RURAL HEALTH CARE SYSTEM IN TAMILNADU –OVERVIEW

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Abstract

Tamil Nadu has emerged as a model State in India in not only providing "State of Art" health care services but also making available excellent human resources and infrastructure. It has been a fore-runner in implementing Maternal, Child Care and Family Welfare Service and has also pioneered programmes and activities for disease control. Like the entire nation our State's health care challenges are diverse and the endeavour of the department of Health and family Welfare is to provide equitable, affordable and quality healthcare services to the people. In the shortfall of female health assistants in PHCs also Tamil Nadu shows a backward position. Operation theatre facility is available only in 6% of PHCs functioning in Tamil Nadu, but Gujarat is having this facility in all its PHCs. On the basis of rural population served, rural area covered, number of villages covered and radial distance covered, Tamil Nadu is not a better placed state. The budget allocation in revenue budget is continuously falling and the fall is very much in Tamil Nadu in comparison with other states except Odisha. All these force the people of Tamil Nadu to make use of private hospitals instead of public healthcare sector (only about 40%).

Keywords: *Health care sector, Child Care and Family Welfare Service, Health assistants, Rural population*

Introduction

The healthcare system consists of a mix of public and private sectors. The provision of healthcare facilities is related to preventive, curative and primitive services. Networks of healthcare facilities at the primary, secondary and tertiary level are run mainly by the State Government. Tamil Nadu is totally committed to address the major concerns and to bridge the gap in the existing health infrastructure and to provide accessible, affordable and equitable healthcare of the highest order to the public. Considerable achievements have been made with regard to the core health indicators.

Rural Health Care System the structure and current scenario in India

The health care infrastructure in rural areas has been developed as a three tier system and is based on the following population norms:

Centre	Population Norms	
Plain Area	Hilly/Tribal/Difficult Area	
Sub-Centre	5000	3000
Primary Health Centre	30,000	20,000
Community Health Centre	1,20,000	80,000

Sub-Centres (SCs)

The Sub-Centre is the most peripheral and first contact point between the primary health care system and the community. Each Sub-Centre is manned by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker MPW(M). One Lady Health Worker (LHV) is entrusted with the task of supervision of six Sub-Centres. Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children. The Department of Family Welfare is providing 100% Central assistance to all the Sub-Centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the Male Worker is borne by the State Governments. Under the Swap Scheme, the Government of India has taken over an additional 39554 Sub Centres from State Governments / Union Territories since April, 2002 in lieu of 5434 number of Rural Family Welfare Centres transferred to the State Governments / Union Territories. There are 146026 Sub Centres functioning in the country as on September, 2005 as compared to 142655 in September, 2004.

Rural health infrastructure - norms and level of achievements (all India)

S.No.	Indicator	National Norms		Achievements
1	**Rural Population (2001) covered by a:**	**General**	**Tribal/Hilly/Desert**	
	Sub Centre	5000	3000	5085
	Primary Health Centre (PHC)	30000	20000	31954
	Community Health Centre (CHC)	120000	80000	2.21 lakhs
2	**Number of Sub Centres per PHC**	6		6
3	**Number of PHCs per CHC**	4		7
4	**Rural Population (2001) covered by a:**			
	MPW (F)	5000	3000	5574
	MPW (M)	5000	3000	11994
5	**Ratio of HA (M) to MPW (M)**	1:6.0		1:3
6	**Ratio of HA (F) to MPW (F)**	1:6.0		1:8
7	**Average Rural Area (Sq. Km) covered by a:**			
	Sub Centre	--		21.35
	PHC	--		134.20
	CHC	--		931.95
8	**Average Radial Distance (Kms) covered by a:**			
	Sub Centre	--		2.61
	PHC	--		6.53
	CHC	--		17.22
9	**Average Number of Villages covered by a:**			
	Sub Centre	--		4
	PHC	--		27
	CHC	--		191

Training and Development

Basic Training of Auxiliary Nurse Midwife (ANM) / Lady Health Visitor (LHV)

Multipurpose Health Worker (Female) and LHV/Health Assistant (Female) play vital role in Maternal & Child Health as well as in Family Welfare Service in the rural areas. It is therefore, essential that the proper training to be given to them so that quality services be provided to the rural population.For this purpose 336 ANM/Multipurpose Health Worker (Female) schools with an admission capacity of approximately 13,000 & 42 promotional training schools for LHV/ Health Assistant (Female) with an admission capacity of 2600 established by the Department of Family Welfare, Government of India. These training institutions are imparting training to prepare required number of ANMs and LHVs to man the Subcentres, Primary Health Centres, Rural Family Welfare Centres and other Health centres in the country. The duration of training programme of ANM is one and half years and minimum qualification for admission to this course is 10th pass. Senior ANM with five years of experience is given six months promotional training to become LHV/ Health Assistant (Female). Health Assistant (Female)/LHV provides supportive supervision and technical guidance to the ANMs in sub-centres.

