Journal of Advances and Scholarly Researches in Allied Education
Vol. 17, Issue No. 2, October-2020, ISSN 2230-7540

Analyzing Medical Facilities in Primary Health Care Centers

Tanveer Alam[1]* Dr. Brajesh Kumar Singh[2]

[1] Research Scholar, Department of Commerce, YBN University, Ranchi, Jharkhand

[2] Associate Professor, Dean of Commerce & Management, YBN University, Ranchi, Jharkhand

Abstract – In a resource-constrained society in developing countries like India, the value of health care infrastructure allocation is frequently undercut and disregarded. This research tries to assess the gap in accessing affordable health care services encountered by the socio-economically disadvantaged parts of society. This study argues that construction of additional facilities for responding to the rising demands of inhabitants in expanding cities is the need of the hour. We suggest a unique strategy for maximising the health care coverage of the peri-urban regions by building the smallest number of new public health care facilities. The southern perimeter, which was built in 1981 and has presently extended again in 2015, is totally bereft of public health care services. Based on our results we may assume that if the government increases the quality and availability of services at PHCs then it is more probable that individuals would pick PHCs for general healthcare-seeking. We feel that the results of the current research have substantial policy implications.

Key Words – Primary Health Centre, Healthcare Services, Accessibility, Public Health Centre

----------X----------

INTRODUCTION

134 countries signed the Alma Ata Declaration pledging 'health for all' at the first worldwide primary health care meeting. For primary health care to be the first level of healthcare near to people's homes was outlined in the Declaration. In its definition of primary health care, it stated that it was "essential health care that is based on practical, scientifically sound, and socially acceptable methods, and technology that is made universally accessible to individuals and families through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development." 1 Article 14 of the Universal Declaration of Human Rights echoes the idealistic notions of primary health care that were based on social justice and fairness. Because of the insufficient public health infrastructure and the diversion of vital medical resources to treat suspected COVID-19 patients, health systems in poorer and lower-middle income nations are particularly vulnerable to the spread of the COVID-19 pandemic. These temporary COVID-19 facilities have been set up in a few of the world's largest and most populated hospitals to give treatment to patients with moderate and severe COVID-19 as defined by the prescribed clinical criteria.

134 countries signed the Alma Ata Declaration pledging 'health for all' at the first worldwide primary health care meeting. For primary health care to be the first level of healthcare near to people's homes was outlined in the Declaration. In its definition of primary health care, it stated that it was "essential health care that is based on practical, scientifically sound, and socially acceptable methods, and technology that is made universally accessible to individuals and families through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development." 1 Article 14 of the Universal Declaration of Human Rights echoes the idealistic notions of primary health care that were based on social justice and fairness. Because of the insufficient public health infrastructure and the diversion of vital medical resources to treat suspected COVID-19 patients, health systems in poorer and lower-middle income nations are particularly vulnerable to the spread of the COVID-19 pandemic. These temporary COVID-19 facilities have been set up in a few of the world's largest and most populated hospitals to give treatment to patients with moderate and severe COVID-19 as defined by the prescribed clinical criteria.

In the developing countries like India, the health care delivery hardly reaches to every nook and corner of the country. After gaining the political freedom, there emerged a national commitment to improve the health of people. The first step in this direction was comprehensive health care approach given by Bhore committee in 1946. This Committee

suggested an integration of preventive, promotive and curative health services from womb to tomb, to every individual irrespective of sex, In the developing countries like India, the health care delivery hardly reaches to every nook and corner of the country. After gaining the political freedom, there emerged a national commitment to improve the health of people.

