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Health services in rural India – Role of CSR in better delivery

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S. Ranganadhan

Management scholar in CSR Corporate Social Responsibility - Centre of Excellence Ashokapuram, Mysore-570 011, Karnataka, India

ABSTRACT *Health is an important aspect in the economic growth of the nation. Health care delivery in rural India need to be strengthened as 68.8% population lives in rural area. The socio-economic conditions prevailing in rural have large impact on the health conditions. The important social parameters like poverty, mal-nutrition, lack of sanitation, hygiene water, education, empowerment of women and living space are to be integrated in the process of providing health services in rural India. In India the three tier health care system is successfully delivering health care. The funds crunch and lack of follow up by the concerned local governments resulted in poor management with poor man power and infrastructure. To provide more precise and effective health care in rural India there is an every need to exploit information system. The successful public-private partnership in some states can be translated to other parts by channelizing social investments which are likely to increase due to recent bill on CSR activities. The paper presents various advantages of information technology and social investments under public-private partnership for providing health to rural population at affordable cost. The investments will open up entrepreneurship in rural areas.*

INTRODUCTION

Health is directly linked to economy of population in any socio group. In rural India the determinants of health are good farm income, farm employment, food crops with nutritional value at farmer's disposal and proper agricultural practices and technologies. Regional in balance in investments due to policies encouraging cash crops and intensive agricultural practices for more production are adding to the problem of health issues in rural area both directly and indirectly. Due to poor economic status agricultural labourers are denied access to good and nutritious food. The limited resources and infrastructure in rural India in terms of clean drinking water, lack of sanitation and communication link are great concern for addressing health issues in rural India. It is very much essential to link knowledge and education to health and well being of rural people. Knowledge makes them to receptive and improves their health. Research and facts relate health inequalities to social-economic factors like poverty, mal-nutrition, lack of sanitation, hygiene water, education, empowerment of women and living space. So, it is essential to address social issues to develop any health care system. (Marmot, 2005). The policies should be towards achieving the three goals of a health system-"population health, system responsiveness and financing fairness" (WHO, 2000). Therefore to provide health in rural areas it is very much essential to address the various socio-economic issues alongside developing strong health care delivery system which are inter- linked. Most successful public-private partnership models in health can be translated to other areas. (http://www.pppindiadatabase).

MATERIALS AND METHODS

The study is based on the secondary data obtained from published reports and available on websites. The paper is based on the analysis of various facts and inference was made to highlight the need for social investments in health sector for wide distribution network of health care centres across the rural pockets of the country. The paper also, details various domains for entrepreneurship development in rural areas.

RESULTS AND DISCUSSION

A comprehensive planning addressing various issues with cohesion among various stakeholders will play a good role in bridging the gap between the rural and urban population for effective health delivery system. Demographic and health infrastructural facilities in rural India were presented in table 1.

Table 1: Demographic and health infrastructural facilities in rural India

Health Institution / Indicator	Sub-Centre (SC)	Primary Health Centre (PHC)	Community Health Centre (CHC)
Average rural area covered (Sq.m)	21.02	129.66	645.21
Radial distance covered (Km)	2.59	6.42	14.33
Average rural population covered	5615	34641	172375
Total number functioning	148366	24049	4833
Housed own building	94380	20015	4688
Housed rented building	35936	1235	118
Housed rent free building	16231	936	28
Under construction	15546	1384	401

In India out of 3118309.39 sq.m area 94.86% is rural with 640867 villages under 640 districts. The average growth rate is 12.18 with 238 population density per sq.m in rural area as against Indian average of 17.64 with 312 population density per sq.m. The rural crude birth rate of 23.3 as against 17.6 in urban and 7.6 crude death rate as against 5.7 in urban are also, a concern. The infant mortality is 48 as against 29 in urban area. The rural health issues are 56% communicable and 29% non-communicable diseases

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(http://www.mohfw.nic.in).The entire gamut of health care and delivery system involves government, NGO's, doctors, academicians, pharmaceutical companies and health insurers with defined role constitute the stakeholder group (www.deloitte.com).

Stakeholders in health management system

1. Government- Planning, policy making and regulation.
2. Non – governmental Organizations- Educating on prevention and providing low cost techniques.
3. Providers- Treatments by diagnosing, investigating and monitor health by follow up.
4. Pharmaceuticals-Research and development.
5. R&D- Devices for diagnosis and treatment and research.
6. Community-Adopt prevention techniques advocated help in feedback on the systems.
7. Health Insurers-Financial coverage to mitigate risk exposure at low premium.
8. Academic Institutions-Improved medical education and training.

