

CHALLENGES IN HEALTH CARE DELIVERY IN RURAL POPULATION

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Our country, since independence continues to be a state which has a large majority of its population living in rural areas. We have nearly 638,000 villages and approx 740 million people reside in these villages. As per the last World Bank report in 2011; 60% of our population is still below the poverty line, in rural areas. The health care need of these people goes largely unmet. This gap in healthcare provisioning is essentially multifactorial.

Deficiency of healthcare has to be expected as some of these villagers live in remote geographic locations; with meagre finances, poor communication (both road & telecom facilities) and such villages have very less population; so the public sector healthcare system does not accord much priority over other areas. The problem of illiteracy (which is as high as 71%) in the rural population; compounded by their poverty further adds to the problem, as early recognition of a serious disease & timely care may not be easily available. Poverty leading to poor nutritional status; inability to procure lifesaving medication; inadequate treatment due to lack of funds further increase the morbidity & mortality rates.

Tradition and beliefs certainly play a negative role in the outcomes. Gender bias is also known to contribute to poorer outcomes in girls as the male child is getting more attention and the family is willing to spend money on a potential bread earner. There is also a burden of the joint family system which is prevalent in rural areas and their limited resources need to be shared with all family members.

Pre hospital Trauma Care is another area of concern. While automation & industrial expansion is occurring in developing countries the preventable death rate in trauma cases is as high as 73.7%; especially affecting the

age group of 15-45 years. The pre hospital trauma care is non-existent, at best is in a very primitive form with lack of trained manpower.

The state agencies responsible for health care are woefully inadequate. One PHC caters to a population of 30,000 & one CHC meets the needs of a population of 1,20,000. These centers are poorly staffed and ill equipped and are incapable of delivering any standard care at any time. More ever: absenteeism of staff in these establishments is as high as 40%. Therefore continuity of care is not guaranteed. This forces the patients to seek treatment from quacks.

The solution to these issues is easy to identify but difficult to implement. Political willpower; allocation of resources and supervision of extended services will go a long way in reaching the masses. There is a need to bolster the public sector effort and increase the number of doctors; paramedical staff & facilities.

Better infrastructure; remuneration, compensation, adequate and accelerated training of doctors & paramedical staff, is essential. Focussed & persistent efforts to mitigate the morbidity of vulnerable groups (cardiovascular centers, neonatal ICUs; dialysis centres; endemic diseases control agencies; ophthalmology care) are to mention a few. Public & private sector co-operation can also make a positive impact.

The situation seems to be bleak but the eternal optimist that I am; I look for a ray of hope in this vast expanse darkness.

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