LITERATURE REVIEW

FAIZA MANZOOR ET.AL (2019) When a patient expresses pleasure with the treatment they got from their doctor or other health care professional, we say they are satisfied with their care. Healthcare facilities are judged on their ability to keep patients happy. The study's goal was to find out how satisfied patients are with their medical treatment, as well as the conduct of their doctors in relation to that goal. Preventive care and prenatal care are included in the scope of the research in an attempt to gauge the level of patient satisfaction with Pakistan's public health sector's provision of these services. Descriptive surveys were employed in this investigation. In this study, we focused on patients in the outpatient department (OPD) of three Pakistani public health institutions. In order to pick 290 participants, we used a simple sampling method that was easy to implement. By calculating Cronbach's Alpha, we tallied the reliability scales. Researchers used regression to investigate whether or not the conduct of physicians moderates the relationship between patient satisfaction and health care services in order to discover whether or not patients are satisfied with their treatment. The physician's conduct was moderated by the SPSS Hayes procedure.. Patient satisfaction is positively influenced by a variety of healthcare services, including preventative and diagnostic care as well as care for pregnant women and their families. According to the research, the physician's conduct greatly modifies the influence of health care services on patient satisfaction. Patient satisfaction with access to health care at hospitals was generally positive, according to the results of a recent survey. The level of satisfaction with laboratory and diagnostic treatment, preventative healthcare, and prenatal care services was good. The study's findings show that the offered hypotheses are statistically significant. Also included are suggestions for additional research in the study's future.

DR. RESHMA S. GAJAKOSH (2019) Health care in India has a number of challenges, some of which are explored in this article. People health centres in India, which are also known as primary health centres (PHCs), are run by the government and provide free or low-cost medical services to the general public. When India's New Economic Policy was implemented in 1991, the country's economy grew rapidly. However, this paid growth in the economy has not been supported by social growth, notably in the health sector. In terms of resource allocation, the health sector has been given a relatively low priority. Public health spending is less than 1% of GDP. It's difficult for rural residents to afford the high costs of private medical care, which is why most are unable to get it. A primary health centre is providing them with high-quality healthcare that will help them improve their health. Researchers set out to evaluate the significance of health care in rural India, as well as the role of primary health centres (PHCs) there. They also wanted to learn more about rural PHCs' challenges and opportunities. Most of the information presented here is theoretical. Secondhand information is used. Rural primary health care centres (PHCs) are the focus of this investigation.

A. DE RIJK ET.AL (2018) In order to maintain and enhance the quality of primary healthcare, it is widely agreed that it is necessary to track its performance. The WHO's methodology for performance evaluation is a comprehensive worldwide standard, but it is challenging to implement in poor countries due to budgetary and data restrictions. Primary Health Center (PHC) performance evaluation metrics in developing countries are reviewed and compared to the WHO Framework for assessing PHC performance. There was a thorough review of research publications published in English-language scientific journals between January 1979 and October 2016. For this investigation, we used tools that were developed for the purpose of this study to evaluate reporting quality and measurements. Classification and description were carried out on the data. It was just fifteen out of 4359 publications evaluated that made it into the research. One publication employed just qualitative techniques, while the other five made use of both quantitative and qualitative approaches. In fourteen papers, the measurement characteristics were well described. Despite the lack of validity testing, eleven papers offered well-established metrics in their articles. Patients' happiness, costs, and efficiency are often included in studies that look at a variety of factors, such as the qualifications of the staff (both trained and unskilled). There was a lack of comprehensiveness when compared to the WHO framework since the articles' metrics did not include all aspects of primary health care (PHC). As a result, the performance evaluation of the PHC should encompass system components as well as appropriate metrics of staff performance beyond the knowledge of procedures. Validation of currently used performance metrics for PHC in poor countries is required as is the development of succinct measures for previously overlooked elements.

MANOJ MOHANAN ET.AL (2016) Quality of treatment varies widely in the Indian healthcare system, from world-renowned institutions to facilities that give care of unacceptable standards of excellence. There is a dearth of trustworthy

data on quality and technological limitations in assessing it, which make it difficult to increase care quality. Improved data quality, improved knowledge of the quality of treatment, and new solutions to long-standing problems are the goals for both public and private sector initiatives. We review the aims and obstacles of attempts to enhance quality of care. In this issue of Health Affairs, we also emphasise the lessons learnt from recent initiatives to assess and enhance that quality. These efforts are based on articles on quality of care in India. State and federal governments must engage with researchers and agencies that execute initiatives to enhance health care in order to advance the quality agenda in light of India's fast changing illness profile and expanding chronic disease burden.