The health care in rural areas is a three tier system covering different population with a 30 bedded community health centre covering four primary health centres (PHC) as a referral centre for six, peripheral sub-centres which are managed by one Female and Male health worker. Data suggests that as on March, 2012, there were 148366 Sub Centres, 24049 Primary Health Centres (PHCs) and 4833 Community Health Centres (CHCs) functioning in the country (http://www.mohfw.nic.in). The average health care units are 7, 27 and 133 of Sub-Centre (SC), Primary Health Centre (PHC) and Community Health Centre (CHC) respectively. The average number of SC per PHC is 6 and PHC per CHC is 5 in the country. According to UN 31% of the rural population in India has to travel over 30 km to get needed medical treatment. The average area covered by sub-centre (21.02), PHC (129.66) and CHC (645.21) in sq.m need to be spread further. Also, villages covered by SC (4) PHC (27) and CHC (133) needs more attention, given the infrastructure like roads, communication and power in rural pockets. The ratio of rural population to doctors is six times lower than in urban areas. There is an overall short fall of manpower at all levels (Table 2). The infrastructure at all levels needs to be strengthened (Table 3).

Table 2: Health personnel in rural India

Class	Personnel	Sanctioned	Serving	Vacant
SC	Health worker(M)	148366	82563	51705 (96734)
SC	Health worker (F)	148366	149065	188715 (2717)
PHC	Health Asst. (M)	24049	21256	14648 (12658)
PHC	Health Asst. (F)	24049	25240	16109 (9152)
PHC	Doctors	24049	31867	28984 (2489)
CHC	Specialists	19332	9914	5858 (13477)
*Figures in parenthesis are shortfall SC=Sub- centre; PHC= Primary health centre; Community health centre				

Strategies for better management and health delivery

General tax revenues are the principle source of finance for publicly delivered health services. One of the pressing issues in the country – affordability of healthcare was sought to be addressed with the introduction of various social insurance programs both at the national and state levels including RSBY, Rajiv Arogyasri, Yeshaswini, etc. These schemes have emerged to provide financial access to the under privileged for quality, secondary or tertiary, health services through provider partnerships on a scale unheard of before and have accelerated insurance coverage from 75 million people in 2007 to over 247 million people in 2011.

Table 3. Per cent staff vacancy and rented location of health units in rural area

Per cent Staff vacancy	HW (M) 7.6 (3.8)	HW (F) 44.4 (65.2)	HA (F) 37.1 (8.2)	HA (M) 34.4 (52.6)	Doctor (PHC) 20.4 (10.3)
Per cent Rented location	SC 24.5	PHC 5.6	CHC 2.4	Total 32.5	-
*Figures in parenthesis are % shortfall					

Successful PPP ventures at present in different states

Role of private sector involvement in health care delivery system needs to be exploited the fullest possible way (Birla and Taneja, 2008). Some of the successful ventures existing in Public–Private Partnerships (PPP) in health Sector can be useful for making replica of ventures

(http://www.whoindia.org).

1. Tertiary Care: Rajiv Gandhi Super-speciality Hospital, Raichur, Karnataka
2. Rural Health Care Delivery and management of PHCs: Arunachal Pradesh
3. Labs, Drug Supply and Diagnostic Services: Hindlabs: MoHFW and HLL Life Care Ltd
4. Health Insurance: Community Health Insurance Scheme: Karnataka
5. Outreach/Health Delivery: Mobile Health Service:Sunderban, W. Bengal
6. RCH Services: Merry Gold Health Network (MGHN) and SAMBHAV Voucher Scheme in UP

Health has been included with other infrastructure sectors which are eligible for Viability Gap Funding up to a ceiling of 20 per cent of total project costs under a PPP scheme. This will steer private sector to take up projects, such as hospitals and medical colleges in rural areas. Information Technology can be used in different ways to improve rural health care and delivery. IT helps support in public health decision making for better management of health programmes and health systems at all levels. A comprehensive Health Information System (HIS) will register a lot of parameters for health system.

Recent provisions under Companies bill on CSR will facilitate direct funding in the form of donations for health facilities. This helps in all health centres to develop its corpus fund over a period of time. Social investments in health sector not only improve the health delivery also, results in rural entrepreneurship.

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Areas of Public-Private Partnership and social investments in rural health sector

1. Contract services: On contract services can be man power and transport like ambulance.
2. Establishing joint ventures: Establishment of hospitals, laboratories and medical colleges/research centres.
3. Involvement of NGO's and other social groups: NGO's and social groups can play major role in educating on health issues.
4. Units with autonomous status: For providing health care at affordable cost.
5. Philanthropic donations: Land and finance for creating health establishments.
6. Community based insurance: Community insurance at low premium.
7. Adoption: Corporate houses can adopt villages.
8. Knowledge portals; e-service: Social investments to provide knowledge.
9. Infrastructure: Construction of hospitals, laboratories and counseling units.
10. Conducting health camps: Conducting health camps to spread awareness on health to rural poor.
11. Capacity building: Trainings to health staff.
12. Establishing community clinics: Establishing community clinics reaching the in accessible areas.

CONCLUSIONS

In conclusion it is seen that there is a greater need for more investments in health sector. Creating a congenial environment with facilities to staff as well as health units and incentive scheme will help retain the health personnel at rural areas. Social investments will also, create employment opportunities in rural area in the form of entrepreneurship for providing health services. Information technology is a better tool to develop entrepreneurship for providing e-services. Social investments in health sector can be channeled through proper policy and by overseeing the services in terms of quality and quantity to assess the levels of coverage.

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