

Review Article

"LIFE IS NOT MERE LIVING BUT LIVING IN HEALTH" - AN OVERVIEW OF RURAL HEALTH PRACTICE

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ABSTRACT

India is home to one-sixth of the world's population. It has shown rapid development in recent years. People who live in rural areas experience many health disadvantages including inequitable access to health services in comparison with urban counterparts. So providing health care to the rural India is a biggest challenge. Evidence based rural health practices thus come to play a vital role in such scenario. This article is an attempt to give insight to the rural health practices, health care workforce and modes of health care services provision in rural India.

Keywords: Rural, Health care, health care practices

INTRODUCTION

India is a pluralistic, multi-lingual and multi-ethnic nation. It is home to one-sixth of the world's population occupying less than 3% of the world's area. It has shown rapid development in recent years. The population below the poverty line is declining rapidly ¹. However 72.2% of India's population still lives in rural areas with a doctor population ratio for the rural areas being 1:30,000 against the all India ratio of 1:1,722, which itself is far too low. People who live in rural areas experience many health disadvantages. These include higher mortality and morbidity rates for some diseases, higher exposure to injury in the workplace, socioeconomic disadvantage, and inequitable access to health services in comparison with urban counterparts. So providing health care to the rural India is a biggest challenge. Evidence based rural health practices thus come to play a vital role in such scenario.

Rural health practice in a broader view should not only include curative aspects but also involve Monitoring the health status to identify community health problems, Diagnose and investigate health problems and health hazards in the community, Inform, educate, and empower people about health issues, Mobilize community partnerships to identify and solve health problems, Develop policies and plans that support individual and community health efforts, Enforce laws and regulations that protect health and ensure safety, Link people to needed personal health services and assure the provision of health care when otherwise unavailable, Assure a competent public health and personal health care workforce, Evaluate effectiveness, accessibility, and quality of personal and population-based health services, and Research for new insights and innovative solutions to health problems ²

Qualitative differences between urban and rural practice

What is rural health practice..?

Problems of access to care for rural patients are one of the major issues for rural populations. Due to great distances between primary health care teams, hospitals and patients, and problems are exacerbated where there is inadequate or no public transport. Poor communities are likely to suffer most. Clinics held for particular patient groups such as diabetics or asthmatics are less accessible to rural patients. The distance between patients and their surgery is obviously one factor determining access to care, although if patients have access to their own transport it may be less of a deterrent than may be thought, because rural dwellers are used to making long journeys. Another factor is the actual availability of services at rural doctors' practices, where there may be fewer services available, especially in branch surgeries and singlehanded or small practices.

Rural practices tend to be small practices. This results in continuity of care and encourages personal doctoring. At a time of immense change, smaller practices probably find changes easier to agree upon but, paradoxically, change may be harder to implement. Delegation is more difficult, a smaller number of doctors have to share the management of practice protocol development, annual reports, health promotion initiatives, staff training, and financial planning, and so on. Practice expenses are higher in small practices, since it is impossible to achieve economies of scale.

Rural practices tend to be remote from centres of population and cover scattered areas. Reduced public transport means more home visiting and significant time spent travelling to patients. Travelling is often difficult and a four wheel drive vehicle may be necessary. Because the doctor is away from the surgery for long periods when visiting patients, staff must be able to manage with less supervision. Similarly teamwork and intra-practice communication can be correspondingly difficult, with reduced opportunities to meet and plan together. Another consequence of remoteness is that staff, colleagues, and friends are often patients, which can affect the dynamics of these relationships. (How does one relate professionally to a colleague one knows to be depressed?) This puts pressure on all concerned, as they try to step out of one role and into another. Branch surgeries are a traditional solution to the problems of remoteness. However, it is difficult to provide modern high standards of care from branch surgeries. Another differences between urban and rural practice is Financial arrangements for rural practices³

These concepts introduce health students to some of the positive and negative aspects of rural practice, as well as opportunities for rural practitioners to have a diverse practice, to become involved in all aspects of health and to initiate change. They provide an understanding of rurality from which health students can learn from their practical experiences during rural placements⁴

Contemporary rural communities

Contemporary rural communities are characterized by diverse populations that include indigenous and non-indigenous and immigrant people's. Rural people see themselves as different from city people; they are proud of their heritage and the type of lives they live. However, life in the rural has changed. Rural communities are declining and there is a net movement of people from the rural areas. As a result rural communities are faced with many social, economic and cultural challenges, all of which impact on the viability of the community. Globalization has indirectly resulted in the decline of the rural sector, a net loss in circulating money and changed community demographics. Young people move from rural communities out of necessity to more populous centers that offer greater opportunities for education, employment and career development. This experience, coupled with community inability to match opportunity available in urban and larger centers, acts as a recruitment and retention disincentive for rural professionals.

The Rural Health Workforce

Thanks to NRHM which has improved the availability of and access to quality health.

Care to the people, especially those residing in rural areas, the poor, women and children. Under this scheme, each village will have a female Accredited Social Health Activist (ASHA) who will be the interface between the community and the public health system (PHCs, CHCs, Rural Hospitals). It has strengthened the existing health care system there by increasing the rural health workforce. ASHA, Anganawadi worker, ANMs, private practitioners, indigenous health workers, allied health staff, pharmacists act as a main rural health workforce, with the diversity and the number of health professionals inversely related to remoteness. Vacancies are reported for all

health professional groups, with the level rising the more remote the setting. Strategies for incentives that encourage health care professionals to practice in a rural area have to be set up. Some of the financial incentives are available during education and training, while others encourage rural recruitment or retention. The type of incentives include: scholarships; loan repayment; tax credits; direct financial incentives, such as residency stipends or payment of malpractice premiums; rural facilities grants; and retention grants. The types of health professions covered include all levels of medicine, nursing, pharmacy, behavioural health, dentistry, allied health, public health, and emergency medical services.