RAJAN RUSHENDER ET.AL (2016) In public health care systems, use rates vary from 10% to 30%. The disparity in access to public health care between rural and urban areas is well-known. The purpose of this research was to determine the degree to which primary health care services are used in a primary health centre and its Subcentres, as well as the variables that contribute to the use of these services. Descriptive research was carried out at the Orathur Primary Health Centre, Cuddalore district, Tamil Nadu, and its sub-centres, which had a total population of 45183 and a sample size of 3220 (80 households in each sub-centre). 60.2 percent of the chosen homes are situated outside of the 5-kilometer radius. 552 of the 560 homes have a male head of household, with the remainder led by a female. 71.96 percent of the study participants held a college degree or above. The PHC was known to 85.5 percent of the respondents. Health care services were deemed good by 71.2 percent of respondents. In the homes of patients with acute and chronic illnesses, only 45.40 percent and 58.80 percent had used the PHC services in the past. A total of 81.65% of the ANC moms had used the PHC for TT vaccination, 77.98% for birth, 75.24% for postnatal care, and 79.09% for immunising their children. ' While primary level services (PHC and Subcentres) are better at preventing and promoting health, they are less effective in treating acute sickness, intranatal care, and family welfare services, as well as conducting specific investigations.

PRIMARY HEALTH CENTRES

The Primary Health Center (PHC) is the primary point of interaction between the villagers and the Medical Officer. Proposed PHCs are intended as integrated curative and preventative health care for rural populations with focus on the prevention, treatment and promotion of health. It is the responsibility of the State Governments to maintain the PHCs under the MNP/Basic Minimum Services Program (BMS). Currently, a PHC is staffed by a Medical Officer and 14 paramedics and various support personnel. There are six subcenters that it serves as a point of contact for. It contains between 4 and 6 patient rooms. As of the 31st of March, 2017, India has 25,650 PHCs. Since 2005, there has been an increase in the number of Primary Health Care (PHC) facilities throughout the country by 2414. Karnataka has 678 primary health care centres (PHC), Assam has 404, Rajasthan has 366, Jammu & Kashmir has 303, and Chhattisgarh has 268. (251).

SIGNIFICANCE OF PRIMARY HEALTH CARE: Primary health care is important because of the following five concepts. First and foremost, it acknowledges the significance of intersectoral engagement in advancing health. This arose as a result of economists' incorrect assumption that economic expansion would invariably "trickle down" to the poor. At the heart of development was a focus on how to improve the living conditions of the poor. After previous programmes failed to effectively tackle critical infectious illnesses by focusing on particular and intense isolated programmes, supervised and directed from the Center, a second rationale was given: Preventive and promotional efforts should not be isolated from those aimed at treating disease, according to a third basic principle. The fourth piece of evidence was that there existed a wide variety of health activities that were inexpensive and effective, but did not reach the vast majority of the world's population. Even more important than that is the fact that it was a forceful protest against the totalitarian efforts of health experts to force people to adhere to their vested interests.

Primary Health Care: Primary health care (also known as "Essential health care") is the initial point of interaction between people, their families, and their local communities and the national health system. Primary health care in India is delivered via a network of primary health centres and its outpatient clinics, all of which are staffed by multifunctional health workers, village health guides, and other specially trained members of the dais (village health workers).

Primary health care is provided, but the "health teams" in rural communities also serve as a link between the rural population and the health system. As a result of India's decision to implement "Health for All" by 2020AD, the primary health care system has been restructured and reinforced.

A member of the Alma-Ata Declaration's signatories, India is dedicated to ensuring 'Health for all'. It is essential to have primary health care facilities as part of the overall healthcare system. At the most basic level, they are the ones who offer primary health care. PHCs play a critical role in achieving the aim of "Health for All," and several regulations are put on them to ensure their proper operation. It is the initial point of interaction between the medical officer and the local community. They were designed to offer rural populations with an integrated curative and

primitive health care system. State governments set up and manage primary health care facilities (PHCs) as part of the Minimum Needs Program (MNP) (BMS).

