COST AND CONCERN IN PRIMARY HEALTH CARE

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The problem of PHC

Under the banner of alternative health care and low cost health models the primary health care (phc) concept has come in for much abuse.

It is amazing to see that almost anyone and everyone who discusses primary health care uses the WHO definition of total well being as their gospel. It might be a well thought out definition representing an ideal state of health but in practice it is foolish to use it as a goal for 'health for all'. Why? Because the definition becomes a weapon for distorting reality in believing that one can strive for what is defined. One loses sight of simpler goals that with some perseverance can be easily achieved. This is what has happened with primary health care. Our policy makers and planners have gone overboard to accommodate the various elements of the WHO definition in their program designs.

The result has been too many dissipated health programs (each havings their own goal under the definition) imposed by the centre (and gladly accepted by the states because of the money that comes with it) without understanding the ground realities, especially the health care demands of the population.

Further, it is not that the state insists on meeting all these program objectives; the idea is not to achieve the objectives but to create the impression that the state is benevolent and is doing its best to serve the people through a large array of programes. This image building is not unique to the health sector but also holds good for education, social welfare and rural development programs. Each FYP keeps adding to the list of programs with the results that we have new lost count of the programs. The consequence of all this has been a bulging bureaucracy.

Public health services in India, especially in the rural areas, have grown, in size through the additive values of this programming. We began in the fifties with 3 national disease control programs, and thanks to the FYPs we are today running a dozen and a half disease control programs, including the latest addition of AIDS. On the one hand the state talks of integration and on the other it keeps delivering new babies which develop their own vested interest. (No wonder we still have program staff in our health program for small pox and plague, both of which were eradicated long ago!). All this goes under the name of primary health care.

The other villain under India's primary health care program is family planning. The India State is sold over to the ideology that all our economic ills, poverty and what have you, are due to the population's rapid, unchecked growth. Hence family planning becomes the core program under public health services. The entire state health machinery is geared towards achieving the FP targets, on matter what happens to the other health programes. Hence FP becomes the focal primary health care program.

Another problem with primary health care in India is that it is meant only for rural areas. Urban areas have the privilege of enjoying medical care but rural areas will get only primary health care. This dichotomous approach hence creates the impression that primary health care excludes

medical care or curative services. It is all this that has earned primary health care a bad name in the country.

In functional terms primary health care as practiced in India is implemented through Primary Health Centres (PHC), one each for 30,000 population (only in rural areas) with six beds for the never-turning-up maternity and emergency cases, one to two doctors and a few inadequately trained and overburdened paramedics who are to provide the services under the various national health programs. It goes without saying that the entire PHC (and its sub centers) staff is engaged in meeting FP targets. The doctors do run OPD clinics at the PHC but the supplies and services are so inadequate that the clientele is automatically restricted in numbers. Hence it is not surprising that the HSSO in its 42nd Round Survey on health care utilisation found that of all routine ailments treated in rural areas only 5% were treated in PHCs. The remaining either went to city public hospitals and dispensaries (20% or to private practitioners (59%) and private hospitals (16%).

The image of the PHC in rural areas is very poor, infact PHCs are regarded by the people as being synonymous with FP centers. Thus the existing version of primary health care is rejected by the people and it therefore unacceptable.

The primary health care we have in mind is closer to what the Bhore Committee had recommended way back in 1946. It was to be a universal comprehensive health care service (common to rural and urban areas) freely accessible to all without any cost to the user, with the lowest health care delivery unit (primary health unit) serving a 10,000 to 20,000 population with 75 beds, 6 doctors (including medical, surgical and obstetrics and gynecology specialists), 6 public health nurses, 2 sanitary inspectors, 2 health assistants, 20 hospital nurses, 3 hospital social workers, 6 midwives, 3 compounders and others. With this structure curative, preventive and promotive services would be provided as an integrated service by a full time salaried staff who would reside at the PHC site. Hence, when we talk of primary health care we mean this minimum decent standard universal health care system in both rural and urban areas, very different from the existing PHC in rural areas and hospital based services in urban areas.

Why has this kind of primary health care not evolved in the country when an entire blueprint of a universal model was available on the eve of India's Independence? After political independence the health Ministers Conferences and the First FYP accepted in principal the Bhore proposals but stated that lack of resources was a major constraint in implementing the entire Bhore proposals. Hence, started a process of pick and chose and the foundation was laid for a programe based approach rather than an integrated health care approach. Gradually the Bhore proposals were forgotten as subsequent Committees made new recommendations, which diluted the former.

The resource constraint theory was an eyewash because the resources needed for the primary health care component of the Bhore proposals was only one percent of the GDP then; another one and a half percent would be needed for the secondary and tertiary care components (including medical/nursing/paramedic education). However, our planners and policy makers thought otherwise and developed the secondary and tertiary care sector, ignoring primary health care completely. Thus today we have well developed city hospitals and a massive medical education infrastructure, which mainly produces doctors for the market. In contrast the rural areas have underdeveloped PHCs which meet the priority needs of the state and not the demands of the population.

