Evaluation Study on Functioning of Primary Health Centres (PHCs), assisted under Social Safety Net Programme (SSNP)

The Social Safety Net Programme (SSNP) assisted by World Bank for family welfare was initiated in 1992-93 for a period of five years in 90 poor performing districts which were characterised by high maternal mortality rate and low levels of institutional deliveries. The programme has envisaged to reduce the maternal mortality rate by creating essential health infrastructural facilities including the post of lady doctor in the identified PHCs for facilitating institutional deliveries of pregnant mothers.

The essential infrastructural facilities that are required to be created in each PHC under the programme included (a) well equipped operation theatre, (b) labour room, (c) an observation ward, (d) two quarters, one each for auxiliary nurse mid-wife and lady health worker, (e) a generator, (f) provision of supply of safe drinking water (g) an ambulance. In addition, however, the post of a lady doctor is required to be created by the concerned state governments. The amount sanctioned per PHC is Rs.10.00 lakh.

Evaluation Study

At the instance of the Planning Commission, the Programme Evaluation Organisation undertook the study to evaluate the functioning of Primary Health Centres (PHCs) assisted under Social Safety Net Programme (SSNP) and their effectiveness in facilitating institutional deliveries.

Methodology

At the time of preparation of design for conducting evaluation study on functioning of CHCs in 1996, it was decided to assess the impact of SSNP simultaneously through a combined design. Accordingly, while carrying out the field survey on CHCs, information on relevant aspects of sample PHCs which were assisted under SSNP were also collected. The methodology in assessing the impact of SSNP on PHCs is, therefore, the same as was adopted in the case of the study on functioning of CHCs.

For testing the hypotheses implicit in the aforesaid objectives, both primary and secondary data were generated through sample survey. A multi-stage sample design was adopted for the study. The sample units at different stages are :States, Districts, PHCs and patients. The first sample units were the six states initially selected to represent the good and poor health status of the population by using infant mortality rate as a stratifying parameter. However, during the field survey, it was found that the three districts in the states of Madhya Pradesh, Rajasthan and Bihar had not received the funds under the Social Safety Net Programme (SSNP). Consequently, it was decided that the study would remain confined to the selected districts of the remaining three states of Haryana, Orissa and Uttar Pradesh where the programme was implemented.

The study design has adopted with and without approach to yield therapeutic results and, therefore, two districts - one assisted and the other not assisted under SSNP were selected from each state in the second stage of sampling. In the third stage, four PHCs from each district were selected. Eight patients from each PHC were selected in the fourth stage of sampling.

Following the above sampling design, 167 patients, 24 PHCs spread over six sample districts of three states were selected for the study. In each selected village, the views of the knowledgeable persons were taken for preparation of qualitative notes on functioning of PHCs.

Health Infrastructure in PHCs - Availability and Adequacy

During 1995-96 none of the 12 assisted sample PHCs was found to be equipped with all the eight essential facilities; viz; well equipped operation theatre, labour room, observation ward, two quarters, generator, drinking water, ambulance and lady doctor that were required to be created in each PHC. Of the eight essential complementary facilities including the post of lady doctor, a maximum of six facilities were created in 3 PHCs followed by five facilities in 4 PHCs, four facilities in 1 PHC and two facilities in 4 PHCs (Table 3.3). Such a variation in creation of essential facilities in sample PHCs against an equal allocated amount of Rs.10 lakh/PHC needs a closer look. This follows that the facilities in PHCs have been created thinly and in an isolated manner as against the envisaged plan of creation of a complete package of complementary facilities in PHCs for facilitating institutional deliveries.

Among the requisite facilities, the post of lady doctor for attending on delivery cases is envisaged to be most essential, but none of the sample PHCs had been posted with a lady doctor. Though, a few facilities like labour rooms, operation theatres and observation wards are available in many of the sample PHCs, such facilities could not be utilised for attending

delivery cases without the availability of lady doctors. This mis-match between the manpower and essential facilities is a matter of serious concern. Interestingly, amidst the existing thin facilities, ambulances are made available in seven out of 12 sample PHCs (Tables 3.1 and 3.2).

Availability of Man-power

The adequacy of doctors against their sanctioned posts seems to be encouraging, as 75 per cent of doctors are in position in assisted PHCs, while 96 per cent of them are found in position in non-assisted PHCs (Tables 3.4 and 3.4A). In this context, however, the observations of PEO field teams reveal that in practice the absenteeism among the doctors from their work places is very high which is observed to be a binding constraint in utilisation of health care services in sample PHCs.

Population Coverage

On an average, the population coverage by a programme assisted PHC is 68386 people and it is 57705 people by a non-assisted PHC against the prescribed norm of 20,000 to 30,000 people per PHC (Tables 4.1 and 4.1A). As far as coverage of sub-centres by a PHC is concerned, it is noticed that at the aggregate level, about 11 sub-centres are served by a programme assisted PHC and the coverage of sub-centres by a non-assisted PHC is about 12 sub-centres against the prescribed norm of 6 sub-centres per PHC.

More coverage of population and sub-centres by a PHC in large majority of the cases are indicative of the facts that adequate number of PHCs have not been established against their requirement. This not only affects the quality and delivery of health care services adversely, but also accentuates the problem of overcrowding in CHCs and district hospitals.

