Journal for Re Attach Therapy and Developmental Diversities
eISSN: 2589-7799
2023 February; 6 (2s): 364-370

Rehab Patient-Benefitting Through Rural Healthcare Network & Social Policies

[1]Rajesh.E, [2]Dr. Somanchi Hari Krishna, [3]Dr. Veena Prasad Vemuri, [4]Dr. Sarika Agarwal, [5]Shekhar Kumar Sahu

[1]Assistant Professor in Special Education, School of Behavioural Sciences, Mahatma Gandhi University, Priyadarsini Hills P.O, Kottayam, Kerala
[2]Associate Professor, Department of Business Management,Vignana Bharathi Institute of Technology, Aushapur Village Ghatkesar Mandal Medichal Malkajigiri , Telangana
[3]I/C Principal, NKES College of Arts Commerce and Science, Mumbai, Maharashtra
[4]Post-Doctoral Fellow (Under PDF of ICSSR), Department of Management Studies (School of Studies in Management and Commerce, Guru Ghasidas Vishwavidyalaya (A Central University), Koni, Bilaspur (CG)
[5]Research Scholar, Department of Commerce M.B. Govt. P.G College Haldwani Nainital, Uttarakhand

Received: 25-November-2022
Revised: 03-January-2023
Accepted: 09-February-2023

Abstract

The policy framework is the set of guidelines for planning and taking action that will make it possible to take a uniform approach to resolving health service priorities from the perspective of a rural setting. Policy directions that allow for innovation and flexibility in responding to the diversity of geographies across the Indian remote community will be based on an understanding of population and patient health, the creation of quality and sustainable care models, the recruitment and retention of engaged, skilled health care providers, and the support of enabling IT/IM tools and processes. The ability to assess the health of a population is crucial for a number of reasons, including the ability to create care models that are both effective and financially viable; the ability to attract and keep qualified medical professionals; and the ability to improve the health of a population as a whole. This article focuses on the myriad challenges and potential answers to expanding access to healthcare in remote and rural areas. There are benefits to living in rural areas, but there are also challenges, especially when it comes to ensuring that locals have easy access to quality healthcare. Isolation, distance, low population density, lack of alternative providers, and bad weather are all contributing factors to these problems. Providing adequate health care to rural and outlying areas is currently hampered by the need to accommodate a wide range of patient needs.

Keywords: Rehabilitation, Rural, Healthcare, Social policies

Introduction

Rehabilitation services integrated into primary health care may become more important as global demographic and health trends continue. The world's population is ageing and suffering from injuries and chronic diseases. By 2050, the number of people over 60 will more than double, and chronic disease rates have risen 13.7 percent in the last decade. These trends will increase the number of disabled people and put new strains on health and social systems, affecting primary health care. As the effects of chronic diseases and an ageing population persist, more and more people will need rehabilitation facilities in close proximity to their homes. Furthermore, primary health care will remain a crucial setting for spotting and referring kids with developmental, cognitive, and other congenital conditions. Because even if they never enter the hospital system, these people will still need extensive rehabilitation over time.

Most medical diagnoses, the identification of functional limitations, and the referral to other service delivery platforms must all take place in rural health care settings. The care platform also monitors whether or not a patient is following their prescribed course of treatment. All of these roles of primary health care contribute to improving patients' ability to function and quality of life over the course of their lives. Patients' physical health improves, but the provision of rehabilitation services as part of primary health care also has positive social effects. Chronic diseases in adults and children can be reduced and their disabling effects mitigated through early intervention. Dementia patients' cognitive decline can be stabilised, arthritic patients'

range of motion can be preserved, and the quality of life of children with cerebral palsy can be improved. One way to achieve this goal is to incorporate rehabilitation services into standard medical care (13, 14). Rehabilitation close to home allows people to stay independent for longer or reduce their dependence on care and financial supports, allowing them to return to school or the workforce sooner. The individual and the community both save money as a result of this. As a result of reducing the likelihood of avoidable complications and secondary conditions, primary rehabilitation can also help patients avoid costly hospitalisations and readmissions. We achieve this by decreasing the probability of complications and avoidable diseases.

Meaning of Rehabilitation

Helping those with health problems adjust to their new environments is an important part of rehabilitation. This allows for the greatest possible degree of independence and the least possible impact on daily life. Illnesses (both short- and long-term), mental and behavioural disorders, physical injuries, and psychological trauma are all considered health conditions. Additional life events, such as pregnancy, ageing, stress, a congenital anomaly, or a genetic predisposition, can also play a role in the development of a health problem. People and organisations are said to "environment" their actions in. The services of a rehabilitation centre can help anyone with a medical condition who is having difficulty walking, seeing, hearing, talking, swallowing, or thinking clearly. The impairments that limit and restrict an individual's functioning are taken into account in rehabilitation, along with other personal and environmental factors (such as the accessibility of assistive technology). Rehabilitation is a patient- or client-centered approach to health care in which interventions are tailored to the individual's unique set of circumstances and desired outcomes.

