectations in terms of services, drugs and attention provided; and hence, private practitioners are preferred. Thus, primary health centres today, despite having the structure of a primary-level care unit, no longer embody PHC ideals.

Case Study of Haryana:-

Health Infrastructure:-(**Economic Survey 2019-20**)The State Government is committed to provide quality and affordable healthcare services to all citizens of the State. There is a constant endeavour to keep communicable and non communicable diseases in check and to have strong and robust systems of recording, reporting and planning.

1.MukhyaMantriMuftIlajYojana (MMIY) :- Under MukhyaMantriMuftIlajYojana (MMIY), 7 types of services, namely surgeries, laboratory tests, diagnostics (X-rays, ECG, and Ultrasound services), OPD/indoor services, medicines, referral transport and dental treatment are being provided free of cost.

2.Public Private Partnership :- Under the Public Private Partnership, State Government is providing CT Scan, MRI, Haemodialysis and Cath Lab services to the people. CT scan services are available in 16 district civil hospitals (Bhiwani, Faridabad, Panchkula, Gurugram, Kaithal, Kurukshetra, Sonepat, Yamunanagar, Palwal, Jind, Sirsa, Ambala City, Ambala Cantt., Rohtak and Panipat).

3. Ayushman Bharat:- The pilot launch of the scheme was conducted across the country on 15.8.2018. Haryana was the 1st State in the claim under the PMJAY scheme. This scheme is on entitlement basis. Every family figuring in defined Socio-Economic Cast Census-2011 data base will be entitled to claim benefits under the scheme.

4.NATIOAL HEALTH MISSION:-

National Health Mission, the following initiatives have been taken:

1. Certificate for securing 1st Rank among the Non High Focus States as per conditionality framework during the period of 2018-19.
2. Child Health and Immunization: Haryana has brought down its under 5 Mortality to 35 per thousand live births with a Remarkable 10 Points Dip. Haryana has brought down its Infant Mortality Rate by 11 points from 41 to 30 per thousand live births as well as Neonatal Mortality with 5 points from 26 to 21 per thousand live births (SRS 2017 released in 2018).

5.AYUSH :-

The Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH) Systems of Medicine have age old

acceptance among various communities in India.AYUSH Department Haryana is providing Medical Relief, Medical Education and Health Awareness through AYUSH to the masses particularly in the rural areas of Haryana State.

6. ESI HEALTH CARE:-

ESI Health Care, Haryana is providing comprehensive medical services and facilities under Employees State Insurance Act, 1948 to 31.25 lakh Insured Persons (IPs) and their dependent members through 7 ESI Hospitals (4 ESI State Hospitals + 3 ESI Corporation Hospitals) and 79 ESI Dispensaries including 3 Ayurvedic Units & 1 Mobile Dispensary located in all over the State.

7.MEDICAL EDUCATION AND RESEARCH :-

The Department of Medical Education & Research was established vide Govt. Notification dated 4th September, 2014 for establishment, up-gradation, expansion and regulation of medical education and research. The State of Haryana is providing quality education through various Medical, Dental, AYUSH, Nursing & Para medical institutions in the state.

(i)Pt. DeendayalUpadhya University of Health Science (UHS), Karnal& PGIMS, Rohthak.

(ii)Government Medical College, Bhiwani,Jind,Gurugram,Narnual,Faridabad, Rewari, Kaithal, Kurukshetra , Panchkula andDental College at Shaheed Hasan Khan Mewati Government Medical College, NalharNuh.

Primary Health Centres :-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.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, 24855 PHCs have been established in the country (as of March 2019).

Total Strength (Haryana) :2019-20 (P) --------PHCs—536, CHCs-133, SUB CENTRES-2655.Hospitals-68.

(Statistical abstract of Haryana-2019-20)

Achievement:- Kayakalp award for PHCs: According to Kayakalp awards criteria for PHClevel facility, the best PHC in each district is awardedRs. 2lakh and commendation award of Rs. 50000/- is given to all PHCs scoring above 70% in each district**.** In Kaithal , Keorak PHC won First Rank award.(As per Memo. No. /HSHRC/QA/2020/1375-1395 dated October 09,2020.).