Community Health Centres (CHCs)

In accordance with the MNP/BMS initiative, the state government is establishing and maintaining community health centres. A CHC must be staffed by four medical professionals, including a surgeon, a physician, a gynaecologist, and a paediatrician, as well as 21 paramedical and other staff members, according to minimal standards. It features a total of 30 indoor beds, as well as an OT, an X-ray room, a labour room, and a lab. At the same time, it functions as a referral centre for four primary health care centres (PHCs).

On March 31, 2017, there were 5,624 Community Health Centers (CHCs) operating in the United States. Increases in the number of CHCs have been seen in Uttar Pradesh (436), Tamil Nadu (350), West Bengal (254), Rajasthan (253) and Madhya Pradesh (91) as well as in West Bengal, Odisha, Jharkhand, Kerala, Gujarat, and Gujarat (80).

As of March 31, 2017, CHCs have access to 14,350 General Duty Medical Officers (GDMOs), in addition to the 4,156 specialists already on staff. Surgeons (86.5%), obstetricians and gynaecologists (74.1%), doctors (84.6%), and paediatricians all face severe shortages (81 percent). Overall, there is a shortage of 81.6 percent experts in the CHCs compared to the number of CHCs that are already in existence. "

First Referral Units (FRUs)

Only if an existing facility (District Hospital, Sub-divisional Hospital, Community Health Center, etc.) is equipped to provide round-the-clock services for emergency obstetric and Newborn Care, in addition to all other emergencies that any hospital is required to provide, can it be declared a fully operational First Referral Unit (FRU). It is important to understand that there are three key factors in determining if a facility is a FRU:

- Emergency Obstetric Care including surgical interventions like caesarean sections;
- New-born care; and
- Blood storage facility on a 24-hour basis

There are now 3,076 FRUs operating in the nation. Some 94.2 percent, 96.3 percent, and 689.9 percent of the FRUs have Operation Theatre facilities, while 68.9 percent of the FRUs have Blood Storage/Linkage facilities.

Health Infrastructure in PHCs

1) Availability and Adequacy of facilities

Essential amenities include a well-equipped operation theatre, labour room, observation ward, two quarters, generator, potable water, an ambulance, and a female doctor are lacking in almost all of the primary health care centres (PHCs). PHCs' facilities are in a terrible state of disrepair. PHCs are almost always unable to provide institutional deliveries due to a lack of resources. The role of a woman doctor to attend to delivery situations is considered the most vital of the necessary amenities, yet the majority of PHCs do not have a lady doctor. Many primary health care centres have labour rooms, operating rooms, and observation wards, but without the presence of female physicians, these resources are seldom used. Concerns about the mismatch between the workforce and critical facilities are warranted. More often than not, there are a lot of ambulances accessible (Programme Evaluation Organisation, Planning Commission, 2001).

2) Availability of Man-power

Despite the fact that PHC physicians are readily accessible, the rate of doctor absenteeism from their professions is quite high. This limits the use of PHCs' health care services (Programme Evaluation Organisation, Planning Commission, 2001).

3) Population Coverage

Insufficient PHCs have been established in comparison to the need. Health care quality and delivery are negatively impacted by this, as well as the issue of overcrowding at community health centres and district hospitals (Programme Evaluation Organisation, Planning Commission, 2001).

Challenges for Primary healthcare and the way forward

India needs more than 27,700 Primary Health Centers (PHCs) to serve the country's estimated 30,000 people (this does not include the estimated 20,000 people in tribal and mountainous regions). In other words, there aren't enough PHCs to go around. In order to provide improved primary healthcare, we must address both the infrastructural and the human resources shortages. In order to implement Indian Public Health Standards to all healthcare systems, we must first deal with these problems. Main care is now unable to adapt to local conditions and requirements because of its strict organisational structure. An important issue in basic healthcare's poor performance is a severe shortage of resources, which affects many states. It is

necessary to investigate and comprehend the factors that lead individuals to seek out private health care as well as the those that keep them from using free government services. There might be a number of plausible causes for this circumstance, including widespread absences, minimal client-provider engagement and inadequate referral networks (Zopey, 2010). With so much variation in India, the basic healthcare package and its delivery system must be tailored to suit local needs. When it comes to improving health care in India, the challenge is how to effectively implement reforms and revive primary health care systems to provide universal coverage, equal access, efficiency and effectiveness via an empowered cadre of health workers. An impartial organisation should keep tabs on district-level access to ensure accountability. Preventive medicine's public health benefits cannot be overstated. Increasing morbidity rates demonstrated the need of routine, comprehensive health exams as an integral part of basic care.