Strengthening rehabilitation in Rural health care: challenges, social policies and ways forward

As a result, rehabilitation advocates are in short supply in rural health care settings, and the field as a whole often struggles from a lack of strong leadership and planning within health systems. Health departments typically focus on mortality rates while giving top priority to both preventative and curative measures. The importance of rehabilitation to the overall health of rural populations is often overlooked, and as a result, rehabilitation is often left out of health financing and planning processes. Included in these methods is the development of comprehensive healthcare plans for rural areas.

Social policies & identified areas to action include:

- Using the Ministry of Health's plans for Rehabilitation in rural health systems, create and strengthen leadership as well as political support for rehab people at the subnational & national levels.
- Ensuring that rehab benefits is factored into health care planning as well as funding, and that countries' efforts to provide universal health care in rural areas take into account rehabilitation services. It is possible to use the already-proposed preliminary version of a "essential package of rehabilitation interventions" that is suited to use in rural community settings.
- Promoting campaigns that emphasise the individual, societal, and economic impact of rehabilitation in rural health care in order to mobilise users, people with disabilities, and rural society to advocate for the rehabilitation in such setting. By doing so, we can make sure that the rehabilitation need is heard by policymakers and those in charge of allocating funds for it.
- Encourage the growth of rehabilitation professionals' organisations that can effectively represent and further the field of rehabilitation.

Limited workforce capacity for rehab patient in rural areas

To offer rehabilitation services, the health care industry, especially primary care, must have enough qualified workers to meet the needs of the population. In primary health care, the rehabilitation workforce is made up of highly educated medical experts who work in places with more resources. Some examples of these specialists are physical therapists, rehabilitation physicians etc. But in many low-income and middle-income areas these people, when they exist, tend to stay in cities because the pay and working conditions are better there. This leaves the rest of the country uncared for. This is the case in a lot of places.

To upgrade rehab patients benefits, the health ministry must take below actions in the context of rural health care:

Investing more resources into educational and training programmes for rehabilitation workers in rural health care and offering financial incentives for patients to work within their communities. Make sure that even in rural areas, there are opportunities for rehabilitation workers to advance in their careers and earn fair wages. Schools could facilitate international student exchange programmes or create degree programmes geared towards rehabilitation professionals. Using state-of-the-art workforce modelling, we can ensure that the population's needs and the country's resources are met by a more evenly distributed set of rehabilitation specialists.

General practitioners in rural health care settings can benefit from telerehabilitation because it allows them to get advice from a rehabilitation professional even when they are far away from the patient. This is an appropriate environment for implementing telerehabilitation.

Improving the capacity and training of primary care physicians to detect the earliest signs of functional decline, refer patients in need of rehabilitation, and keep tabs on vulnerable populations at risk for the onset of health problems that could compromise their ability to function is crucial. As an additional measure, instructing rural community health workers in the art of delivering post-stroke exercise programmes.

Investing in professional-friendly work settings is key to maximising the effectiveness of the rehabilitation workforce in terms of both output and distribution. Examples of such settings include those with strong supervisory structures, ample room for professional growth, and thriving industry groups.

Review Literature

Patients in rural areas often choose not to use the local hospital, despite the fact that it provides the same level of care as other facilities. Patients' (payment type, health status, age, and race) and hospitals' (size, ownership, and distance) characteristics are found to have an impact on rural patients' decisions to seek care outside of their immediate area (Chilimuntha et.al., 2013). Residents of outlying areas have faith that urban hospitals can handle any medical emergency. Consequently, rural hospitals either remain closed or operate with no patients. Many parts of the country are inconvenient to reach because they rely on weather conditions rather than being serviced by year-round roads. As a result, there has been a dramatic rise in tardiness to work, and the facility has had to be shut down. Many government-employed physicians practise private medicine instead of going to their assigned clinics (Bhandari et.al, 2007).

Government hospitals frequently lack even the most basic healthcare facilities, such as beds, X-ray machines, and the like, making them inadequate in the face of epidemics and other potentially fatal health crises (Kumar et.al., 2012). Encephalitis is one example where the government's efforts to curb the disease's spread in rural areas have been hampered. Private medical practise has grown increasingly unchecked as a result of the indifference of public health professionals. They have some quacks in their midst. Below fifteen percent of households in both Bihar and Uttar Pradesh use government-funded programmes. Reference: (Bhat et al., 2004). Nearly 63% of rural homes rely on private practitioners for their primary medical care. Many people in rural areas mistakenly believe they are qualified to practise medicine because they have completed an allopathic medical school.