The staffing pattern of the school varies according to the no. of annual admission capacity of the trainees. However, the school with 40 admission capacity is manned by one nursing officer, two sister tutors, 4 PHN and other supportive staff. Other approved costs besides salary to staff are stipend to trainee, contingency and rent. The detail of financial norm which is effectedsince7.2.2001isas follows:

Item	Norm(In Rupees)
1. Salary & allowances of staff	As per State Government
2. Stipend for trainees	500/- per month/trainee
3. Contingency	10,000/- per annum / school
4. Rent*	60,000/- per annum /school

* Rent payable in respect of such schools, which are functioning in rented buildings.

Basic Training of Multipurpose Health Worker (Male)

The Basic Training of Multi Purpose Health Worker (Male) scheme was approved during 6th Five-Year Plan

and taken up since 1984, as a 100% Centrally Sponsored Scheme. This training is provided through 56 training centres – through Health & Family Welfare Training Centres and through basic training schools of Multipurpose Health Workers (Male). Initially, the schools were sanctioned at the existing Health & Family Welfare Training Centres and later on expanded to other new basic schools. The training is of one-year duration and on successful completion of the training, the Male Health Worker is posted at the sub-centre along with an ANM/Health Worker (Female). The main functions of Male Multi Purpose Health Worker are in the areas of National Health Programmes like Malaria, Leprosy, T.B. & limited involvement in U.I.P, Diarrhoea Control Program and in family welfare services.

The financial norms for this scheme have been revised w.e.f. 7.2.2001. Under the scheme the salary of the staff, rent for school and hostel, stipend, educational aids and training material, hiring for bus and contingency are supported. The financial norms have been revised as follows:

(in Rupees)

Item	Norm
1. Salary & allowances	As per State Government
2. Rent(for new schools)	10,000/ month
3. Rent for hostel (for new schools)	250 / month / trainee
4. Stipend	300 / month / trainee
5. Educational Aids and Training Material	15,000 / annum
6. Transportation (for hiring bus)	30,000 / annum
7. Contingency	50,000 / annum

Maintenance and Strengthening of Health and Family Welfare Training Centres (HFWTC)

The HFWTCs are the training centres of DoFW, GOI which provide primarily short-term in-service training programmes to the doctors, nurses and para-medical personnel in the rural areas in a defined region. At present these training centres are imparting various in-service training for RCH programme. Apart from in-service education, 19 centres also responsible for conducting the basic training of Male Health Worker's course of one year.

The training centres have multi-disciplinary staff from biomedicine, social services, health education, public health and nursing and statistics. Apart from the salary of the staff of the training centres, other assistance under the scheme includes contingency, rent for training centres and payment to guest faculty. The financial pattern of assistance for this scheme has been revised since 7.2.2001. The detail of the financial norms are as follows: (in Rupees)

Item	Revised norms
1. Salary & allowances of the staff	As per State Government
2. Contingency	15,000 / annum
3. Rent*	40,000 / annum
4. Payment to Guest Faculty	50,000 / annum

*Rent payable in respect of such centres that are functioning from rented buildings.

Strengthening of Basic Training Schools

This is a new scheme, which is introduced during the 10th Plan period. This scheme envisages strengthening basic training schools of ANM/LHV. The main objective of the scheme is physical strengthening of the training schools for making these schools workable/ suitable, which have gone into dilapidated condition.

The provision under the scheme is maximum of Rs.21.5 lakhs per ANM/LHV school for following activities.

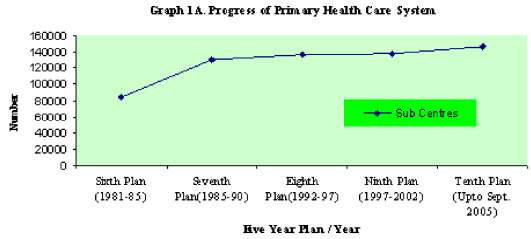
Activities	Rs. in lakhs (maximum)
1. Repair*/up-gradation** for the buildings - Trg. Centre, hostel & the field practice area	20.00
2. Furniture & Equipment	1.00
3. Books/A.V. Aids	0.50

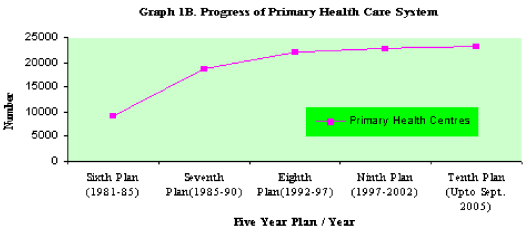
*Will include replacement/repair of floor/roof, plastering, electric cable, water storage tanks, wall-cupboard, doors, windows, sanitary fixtures, internal water supply (piping), septic tank, leakage, painting etc.