Utilisation of Medical Services

It is noticed that none of the sample PHCs has attended the delivery cases during 1995-96 (Tables 4.2 and 4.2A). This corroborates the earlier finding which has indicated that such PHCs are not found equipped with all essential complementary facilities including the posts of lady doctors for attending on delivery cases. This tends to suggest that Social Safety Net Programme has not been able to achieve the objective of facilitating and popularisation of institutional deliveries.

The average utilisation of cases in PHCs with SSNP is 30 cases/day/doctor, while it is 25 in non-assisted PHCs. However, the inter-PHC comparison of utilisation rate reveals a variation across the sample states.

The utilisation rate of health care services in PHCs as observed above should not be taken as reflection of true performance and functionality of PHCs. In this context, qualitative information gathered by PEO field teams through their indepth probing and discussions reveals that in the absence of doctors, the cases coming to PHCs are attended by para-medical and auxiliary para-medical staff. It was also observed by the field teams that since the PHCs were not equipped with diagnostic facilities, the patients preferred to visit tertiary/district hospitals for treatment of their ailments.

Utility of PHCs - Beneficiaries' Views

The profile of beneficiaries reveals that a maximum of 32.93 per cent of beneficiaries have sought the treatment for minor ailments, like, cold, cough and fever. This is followed by the cases suffering from water borne diseases (14.63%), vaccine preventable diseases (8.54%), respiratory diseases (8.53%) and gynaecological complications (4.88%) respectively (Table 5.2). Similar results are found for non-assisted PHCs (Table 5.2A).

As many as 51.22 per cent of beneficiaries belonging to programme assisted PHCs are found to be dissatisfied with the functioning of PHCs (Table 5.3). Further, of the dissatisfied beneficiaries, a majority have complained about medical and para-medical staff of PHCs. The main reasons for their dissatisfaction included non-availability of medical and para-medical staff (42.85%), not examined by doctors (52.38%) and proper attention not given (35.71%). The second important reason for dissatisfaction of beneficiaries was the non-availability of medicines in PHCs. About 66.67 per cent of the beneficiaries expressed this view. Similar results are obtained for non-assisted PHCs also (Table 5.3A).

Despite inadequacies in the delivery of health care services by PHCs, a vast majority of about 89 per cent of beneficiaries belonging to programme assisted PHCs and about 96 per cent beneficiaries from non-assisted PHCs have still expressed their preferences for PHCs for seeking health care services over other alternative sources of treatment (Tables 5.4 and 5.4A).

It is revealed that 54.88 per cent of beneficiaries belonging to assisted PHCs and 94.12 per cent belonging to non-assisted PHCs have incurred private expenditure on various items while seeking treatment in PHCs. A majority of 73.33 per cent beneficiaries belonging to assisted PHCs and 52.50 per cent belonging to non-assisted PHCs have incurred private

expenditure below Rs.100 per illness episode. Besides, major chunk of expenditure made by the sample beneficiaries of all categories is on purchasing medicines (Tables 5.5 and 5.5A).

The income profile of beneficiaries belonging to programme assisted PHCs reveals that the beneficiaries whose average monthly income was below Rs.500 have formed a small percentage of 3.66, while a majority (63.41%) of the beneficiaries are from the monthly income group of above Rs.1000 (Table 5.6). Similar results are obtained for non-assisted PHCs also.

The low-income group households seem to stay away from the public health care delivery system primarily because of non-availability of medicine, indirect cost on transport and high opportunity cost in terms of foregone income (due to loss of wage income say). They, therefore, seem to depend on cheaper alternatives, such as traditional Indian medicines or unqualified medical practitioners.

It is interesting to note that a large majority beneficiaries of the public health delivery system have expressed willingness to pay for the services if the quality of delivery improves. In the PEO sample survey the beneficiaries were asked if they would be willing to pay 25% of the market cost of treatment if the quality of delivery improves. About 62% of the beneficiaries replied in the affirmative. This is not surprising in view of the fact that the beneficiaries do incur both direct (medicine, clinical tests) and indirect (transport, loss of wage income, inconvenience) costs for availing public health care facilities.

Suggestions

The study brings out the fact that the PHCs have not been able to deliver the intended health care and medical services to the people in the rural areas. The following suggestions are made for improving their performance.

1. To ensure the availability, adequacy and functionality of health infrastructural facilities including the medical and para-medical staff in PHCs, there is an urgent need to emphasise the systemic mechanism of supervision, monitoring and review of the functioning of primary health care institutions. This will not only help improve the quality of health delivery system, but also ensure optimum use of public resources.

2. A holistic approach to primary health care system needs to be adopted which should strive to integrate the allopathic system of medicine with Indian systems of medicine. The Indian systems of medicine has advantage over the western system of medicine on many counts. For instance, the allopathic treatment and medicines

are becoming increasingly unaffordable and the study has clearly brought home the point that non-availability of medicines in PHCs is one of the main constraints being faced by the people in general and the poorest of the poor in particular.

3. If the adequate number of lady doctors are not available for posting in the rural areas, the para-medical staff especially the Nurses should be provided training on obstetric/gynaecology so as to enable them to popularise and facilitate the institutional deliveries.

4. The existing PHCs should be made equipped with essential infrastructure and diagnostic facilities which will help increase the utilisation rate. Besides, medicines should be made available in PHCs especially for those who are living below the poverty line.

5. To overcome the hardships being faced by the people in the rural areas due to non-availability/absenteeism of doctors, it is suggested that the local village level health workers as paramedics should be trained on basic medicine, health care, hygiene and nutrition for posting in PHCs and their functioning should be monitored and supervised by PRI's.