A similar situation exists for support staff, with 27 percent of pharmacist positions and 50 percent of laboratory technician positions empty (Rao et.al.). A 2007 World Bank study of Delhi's healthcare sector found that, compared to their colleagues in private hospitals, doctors in primary care centres were less competent and put in fewer hours. The graduate of the medical education programme lacks the skills necessary to perform competently in areas of need. Students who take out loans to pay for a private medical education usually want to work in fields where they can recoup their investment. When it comes to developing countries, India is the leader in the export of trained medical professionals. Nearly five percent of American doctors and almost ten percent of British doctors had medical training in India in 2008. (Kaushik, et. al, 2008). Mahalakshmi, G. (2017), clarifies how the government is currently operating and how it is promoting these much-needed and lauded health schemes in these areas. The article intended this. After reading articles in the Telugu newspaper Eenadu and other media reports, the author took action. This investigation relied on newspapers and other printed media. The towns were carefully chosen to represent different sizes and economic situations across the

nation. Maloth, C. M. (2017), study highlights ASHA workers' roles in the villages studied. ASHA employees promote family planning and reproductive and child health. ASHA workers promote reproductive health and safe motherhood, guarantee a healthy birth, limit the number of children a mother has, ensure a healthy age range for children, and provide family planning. The researcher will ask the ASHA worker a series of questions to gather information about their performance in their local communities.

Research Methodology

This research is descriptive in nature. Total 80 respondents has filled structured questionnaire out of 100. Researcher approached to rural men, women, social workers etc. The descriptive statistics & t-test has been implemented to analyse the results through SPSS. The study tried to find the gap between the social policies dimensions which has not been yet implemented in rural areas for rehab patients benefits.

Objective of the study

- The find a wide variety of strategies & social policies to improve access to health care in rural and remote communities
- To examine the relation between rehab benefits & rural healthcare network.

Hypothesis of the study

H1 : There is no significant relationship in between rehab patients' social policies & rural healthcare network
H1 : There is a significant relationship in between rehab patients' social policies & rural healthcare network

Results & Discussion

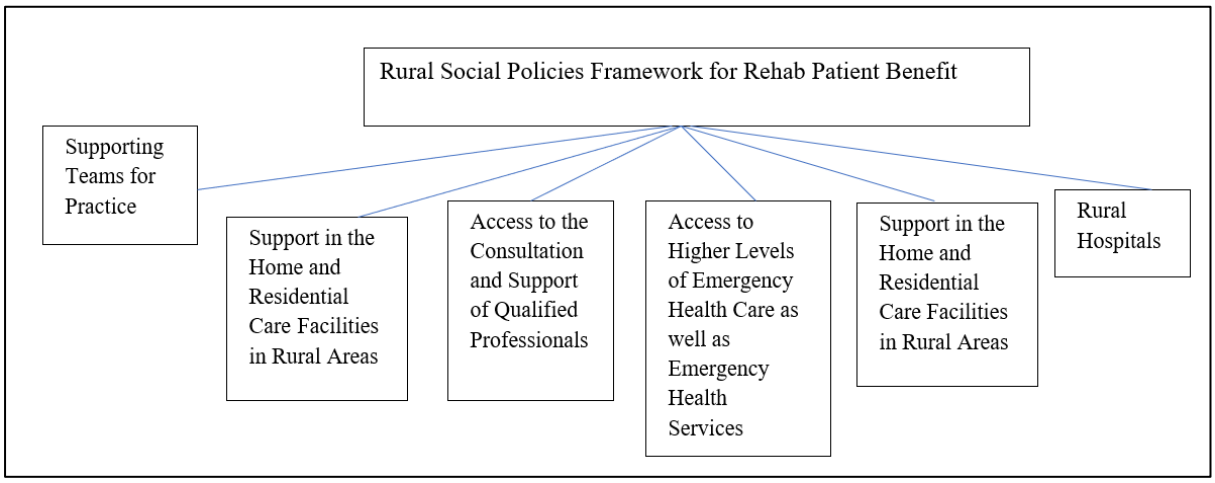

Figure 1 : Conceptual Framework

Table 1: Descriptive Statistics

Descriptive Statistics					
	N	**Minimum**	**Maximum**	**Mean**	**Std. Deviation**
Supporting Teams for Practice	80	1	4	2.97	.927
Support in the Home and Residential Care Facilities in Rural Areas	80	1	4	2.86	.901
Access to the Consultation and Support of Qualified	80	1	4	3.28	.813

