Specialty Health Care in Rural Areas of West Bengal (India):
A Policy Document

Ashok Kumar Biswas, The Ministry of Health-Tabuk Region, Tabuk, Saudi Arabia
Edward Gebuis, MCH Den Haag, Leiden, Netherlands
Petrica Irimia, Henri Coanda, Alba Iulia, Romania

ABSTRACT

The health care system of WB needs a massive change from every aspect. However, changing a system which is running for years is in itself a challenge. Therefore, change in the health policy needs to begin either from the foundation up or according to the importance of proposed legislation. Rural health care system without specialty care has always been the underdog of WB health system. However, most improvement can be made there. This policy document proposes a basic specialty care in rural areas of WB, intended to improve health care for a maximum possible population.

KEYWORDS

India, Policy Document, Rural West Bengal, Specialty Care

1. INTRODUCTION

Social services including health services have never been equitably distributed throughout society. Those who have access are making greater use of the facilities than people without knowledge or access to them (Ray, Basu, & Basu, 2011). No wonder that health care system is a dilemma for average people, and it affects everyone at every corner of the globe. Most of the health care systems are more concerned with profit than services. Moreover, the high cost of health care makes it impossible for many to afford (Waal, 2015; Oosterom, 2015) while the quality of life (QoL) directly depends on the quality of care (QoC) (Biswas Leshabari, & Gebuis, 2015). Although the United States of America is considered to be the best in the world in terms of quality of health care; millions of its citizen are still uninsured. Reports say it was 49.9 million in 2010 which increased by 1 million since 2009. Moreover, according to life expectancy, the USA is at 42nd place in the world even after being the biggest spender on health care. Altogether, a health care systems swing between what is needed for people and what is affordable (Waal, 2015). In short, it is not the money that gives the best health care; reaching maximum people at every socioeconomic level is quite a challenge for every country.

Globally health care systems are being questioned every single moment. Canada spends more on healthcare (not into insurance companies) for a public funded universal healthcare system, but the quality of the care is not equivalent to others. Ghana started national health insurance scheme since 2003 which is affordable and significant for everyone, but care centres being in the urban areas are out of reach for maximum people who live in suburban areas or villages. On the other hand, citizens in Brazil pay 70% of their income as tax and still have to choose between government and private health care considering spectrum and quality of treatment. Flaws in the public system are

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still unavoidable, and they have to pay full out of pocket in private sectors. In contrast, Australia with high life expectancy and better care has to invest much more for flying doctors and communications because of the environmental and transport barriers. In short, no health care system is perfect around the world and India is not an exception (Waal, 2015; Oosterom, 2015; Kurrle, 2015).

India has just one doctor for every 1.700 people. According to WHO criteria, to maintain required doctor population ratio India will need more 400,000 physicians by 2020 (Kumar, 2013). Situation in West Bengal, one of the densely-populated states of India, is far more alarming with doctor population ratio 1:2600 (“College of Medicine,” 2015). Moreover, most of the health services are centralized in cities and villages are left with very few or no trained doctors (Kumar, 2013). Instead of universal health care system, West Bengal has both private and public health care facilities to choose from almost like Brazil or China (Waal, 2015). Unfortunately, the private network is not reachable for everyone for the developing country like India where half of the population lives below poverty line (Kumar, n. d.). Because of current political change, West Bengal has upgraded financially to some extent although still contains 21.9% of the population below poverty line (Bureau, 2013). As a result, the health care system is a challenge for West Bengal government and its people.

2. ISSUE AT HAND

The problem of lack of professional health service providers in rural areas has been an area of discussion in India since the 1960s (“Indian approaches,” n. d.). The total population of West Bengal is 91,276,115 (2011 Census) which were 80,176,197 in 2001 (“West Bengal Population,” n. d.). However, health care system instead of improving or changing policies became worse than before and currently declining with the same nature (“West Bengal Population,” n. d.). Around the year 2008 West Bengal Government introduced telemedicine and national health insurance coverage that went unsuccessful within few years (Mitra, 2011; Dasgupta, 2008; Mehta, 2015). Undoubtedly, health care system in West Bengal is still developing and needs massive modification and in some parts thorough change of the policy (“ঝোপপঁচিশ মানিটের জীবন অনুষ্কোহ দরিদ্রের জন্য প্রথম,” n. d.). However, to begin with, one of the major issues would be

2.1. Specialty Care in Rural Areas

68.13% of the whole population of WB lives in the interior village, and almost 22% people are below poverty line (“Indian approaches,” n.d.). Hence, a vast number of individuals are far away from the private health care system, and they have to depend on the public healthcare. Unfortunately, the number care centers in villages are too less to the number of people live there (Table 1) (Kumar, 2013; “Medical Institutions,” 2011). Although, primary care is available in couple of villages, situations become out of control when people have to die on the way to hospital for some health conditions that could be monitored by specialists.

Unfortunately, rural and suburban areas are mostly covered by rural health centres, primary care centres and most of it still dependent on treatment from traditional doctors who do not have any formal medical training. Research shows that majority of the rural population who asked to be under the supervision of specialist care preferred government health facilities (38.58%), followed by unqualified quacks (29.27%) due to low cost as well as living in close proximity (Ray, Basu, & Basu, 2011).

Specialty care in government set up starts at the Sub-divisional level, and all sub-divisional (also other higher Centres) hospitals are situated in the middle of cities. As a result, people who seek a medical specialist in any field have to visit hospitals in the cities which can be too distant for an individual who is ill, old or the distance is too costly and time consuming to travel. Moreover, the
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