CONCLUSION

There has been a reduction in primary health care's spirit to just providing primary health care. Rather than focusing on improving health care, more resources are being allocated to the construction of health care facilities. The value of having a well-developed network of personal recommendations is undervalued. Instead, the primary level of care has been given greater attention, although even that has not been well implemented. There has been a glaring omission of the multi-sectoral approach and the cross-sectoral ties required for a healthy healthcare system. There is a lack of a comprehensive approach to primary care. The poor performance of primary healthcare facilities isn't just due to a lack of funding for the health sector. Primary healthcare must be redesigned in terms of its structure, design, and approach.

REFERENCE

1. Rajan Rushender et. al. : “A study on effective utilization of health care services provided by primary health centre and sub-centres in rural Tamilnadu, India” DOI: http://dx.doi.org/10.18203/2394-6040.ijcmph20161357

2. Dr. Reshma S. Gajakosh (2019). “A Study of Problems and Prospects of Primary Health Centers in Rural Areas” Vol. 6, Issue 3, pp. 1-3

3. Faiza Manzoor et. al.: “Patient Satisfaction with Health Care Services; An Application of Physician’s Behavior as a Moderator”; doi:10.3390/ijerph16183318

4. Manoj Mohanan et. al. (2016). “Quality Of Health Care In India: Challenges, Priorities, And The Road Ahead “doi: 10.1377/hlthaff.2016.0676 HEALTH AFFAIRS 35, NO. 10: pp. 1753–1758

5. Allen, A. (2003). Environmental planning and management of the peri-urban interface: perspectives on an emerging field. Environment and Urbanization, 15(1), pp. 135–148. doi:10.1177/095624780301500103.

6. Balarajan, Y., Selvaraj, S., & Subramanian, S. V. (2011). Health care and equity in India. The Lancet, 377(9764), pp. 505–515. doi:10.1016/S0140-6736(10)61894-6.

7. Duggal, R. (2001). Evolution of health policy in India. Centre for Enquiry into Health and Allied Themes

8. MoHFW. (2012). National Urban Health Mission. New Delhi: Ministry of Health & Family Welfare, Government of India.

9. Prinja S, Jeet G, Verma R, et al. (2014). Economic analysis of delivering primary health care services through community health workers in 3 North Indian states. PLoS One; 9:e91781.doi:10.1371/journal.pone.0091781

10. Phua KH (2018). Governance issues in health financing. Elsevier: Reference Module in Biomedical Sciences.

11. Fryatt R, Bennett S, Soucat A. (2017). Health sector governance: should we be investing more? BMJ Glob Health; 2:e000343.doi:10.1136/bmjgh-2017-000343

12. Magnussen L, Ehiri J, Jolly P. (2004). Comprehensive versus selective primary health care: lessons for global health policy. Health Aff; 23: pp. 167–76.doi:10.1377/hlthaff.23.3.167

13. N Chaudhury, J Hammer, M Kremer, K Muralidharan, F H Rogers Missing in action: teacher and health worker absence in developing countries J. Econ. Perspect, volume 20, issue 1, pp. 91 - 116

14. R Horton Countdown to 2015: a report card on maternal, newborn, and child survival Lancet, volume 371, issue 9620, pp. 1217 – 121

15. Dr. Navitha Thimmaiah (2013). “Accessibility of Primary Health Care Services: A Case Study Of Kadakola

Primary Health Centre In Mysore District "Vol. 2 | No. 12 | December 2013

Corresponding Author

Tanveer Alam*

Research Scholar, Department of Commerce, YBN University, Ranchi, Jharkhand