Professionals					
Access to Higher Levels of Emergency Health Care as well as Emergency Health Services	80	1	4	3.49	.847
Rural Hospitals	80	1	4	3.72	.811
Support in the Home and Residential Care Facilities in Rural Areas	80	1	4	2.18	.924
Valid N (listwise)	80				

Table 1 showing the descriptive results where the statement having highest mean (Mean = 3.72 and Standard Deviation = .811) followed by "Access to Higher Levels of Emergency Health Care as well as Emergency Health Services" having highest mean value (Mean = 3.49 and Standard Deviation = .847). Similarly, the statement "Access to the Consultation and Support of Qualified Professionals" is also main dimension for rural healthcare with a mean value of (Mean = 3.28 and Standard Deviation = .813). probably the statement "Supporting Teams for Practice" plays a major role in developing rural healthcare services with a mean value of Mean = 2.97 and Standard Deviation = .927). The least mean value statements are " Support in the Home and Residential Care Facilities in Rural Areas" & "Support in the Home and Residential Care Facilities in Rural Areas" having mean values of " (Mean = 2.97 and Standard Deviation = .927) & (Mean = 2.18 and Standard Deviation = .924). The results indicates that rural hospitals are much needed for rehab patients & health ministry must opt some benefitting social policies for rural healthcare.

Table 2: One-Sample Test

One-Sample Test						
	Test Value = 0					
	T	Df	Sig. (2-tailed)	Mean Difference	95% Confidence Interval of the Difference	
					Lower	Upper
Supporting Teams for Practice	88.981	80	.000	3.054	2.27	2.98
Support in the Home and Residential Care Facilities in Rural Areas	79.903	80	.001	2.998	2.69	3.01
Access to the Consultation and Support of Qualified Professionals	94.789	80	.000	3.980	2.81	3.22
Access to Higher Levels of Emergency Health Care as well as Emergency Health Services	98.567	80	.001	3.678	3.01	3.29
Rural Hospitals	104.345	80	.000	2.789	2.76	3.19
Support in the Home and Residential Care	78.234	80	.000	2.456	2.19	3.34

Facilities in Rural Areas						

The results of t-test indicated that highest value for t-test falling for the dimension rural hospitals. It is clearly analysed that rural hospitals are highly required in remote areas and for the same, many social policies are needed to frame in this context.

Hypothesis Testing Results

The observed findings of the study highlight that rural hospitals is the most important dimension which somehow the main reason to frame social policies for rehab patients. Although, health care as well as emergency health services is also one of the main reason for the same and therefore, the null hypothesis "There is no significant relationship in between rehab patients' social policies & rural healthcare network" is rejected & alternative hypothesis is accepted.

Findings of the Study

- Reliable and user-friendly rehabilitation referral systems should be established both inside and outside of primary care settings. Referral mechanisms are said to "keep up" with services if they are able to adapt to the increasingly complex and disjointed nature of medical care.
- It is of the utmost importance to inform and educate the rural health care workforce on the importance of early referral to rehabilitation programmes as well as the numerous benefits that can be gained from undergoing rehabilitation for a wide variety of health conditions. Staff members can be reminded to discuss rehabilitation options with patients through the implementation of various measures, such as in-house educational sessions, tweaks to existing protocols, and visual cues installed in the workplace.
- Creating more settings where health care professionals in rural areas can work together to improve patient care and rehabilitation services is a priority. Rehabilitation referral rates can be improved through team meetings, co-location of services, and other inter-professional models of service delivery, among other strategies for building mutual understanding and trust among rural health care providers.

Conclusion

Rehabilitation is a great illustration of the fundamental qualities and benefits of rural health care, despite the fact that it has not been integrated very well up to this point. It addresses the broader health determinants through multisectoral coordination, improves accessibility for people with rehabilitative needs, and provides individuals and families with the tools they need to take control of their own health and functionality in the face of a wide range of underlying health conditions. Immediate action is required to overcome the difficulties inherent in elevating rehabilitation to a higher position on the rural health care agenda in all outlying areas, regardless of the level of resources available in those places. As populations age and the number of individuals living with noncommunicable and chronic health conditions rises, the global demand for rehabilitation services will increase. In order to keep up with this rising need, the health care system as a whole, but especially rural health care delivery, must expand. It is forecasted that the historically erratic growth rates of India's rural areas will persist into the future. The implications of these changes for the sustainability of local economies and the provision of essential services in rural areas may be substantial even if the absolute changes are not. Oftentimes, sudden changes in the demographic composition of a population accompany such population shifts. In many parts of the country, the elderly population is disproportionately affected when the younger generation leaves rural communities in search of other employment or educational opportunities. Because of the lack of assistance available, it is more challenging for these seniors to overcome obstacles like lack of transportation to reach medical care. Many rural areas have a young population, and as a result, their communities' infrastructures have evolved to accommodate them. Many of these neighbourhoods are like this. Concerns about the ability of local communities to care for an ageing population are beginning to surface as the population ages.