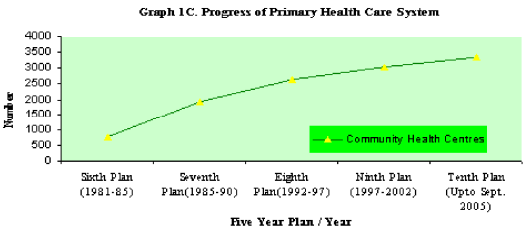
** will include minor extension

The Centres Functioning

The entire family welfare programme is being implemented through Primary Health Care system. The Primary Health Care Infrastructure has been developed as a three tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System. Progress of Sub Centres, which is the most peripheral contact point between the Primary Health Care System and the community, is a prerequisite for the overall progress of the entire system. A look at the number of Sub Centres functioning over the years reveal that at the end of the Sixth Plan (1981-85) there were 84,376 Sub Centres. The figure rose to 1,30,165 at the end of Seventh Plan (1985-90) and to 1,36,258 at the end of Eighth Plan (1992-97). At present, as on September, 2005, 1,46,026 Sub Centres are functioning in the country.



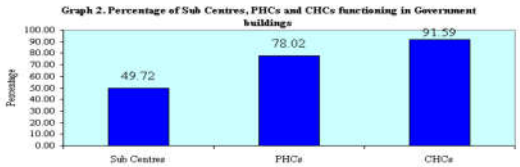




Similar progress can be seen in the number of PHCs which was 9115 at the end of sixth plan (1981-85) and the figure almost doubled to 18671 at the end of Seventh Plan (1985-90) and rose to 22149 at the end of Eighth Plan (1992-97). As on September, 2005, there are 23236 PHCs functioning in the country. In accordance with the progress in the number of SCs and PHCs, the number of CHCs has also increased from 761 at the end of Sixth Plan (1981-85) to 1910 at the end of Seventh Plan (1985-90) and 2633 at the end of Eighth Plan (1992-97). As on September, 2005, 3346 CHCs are functioning. According to the figures of population based on 2001 Population Census, the shortfall in the rural health infrastructure comes out to be of 19636 Sub Centres, 4337 PHCs and 3206 CHCs.

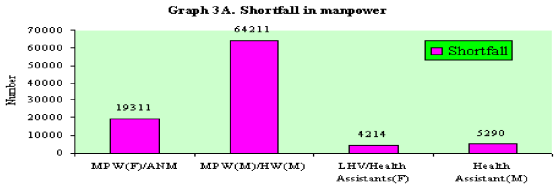
Building Status

About 49.7% of Sub Centres, 78.0% of PHCs and 91.5% of CHCs are located in the Government buildings. The rest are located either in rented building or rent free Panchayat/ Voluntary Society buildings. As on September, 2005, in case of Sub Centres, overall 60762 buildings are required to be constructed. Similarly, for PHCs 2948 and for CHCs 205 buildings are required to be constructed.

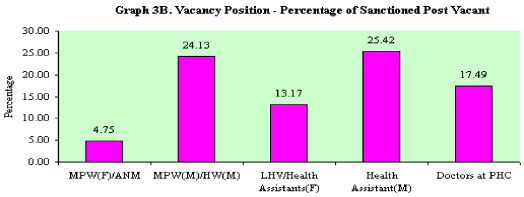


Manpower

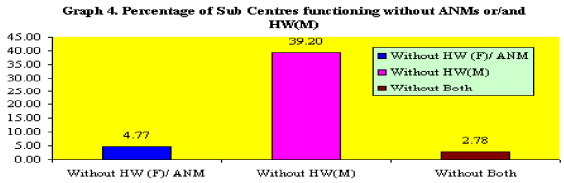
The existing manpower is an important prerequisite for the efficient functioning of the Rural Health Infrastructure. As on September, 2005 the overall total shortfall (which excludes the existing surplus in some of the states) in the posts of MPW(F) / ANM was 19311. Similarly, in case of MPW(M), there was a shortfall of 64211. In case of Health Assistant (Female)/LHV, the shortfall was of 4214 and that of Health Assistant (Male) was 5290.