NRHM foresaw improved health management in India through capacity development of in-service health personnel and their training duties in the public health system and implemented many training course⁵

Rural health practice

Rural health professionals have common practice characteristics that are different to urban counterparts. They have a broad scope of practice and diverse practice skills, are professionally isolated, and find it difficult to access professional development programs but have more autonomy in their practice. Rural health workforce is aging, practitioners have high workloads and often live a "fish bowl" existence⁶ Most of the health care is provided by quacks who are not qualified in any system of medicine. There is no check on these quacks and many villagers die without any valid treatment.

Rural practice, requires practitioners to be highly skilled, have a broad well-developed knowledge-base and be capable of working in resource-poor environments with little collegiate support. While many studies argue that rural health professionals should have specialist training before they begin to practice in these environments, rural health professionals report that maintaining currency of their skills and knowledge-base is difficult. The need for many rural health practitioners to travel to access professional development, training and education is identified as limiting their ability to access educational opportunities. The issue of professional isolation is reported in the literature as a key factor impacting on health professionals' decisions to work and/or stay in rural practice.

Recruitment and Retention

There is a need to increase the number of medical students recruited from rural areas, Substantial exposure to rural practice in the medical undergraduate curriculum, Specific flexible, integrated and coordinated rural practice, vocational training programs, Specific tailored continuing education and professional development programs which meet the identified needs of rural family physicians. Appropriate academic positions, professional development and financial support for rural doctor-teachers to encourage rural research and education. In view of above Govt of India had made significantly "higher monetary incentives" for doctors who accept positions in primary healthcare centres in the "most difficult and inaccessible areas." Increase in pay for doctors would depend on the location, with salaries rising with the toughness of the area⁷

Addressing the rural health workforce shortfalls should be focussed at all government levels and it appears that the preparation for rural practice programs at the undergraduate and postgraduate levels is one area being targeted as part of a recruitment and retention strategy. There is a growing body of evidence that indicates that students who are recruited from rural communities and educated in rural universities are more likely to practice in the rural areas after graduation. The Medical Council of India, in consultation with the country's health ministry, has started an alternative model of medical education that includes four year bachelor of rural health care course that would be open only to students who have completed all their school education in villages. Graduates from the programme would be allowed to practise medicine only in rural areas and would be prohibited from offering services in urban areas⁸

Models of service provision

Meeting the needs of rural communities by providing quality health services is a priority. The challenges that are faced all governments is how to fund equitable, quality services that provide the range and diversity of health expertise in rural areas that urban people take for granted. Models that are currently used to supplement and/or replace existing services include: Integrated services, e.g., multi-purpose centers, regional health services ;Discrete service providers, e.g., general practice, nurse practice models, case

management; Outreach arrangements, e.g., mobile services, visiting medical specialists, oral health services; Information Technology, e.g., telehealth, oral health education and training⁶

Sustainable, effective models of service provision that are integrated and multidisciplinary in nature will only be achieved if there is collaboration between rural communities, rural health practitioners and the health bureaucracy.

Working on this lines, Medical Council of India (MCI) has amended post graduate medical education regulations to make it mandatory for candidates seeking admission in post graduate courses to have served in rural areas for at least one year⁹

Some states like Karnataka have also made reservations for seats in MBBS courses for candidates who have studied in rural areas so that after finishing Medical courses they can go back to their native places and service/ practice in rural areas¹⁰

As recommended by the National Rural Health Mission (NRHM) task force for medical education¹¹ and proposed by the study group headed by GP Dutta, the Ministry of Health and Family Welfare, (MOH and FW) and the Medical Council of India (MCI) has decided to start an 'updated alternate model of the medical education course, for creating a new cadre of doctors catering to the rural areas. The course is to be named the 'Bachelor's Degree in Rural Health Care' (BRHC)¹²

The duration of the course will be 3.5 years and it will include six months of internship. The candidates will be recruited from among those passing the senior secondary examination with chemistry, botany, and zoology, from schools in the notified rural areas. The curriculum is being worked out by the MCI. After graduating, the candidate is expected to go back and serve the rural community from which she or he has come. The degree will be registered by the MCI in a separate schedule¹³

CONCLUSION

All people have a right to an equitable range of health services. It is recognized that with increasing remoteness the diversity of services that can be provided is limited.

The popular portrayal of rural communities as crippled by adversity such as that described re-

duce the potential for these communities to attract and retain health professionals. Rural practice is challenging and rewarding but must be sold if these communities are to be serviced equitably. Government initiatives including incentive and remuneration initiatives must be coupled with local government and industry strategies to promote rural living and rural practice if health professionals are to be recruited and retained. In addition, the number of students undertaking health education programs must be increased and rural practice preparation included in all health curriculums if workforce needs are to be met.

The recognition that rural health care is a very important part of national health care delivery

system, the country has created huge rural health infrastructure, along with the formation of a massive health care manpower consisting of over 5 lakhs trained doctors working under plural systems of medicine and a vast frontline of over seven lakhs nurses and other health care workers; 25,000 primary and community health care centers; and 1.6 lakhs subcentre's. But still contribution from all us with constant monitoring and evaluation and strengthening coupled with proactive approach is the need of the hour¹⁴

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