FINANCING PRIMARY HEALTH CARE

Over the years the states health resources (excluding water supply) have been consumed in the following manner:

Curative Care	40% (80-85% in urban areas)
Medical Education	8% (100% urban)
Disease Control Programe	15% (40% urban)
Family Planning	10% (80% rural)
Health Insurance	5% (100% urban)
Health Administration	13% (80% urban)
Others (Non allopathic systems, paramedic training, MCH, Drug Manufacture, FDA, etc)	9% (70% urban)

It is evident from the above what rural areas are getting or what PHC (which in India is synonymous with rural health services) gets. This is also reflected in health facility statistics which show that even after 40 years of planned development rural areas have 31% of hospitals, 18% of beds and 25% of qualified allopathic doctors (40% all system doctors) to serve the 75% of population which resides in villages.

Today an average PHC (in Maharashtra) gets between Rs. 7,00,000 to Rs. 8,00,000. Out of this, Rs. 80,000 to Rs. 1,20,000 is for curative care, of which 80% is on salaries. To support the larger staff under the disease control programe between Rs. 4,00,000 to Rs. 5,00,000 is spent on these programes (salaries being 65%). The remaining Rs. 2,50,000 to Rs. 3,00,000 is for family planning, which basically supports the subcentres under the PHC (70% of it on salaries). All this works out to about Rs. 25 per capita (1990-91 prices) for the 30,000 population the PHC covers).

What do we conclude from the above? Firstly, given the current prices of goods and services the resources made available to the PHC are grossly inadequate. What the rural health services gets from the national public health expenditure is about one-third of the resources on a per capita basis. Secondly, the mix of services available at the PHC and its sub-centers is non-curative oriented. Thirdly, salaries takes away two-thirds of the resources, i.e. effective benefits that can accrue to people is very small; hence very few people from the catchment population benefit. Fourthly, field level experience shows that the largest proportion of time of all health workers is spent on promoting the FP programe and fulfilling its targets. Fifthly the staff composition to the population it is supposed to serve is grossly inadequate. And finally, health care priorities are imposed from above and hence the programe components have very little relevance for the local situation of the PHC.

How does one remedy this situation? Today the health ministries of various States and the Central government are together spending Rs. 55 billion on the various health care programes, working out to Rs. 65 per capita. A macro fiscal policy change to redistribute this resource on an actual per capita basis would make available to PHCs three times the resources they presently get. This in itself would help generate more resources from existing allocations and would help strengthen the rural health services considerably.

The question here is whether this is possible under the present system, especially so under the structural changes being undertaken to fit the Indian economy in the global market.

We have mentioned above of the existing rural-urban dichotomy. The urban areas are generally a part of the industrial economy, which facilitates their being organized. The organized sector has the ability and means to raise demands on the state to meet their social needs like health care,

education, water supply etc. Also, the officials of the State are located in the urban areas and hence have a vested interest in giving primacy to its development.

The rural areas lack this clout and are subject to programs that may not necessarily meet their demands. Field experience has shown us that the primary health related demand of the rural population, their urban counterparts is curative care and safe delivery. Since they don't get it from the PHC's they either use rural private practitioners or urban health services.

Why does the state persist with this rural – urban dichotomy? Lack of resources or concentration of resources in urban areas is not the only reason. We have indicated above the possibility of resource redistribution. It is the ideology reasons, which form the real barrier. Efficient medical services have an immediate impact on survival indicators, which means higher population growth rates. Hence rural areas are given the most minimum possible curative care and the highest possible attention for fertility control. Maurice King's recent article, propounding this ideology has generated a heated debate in India. It was refreshing to see that Maurice Kings viewpoint did not find any significant support amongst the Indian intelligentsia, including many who are strong supporters of the population control program. However, the official intelligentsia was unmoved by King's remarks. Does their silence mean agreement?

This ideology is part and parcel of capitalism and with liberalization, the MNC boom and privatisation it is bound to get a boost because inflation, unemployment and poverty are going to witness a rapid rise. The structural adjustments under process will remove the insulation, which the Indian economy enjoyed. This insulation had protected the Indian economy from global recession, but during the last decade, especially since Rajiv Gandhi, the protection has been gradually removed; Manmohan Singh and Narasimha Rao have only snapped the umbilical chord.

How would this NEP affect the health sector? In the health sector, especially, the public health sector, there will be no direct impact for the simple reason that the health sector in India is already in the form that suits this ideology. The processes which began in the early eighties like user-charges, privatisation of certain services (contracting) etc. will perhaps be strengthened. Of course, the opposition to the user charges has been very strong but there is always the backdoor entry which is used-private & paying wards are being increased and these taken away most of the resources; the general wards and free wards get neglected and lose their credibility. The private sector is the direct beneficiary.

The overall allocations to the public health sector are unlikely to decline. On the contrary they may rise, not for the benefit of the people but to provide subsidies to the private health sector.

On the other hand the private sector will grew further but in a more organized manner with large-scale corporate sector participation. The new medical technologies have facilitated corporatisation of health care services with a declining role of the professional. The middle classes (whose absolute number is greater than the total population of USA or many European countries put together) will be main clientele for this kind of health care with insurance programs playing a major role.

These developments in the long run will make primary health care redundant but for some years to come primary health care in rural areas will continue the way it exists as if nothing happened. Primary health care never really mattered and under the new policies it won't make any

difference. Of course rural and urban poverty will get more intense and the health sector will have no solutions to offer.

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