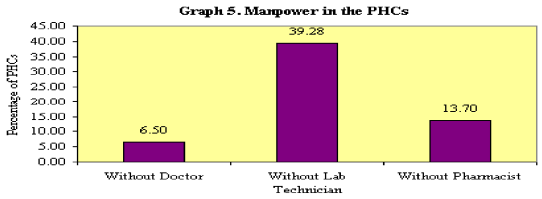
Even out of the sanctioned posts, a significant percentage of posts are vacant at all the levels. For instance, about 4.7% of the sanctioned posts of MPW(Female)/ ANM were vacant as compared to about 24% of the sanctioned posts of MPW(Male)/Male Health Worker. At PHC, about 13.1% of the sanctioned posts of Female Health Assistant/ LHV, 25.4% of Male Health Assistant and 17.4% of the sanctioned posts of doctors were vacant.



At the Sub Centre level the extent of existing manpower can be accessed from the fact that about 4.77% of the Sub Centres were without a Female Health Worker / ANM, about 39.2% Sub Centres were without a Male Health Worker and about 2.78% Sub Centres were without both Female Health Worker / ANM as well as Male Health Worker. This indicates a large shortfall in Male Health Workers, resulting in poor male participation in Family Welfare and other health programmes and overburdening of the ANMs.

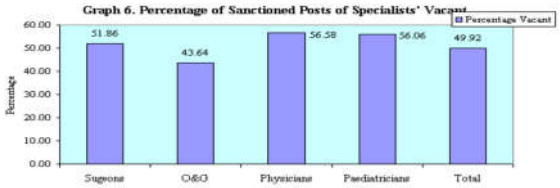


PHC is the first contact point between village community and the Medical Officer. Manpower in PHC include a Medical Officer supported by paramedical and other staff.



As on September, 2005, about 6.5% of the PHCs were without a doctor, about 39.2% were without a Lab technician and about 13.7% were without a Pharmacist

The Community Health Centres provide specialized medical care in the form of facilities of Surgeons, Obstetricians &Gynaecologists, Physicians and Paediatricians.



The current position of specialists manpower at CHCs reveal that out of the sanctioned posts, about 51.8% of Surgeons, 43.6% of Obstetricians &Gynaecologists, 56.5% of Physicians and about 56% of Paediatricians were vacant. Overall about 49.9% of the sanctioned posts of specialists at CHCs were vacant. Moreover, there was a shortfall of 6110 specialists at the CHCs as compared to the requirement for existing infrastructure on the basis of existing norms.

Health care system in Tamilnadu

The provision of health services in India by the public sector is the responsibility shared by the state, central and local governments although it is effectively a state responsibility in terms of service delivery. State and local governments incur about three-quarters and the center about one-quarter of public spending on health. The responsibility of health is at three levels. First, health is primarily a state responsibility. Second, the center is responsible for health services in Union Territories without legislature and is also responsible for developing and monitoring national standards and regulations, linking states with funding agencies and sponsoring numerous schemes for implementation by state governments. Third, both the center and the states have a joint responsibility for programmes listed under the concurrent list (regulation of medical and other professions, spread of diseases across states and drugs and poison). Goals and strategies for the public sector in health care are established through a consultative process involving all levels of the government through the Central Council for Health and Family Welfare. In this chapter we present an overview of the organization of the health and family welfare department and health infrastructure in Tamil Nadu. This overview is essential in order to better understand the management of the Reproductive and Child Health Programme in the state.

Organization of the Department of Health and Family Welfare

1. Directorate of Family Welfare 2. Directorate of Public Health and Preventive Medicine 3.Directorate of Medical and Rural Health Services 4.Tamil Nadu Medical Services Corporation 5.Reproductive Child Health Project and 6.DANIDA Health Care Project 7.Tamil Nadu State AIDS Control Society 8.Tamil Nadu State Health Transport Department 9.Directorate of Medical Education 10.Directorate of Indian Medicine and Homeopathy 11.Directorate of Drugs Control 12. Tamil Nadu State Blindness Control Society

Due to all these efforts, health indicators in Tamil Nadu show a glowing picture and health indicators such as IMR, MMR and CDR, CBR, LEB and TFR are bright in comparison with the national average and many other states taken for the analysis except Kerala. The Table 1 shows important health indicators both in Tamil Nadu and in India.