References

1. Bosch-Bayard RI, Llibre-Rodriguez JJ, Fernández-Seco A, Borrego-Calzadilla C, Carrasco-García MR, Zayas-Llerena T et al. Cuba's strategy for Alzheimer disease and dementia syndromes. MEDICC Rev. 2016;18(4):9–13. doi:10.1590/medicc.2016.18400004.
2. Bhat, Ramesh and Nishant Jain (2004): Analysis of Public Expenditure on Health using state level data, Indian Institute of Management (IIM), Ahmedabad, June' 2004 (excerpted from http://www.iimahd.ernet.in/publications/data/2004-06-08rbhat.pdf).
3. Bhandari, Laveesh and Siddhartha Dutta (n.d.): Health Infrastructure in Rural India (accessed at www.iitk.ac.in/3inetwork/html/reports/IIR2007/11-Health.pdf).
4. Chilimuntha, Anil K., Kumudini R. Thakor and Jeremiah S. Mulpuri, (2013): Disadvantaged Rural Health – Issues and Challenges: A Review. National Journal of Medical Research, 3 (1), 80-82, (excerpted from http://www.scopemed.org/?mno=36128).
5. Hubermann L, Boychuck Z, Shevell M, Majnemer A. Age at referral of children for initial diagnosis of cerebral palsy and rehabilitation: Current practices. J Child Neurol. 2016;31(3):364–9. doi:10.1177/0883073815596610-r.
6. Kanchanachitra, C., Lindelow, M., Johnston, T., Hanvoravongchai, P., Lorenzo, F. M., Nguyen, L. H., Wilopo, S. A., & dela Rosa. J. F. (2011). Human resources for health in southeast Asia: shortages, distributional challenges, and international trade in health services. The Lancet, 357(9767), 769-781.
7. Kumar, Avneesh and Saurav Gupta (2012): Health Infrastructure in India: Critical Analysis of Policy Gaps in the Indian Healthcare Delivery, (Occasional paper), Vivekananda International Foundation (excerpted from http://www.vifindia.org/sites/default/files/health-infrastructure-in-i ndia-critical-analysis-of-policy-gaps-in-the-indian-healthcare-delivery.pdf).
8. Kaushik, Manas, Abhishek Jaiswal, Naseem Shah and Ajay Mahal (2008): High-end physician migration from India, Bulletin of the World Health Organization, 86(1).
9. *Lamba, K., & A. (2021). Infant Mortality, Poor Child Health and Other Deprivation: A Challenge for Sustainable Development Goals in Haryana. Kaav International Journal of Economics, Commerce & Business Management, 8(2), 1-6.* https://doi.org/10.52458/23484969.2021.v8.iss2.kp.a1
10. Mahalakshmi, G. (2017). A Study On The Opportunities For Corporate Participation In The Health Schemes Initiated By The Government In Rural Areas Of Andhra Pradesh. Kaav International Journal of Economics, Commerce & Business Management, 4(2), 101-108.
11. Maloth, C. M. (2017). Asha Role Performances In Reproductive And Child Health (R&Ch) Care And Family Planning In Warangal District Of Telangana State. Kaav International Journal of Arts, Humanities & Social Science, 4(3), 11-20.
12. Nguyen C, Lefevre-Colau MM, Poiraudeau S, Rannou F. Rehabilitation (exercise and strength training) and osteoarthritis: a critical narrative review. Ann Phys Rehabil Med. 2016;59(3):190–5. doi:10.1016/j. rehab.2016.02.010.
13. Rao, Mala and David Mant (n.d.): Strengthening primary healthcare in India: white paper on opportunities for partnership, BMJ Journals
14. Shaikh, S. A., Ismail (2016). Environmental Pollution: Health Effects And Operational Implications For Pollutants. Kaav International Journal of Science, Engineering & Technology, 3(1), 14-26.
15. World Health Organization. Environmental health in emergencies. Accessed October 31, 2018. Retrieved from https://www.who.int/environmental_health_emergencies/en/
16. World Health Organization. (2006). The World Health Report 2006 – working together for health. Retrieved from https://www.who.int/whr/2006/en/ .