Problems :-

1. These are viewed as a vehicle for programme and schemes, rather than as a provider of integrated care.
2. Primary health centres viewed with derision within the health system as a hospital that does not have many facilities.
3. Primary health centres viewed as a small hospital that has nothing much in terms of facilities or drugs.
4. Community finds very few services of primary health centres relevant to their basic curative care needs.
5. Primary health centres viewed (by doctors) as place where professional support from peers is absent. Doctors work gets reduced to administrative work.

6. Few drugs available for curative care at these centres. The higher tiers better suited for curative care. Health system.

7. Non-incentivised OPDs get less attention.

8. In coping with too many schemes and programme, health workers concentrate only on activities with targets.

9. There is focus on reporting activities rather than doing them.

10. Doctors hesitate to take risks due to fear of punitive action and lack of peer support (nurses are protected by doctors to some extent) Community.

Remedies for improving Primary Health Centres:

1. Guaranteed presence of the doctor, attention from the doctor and other staff, strong drugs and more ‘variety’; all laboratory reports must come on time.

2.Instant relief must be obtained; and the patient must not be asked to come again and again.

3.Even if primary health centres are geographically a little distance away, these can be visited if the trip is worth the effort.

4.Focus on horizontal strengthening of health systems through improving infrastructure, human resources and drugs—in conformation to national quality standards.

5. Expand the ‘service model’ of primary health centres to provide comprehensive care—through widening the basket of services provided at primary health centres.

6. Rethink about the roles of doctors at primary health centres to ensure better utilization of their professional expertise.

7. Expand the roles for nurses and other practitioners at primary health centres (and consider advanced trained nurse practitioners and non-physician clinicians as main providers at these centres).

8. Balance the attention given to indicators of vertical programmes and outpatient care at primary health centres in district and state-level reporting systems.

9. Provide routine mentorship and backing/support for staff at primary health centres to counter professional isolation and risk-aversion tendencies.

10.The Strengthening of primary health care system has to be attained through the participation of the people.

References:-

1. World Health Organization. Primary health care: report of the International Conference on primary health care Alma-Ata, USSR, 6–12 September 1978. Geneva: World Health Organization, 1978.

2. United Nations Development Programme. Sustainable development goals, 2016. Available: http://www.undp.org/content/undp/en/home/ sustainable-development-goals.html [Accessed 25th Sep 2018].

3. World Health Organization. Global conference on primary health care: towards health for all, 2018. Available: http://www.who.int/ media centre/events/2018/global-conference-phc/en/ [Accessed 17th Nov 2018].

