GOVERNMENT OF INDIA
MINISTRY OF HEALTH AND FAMILY WELFARE
DEPARTMENT OF HEALTH AND FAMILY WELFARE

LOK SABHA
STARRED QUESTION NO. 314
TO BE ANSWERED ON THE 16TH MARCH, 2018
HEALTHCARE FACILITIES IN RURAL AREAS

***314. ADV. SHARADKUMAR MARUTI BANSODE:**
SHRI SUKHBIR SINGH JAUNAPURIA:

Will the Minister of **HEALTH AND FAMILY WELFARE** be pleased to state:

(a) whether around 600 million people in the country, mostly in the rural areas, have little or no access to healthcare facilities and if so, the details thereof;

(b) whether the Government is considering any mechanism/scheme/plan to train more health professionals and depute them in rural areas and if so, the details thereof;

(c) whether various Government hospitals in rural areas are facing the problem of infrastructure to accommodate critical care patients; and

(d) if so, the details thereof?

ANSWER
THE MINISTER OF HEALTH AND FAMILY WELFARE
(SHRI JAGAT PRAKASH NADDA)

(a) to (d) : A Statement is laid on the Table of the House.

STATEMENT REFERRED TO IN REPLY TO LOK SABHA STARRED QUESTION NO. 314* FOR 16TH MARCH, 2018

(a) The healthcare needs of the rural population are a priority for the country. As per Census 2011, the rural population of India is 833.7 million.

As per Rural Health Statistics (RHS) 2016-17 and 2015-16**,** both Average rural area (Sq. Km) covered by sub centre (SC), Primary Health Centre(PHC) and Community Health Centre(CHC) and average radial distance (Km) covered by them had decreased over the year. Similarly, Average number of villages covered by CHC had also decreased and that covered by PHC and SC remained constant, thereby having an increasing trend for access and coverage by SC, PHC and CHC.

Moreover, as per RHS (2016-17), increase in number of health facilities is shown in the table given below:

Health Facility	RHS 2005	RHS 2016-17
Sub Centres	146026	156231
Primary Health Centres	23236	25650
Community Health Centres	3346	5624

Additionally, 1390 Mobile Medical units are also functional in the country to serve the people living in the remote areas.

(b) The Government has taken various steps to train more health professionals and depute them in rural areas, these efforts include-

(i) 50% of the seats in Post Graduate Diploma Courses are reserved for Medical Officers in the Government service, who have served for at least three years in remote and difficult areas. After acquiring the PG Diploma, the Medical Officers has to serve for two more years in remote and/or difficult areas.

(ii) Incentive at the rate of 10% the marks obtained for each year in service in remote or difficult areas as upto the maximum of 30% of the marks obtained in the entrance test for admissions in Post Graduate Medical Courses.

(iii) Support is provided to States/UTs for hard area allowance to specialist doctors for serving in rural and remote areas and for their residential quarters so that they find it attractive to serve in public health facilities in such areas.

(iv) Initiatives for up-skilling of MBBS doctors to provide Life Saving Anaesthetic Skills (LSAS) and Emergency Obstetric Care (EmOC) have been put in place.

(v) The States are encouraged to adopt flexible norms for engaging specialists at public health facilities. These include various mechanisms for 'contacting in' and 'contracting out' of specialist services, methods of engaging specialists outside the government system for service delivery at public facilities and the mechanism to include requests for these in the state Program Implementation Plans (PIP) under the National Health Mission.

(vi) The ratio of teachers to students has been revised from 1:1 to 1:2 for all MD/MS disciplines and 1:1 to 1:3 in subjects of Anesthesiology, Forensic Medicine, Radiotherapy, Medical Oncology, Surgical Oncology and Psychiatry in all medical colleges across the country. Further, teacher: student ratio in public funded Government Medical Colleges for Professor has been increased from 1:2 to 1:3 in all clinical subjects and for Associate Professor from 1:1 to 1:2 if the Associate Professor is a unit head. This would result in increase in number of specialists in the country.

(vii) Enhancement of maximum intake capacity at MBBS level from 150 to 250.

(viii) relaxation in the norms of setting up of Medical College in terms of requirement for land, faculty, staff, bed/bed strength and other infrastructure.

(ix) Strengthening/upgradation of State Government Medical Colleges for starting new PG courses/Increase of PG seats.

(x) Establishment of New Medical Colleges by upgrading district/referral hospitals preferably in underserved districts of the country.

(xi) Strengthening/ upgradation of existing State Government/Central Government Medical Colleges to increase MBBS seats.

(c) & (d) Public Health and Hospitals being a State subject, the primary responsibility of providing healthcare services including strengthening of health facilities lies with the State/UT Governments. However, under NHM, technical and financial support is provided to State/UTs for strengthening their overall health system for provision of accessible, affordable and quality health care to all the citizens based on the proposals submitted by State/UTs in their NHM-Programme Implementation Plans (PIPs), within their overall resource envelope. This support inter alia includes support towards strengthening of infrastructure to accommodate critical care patients.