Health Indicators	Tamil Nadu	India
Crude birth rate(per 1000 population)	15.6	21.4
Crude death rate (per 1000 population)	7.3	7.0
Total Fertility rate(per women)	1.7	2.4
Neonatal Mortality Rate(per 1000 live births)	19 (2010)*	33 (2010)*
Under Five Mortality Rate (per 1000 live births)	27	50 (2015)
Maternal Mortality Rate(per lakh live births)	73	178
Life Expectancy at Birth	68.9 (2010)	65.8 (2012)
Male	67.1	64.16
Female	70.9	68.48
*Sample Registration Survey, 2012 , Economic and Political Weekly, 2.4.2016.		

Health Centers and their Shortfalls

Tamil Nadu has a strong medical base in comparison with other states. In early 1980s, there were only about 400 PHCs and 4000 SCs across rural areas of Tamil Nadu. In 2015, it had 8706 SCs, 1372 PHCs and 385 CHCs. The details regarding the number of SCs, PHCs and CHCs in 1985, in 2005 and at the end of March 2015 are presented in Table 2.

Table 2 No. of SCs, PHCs and CHCs in different states during 1985 to 201

State	1985			2005			2015		
	SCs	PHCs	CHCs	SCs	PHCs	CHCs	SCs	PHCs	CHCs
Bihar	8299	796	52	10337	1648	101	9729	1883	70
Gujarat	4869	310	22	7274	1070	272	8063	1247	320
Karnataka	4964	365	98	8143	1681	254	9264	2353	206
Kerala	2270	199	4	5094	911	106	4575	827	222
MP	6615	680	58	8874	1192	229	9192	1171	334
Maha.	6391	1539	147	10453	1780	382	10580	1811	360
Odisha	4127	484	59	5927	1282	231	6688	1305	377
TN	5860	436	30	8682	1380	35	8706	1372	385
UP	15633	1169	74	20521	3660	386	20521	3497	773
All India	84376	9115	761	146026	23236	3346	152326	25020	5363

Maha. = Maharashtra, UP=Uttar Pradesh, TN=Tamil Nadu, Reqd.=Required
In Post. = in position, Short=shortfall, *=Exces

It is easily observed that there is much increase in the number of SCs, PHCs and CHCs between 1985 and 31st March, 2015 in every state including the developing states. The number of sub-centers in Tamil Nadu increased from 5860 in 1985 to 8706 in 2015, PHCs from 436 to 1372 and CHCs from 30 to 385 in the respective years. In the same way, India the country experiences a good increase in the number of health centers

It is appropriate to compare the existing number with the minimum required. The difference is called shortfall. As for as shortfall is concerned, of the nine states taken for discussion all states excluding Karnataka, Kerala and Tamil Nadu have shortfall in these infrastructures in comparison with the minimum requirement. The details of the shortfall are given in Table

National Rural Health Mission

Under the mandate of National Common Minimum Programme (NCMP) of UPA Government, health care is one of the seven thrust areas of NCMP, wherein it is proposed to increase the expenditure in health sector from current 0.9 % of GDP to 2-3% of GDP over the next five years, with main focus on Primary Health Care. The National Rural Health Mission (NRHM) has been conceptualized and the same is being operationalised from April, 2005 throughout the country, with special focus on 18 states which includes 8 Empowered Action Group States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttaranchal, Orissa and Rajasthan), 8 North East States (Assam, Arunachal Pradesh, Manipur, Meghalaya, Mizoram, Nagaland, Sikkim and Tripura) Himachal Pradesh and Jammu & Kashmir.

Conclusion

It is the duty of the state take suitable measures to regain its position in the health status. The foremost thing the government of Tamil Nadu has to do is to fill the vacancies in all its health centres. It is also necessary to increase the number of health centres according to the increase in the state population. The facilities available in these centres, particularly operation theatre facility should be enhanced. The amount allotted to public health in revenue budget should be increased at least to 6% so to provide enough funds for improving every facility required for the good performance the public healthcare sector in rural Tamil Nadu as it is first and best scope for the rural poor and also to avoid impoverishment of rural households.

References

1. Nandraj S (2012) Unregulated and Unaccountable, Private Health Providers. Econ PolitWkly 47: 12-17.
2. Muraleedharan V, Dash U, Gilson L(2011) Tamil Nadu 1980s-2005: A Success Story in India. LSHTM, London.
3. Government of Tamil Nadu (2013) Statistical Handbook, Chennai.
4. http://cms.tn.gov.in/sites/default/files/documents/hfw_e_pn_2017_18_0.pdf
5. http://www.tn.gov.in/dear/Health.pdf
6. http://shodhganga.inflibnet.ac.in/bitstream/10603/16898/11/11_chapter%204.pdf
7. https://www.omicsonline.org/open-access/public-healthcare-sector-is-losing-its-importance-in-rural-tamil-nadu-2315-7844-1000199.php?aid=88694