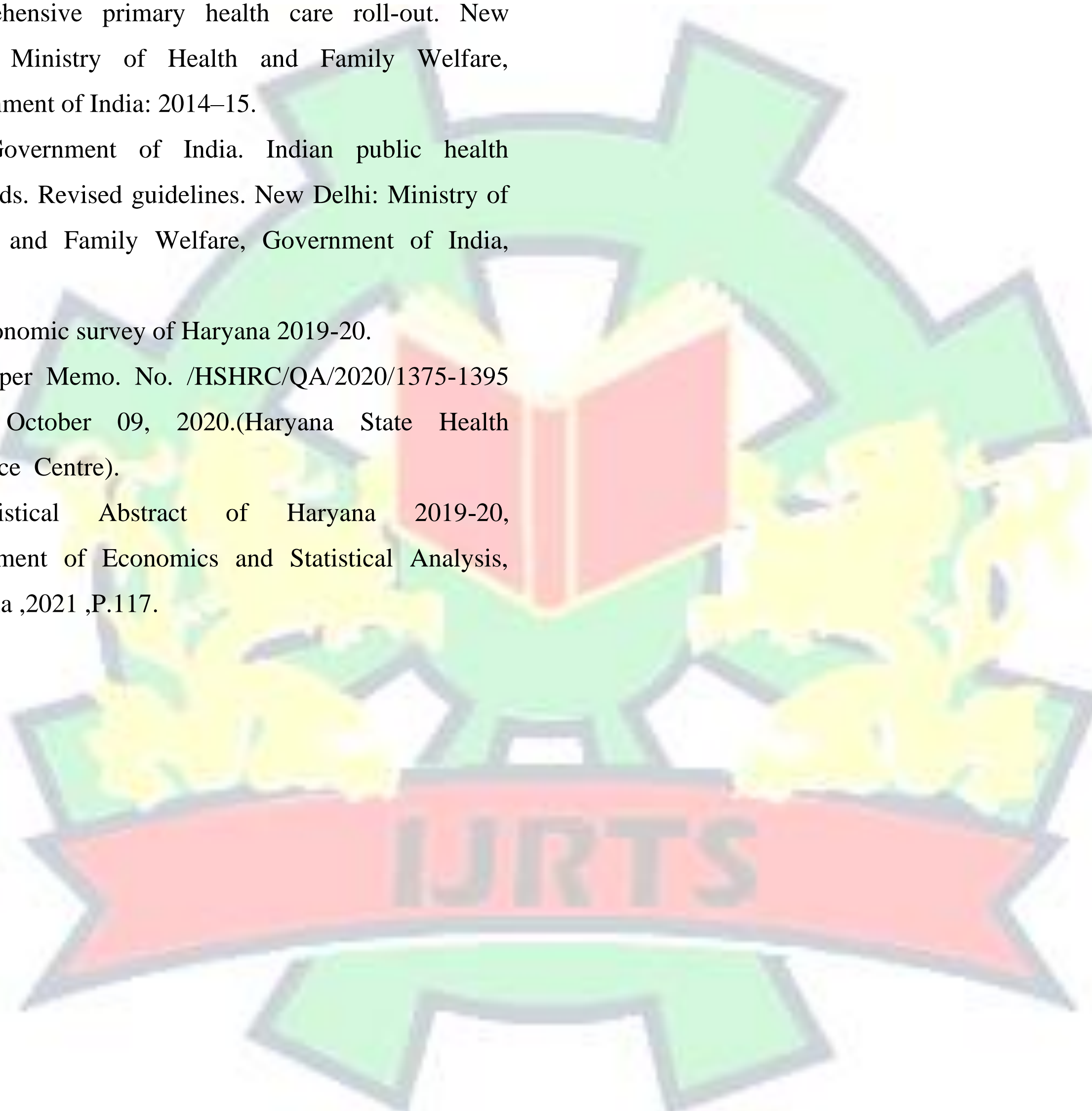
4. Lawn JE, Rohde J, Rifkin S, et al. Alma-Ata 30 years on: revolutionary, relevant, and time to revitalise. Lancet 2008;372:917–27.

5. Rifkin S. Health for all and primary health care, 1978-2018: a historical perspective on policies and programs over 40 years. Oxford Research Encyclopedia of Global Public Health. 2018.

6. Government of India. Report of the health survey and Development Committee, vol. II (chairman: Bhore. Delhi: Manager of Publications, 1946.

7. Government of India. Planning Commission of India. five year plans # 1-10. Available: http://planningcommission.gov.in/sectors/health. php?sectors=hea [Accessed 22nd Jul 2018].

8.Sodani P, Sharma K. Strengthening primary level health service delivery: lessons from a state in India. J Fam Med Primary Care 2012;1:127–31.



9. Powell-Jackson T, Acharya A, Mills A. An assessment of the quality of primary health care in India. Econ PolitWkly 2013;48:53–61.

15. Bhaumik S. Health and beyond strategies for a better India: concept paper on primary health care in India. J Fam Med Primary Care 2014.

16. Government of India. Report of the Taskforce on comprehensive primary health care roll-out. New Delhi: Ministry of Health and Family Welfare, Government of India: 2014–15.

17. Government of India. Indian public health standards. Revised guidelines. New Delhi: Ministry of Health and Family Welfare, Government of India, 2012,

18. Economic survey of Haryana 2019-20.

19.As per Memo. No. /HSHRC/QA/2020/1375-1395 dated October 09, 2020.(Haryana State Health Resource Centre).

20.Statistical Abstract of Haryana 2019-20, Department of Economics and Statistical Analysis, Haryana ,2021 ,P.117.