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Health care in Uttar Pradesh: Tackling Urban-Rural Disparities

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Abstract: A society's health is directly correlated to the social and economic inequality. India being a multicultural, diverse and yes, overpopulated nation, bridging the gap between such inequalities is of utmost importance. Even though India has seen rapid economic growth in the past few decades, the growth is uneven. This uneven growth can be seen through the current healthcare system in our nation. This paper tries to shed some light on the disparity between the rural and urban population and its effect on the economy. An effort has been made to find a probable way forward.

INTRODUCTION

In rural parts of India, children and adults face a life full of uncertainty. Earlier, food was considered to be the key element to survive but as time evolves, as the society faces more complex challenges every passing day, spending patterns keep shifting among urban and rural population. According to the latest National Sample Survey Organization (NSSO), food is not the predominant expenditure for rural population. In fact, the combination of healthcare and non-food category has taken a major chunk of rural expenditure.

Many a times India has been criticized for having one of the emerging world's most dilapidated health systems. Even though, the government has put in efforts to tackle such claims, by recently increasing the spending on health to 3% from 1% in our nations GDP, we are yet to find a solution to our problem.[1] Our nation's 75% of health infrastructure which consists of doctors, surgeons, specialists and other resources;have a higher density in the urban cities where only 27% of India's citizenry resides[2]. There is no doubt that there is a persistentscarcity of adequate health services for the rural population. The majority of the healthcare indicators which we will come across further down the study show the sad predicamentthat the rural healthcare system faces. Policymakers often argue that there is a close relation between gender inequality and unequal access to healthcare. Multiple pregnancies, predilection for sons, feeling of powerlessness to

take a stance against the family along withunderlying patriarchal social customshave impacted the health of women, including maternal mortality, infant mortality, ante-natal anemia, low birth weight among others. We will touch upon this argument later in this study.

It's not only the adequate medical care we need to focus on but, also the preemptive care facilities.Every 5th year plan raises this point, every year the plans are shelved, and year after year we come up with a brand new death statistic. So the question to ask is;

Where are we going wrong?

LITERATURE REVIEW

Rama Baru et al (2010) in "Inequities in Access to Health Services in India: Caste, Class and Region" have given us a deep insight on how inequities are caused and the factors that further deepen these inequities. They have briefly considered the three major forms of inequities: historical, socio-economic, and in form of provision and access. What's interesting is the explanation of key determinants; availability, affordability and accessibility. Furthermore, they have explained the inequities in preventative and curative services. There is a fundamental setback in utilizing such services to its capacity. They indicators may or may not be at an acceptable level but there is a considerable amount of variation across socio-economic groups. Even if such services are available, the question of affordability again sets us back. There is an ever widening gap in the health expenditure burden between across class, caste and region. People who can't finance healthcare directly through household resources depend on borrowings. Poorer section of the society relies significantly on borrowing but this only adds to further impoverishment of the households. The government expenditure on health is low when compared with other countries at the same level of income; there is lack of investment. This has led to accelerating the privatization of health services. There are other factors that add to this demise but the key to moving forward would be to investing more, comprehensive regulation of public and private sectors, new system of evaluating performance and progress of the industry, and keeping health security as a priority in our nation.

Like Mac Orlan once said, "Humanity is first and foremost a stomach". It's true for our nation. Jean Dreze (2012) expresses great concern for nutrition in the society; however, the policymakers neglect these issues. The undernutrition levels are extremely high; the body mass index also supports the argument. A decent society cannot be built when hunger, malnutrition and ill health are so prevalent in our nation. One of many astounding facts is that there are only two other countries (Bangladesh and Nepal) that have a higher proportion of underweight children in India. In fact, Bangladesh is doing better than India in terms of wide range of nutrition and health indicators, in spite of much slower economic growth and lower baseline incomes. This calls for a reconsideration of the food policy in our country. Beyond the existing programmes such as mid-day meals, NREGA etc., there is scope for further improvement by putting in legal safeguards for children's right to food. The situation is alarming and it hasn't reached a point of resolve. Furthermore, Ashok Kotwal (2012) reminded us how India has the dubious distinction of having the largest share of world's poor. Around 80.36% of India's population earns less than $2 a day. At such strikingly low level of income, a chronic poverty cycle begins. Poverty results in malnutrition, low level of education, lack of physical strength, which lowers the chances of employment. In rural areas, the population has little access to health care facilities; therefore, infant mortality rates are naturally high in them. This leads them to overcompensate in order to earn a living. More members of the family, more people to contribute to the family income. But, this also raises the number of mouths to feed. And thus, poverty begets poverty.

PURPOSE OF THE STUDY

There has always been a gap between the rich and the poor. The sad truth is that penurious families will remain a victim of poverty, regardless of their potential and endurance. Why?We have anexpansivedomain of services like hospitals, diagnostics and device manufacturers, pharmaceutical companies, drug manufacturers, health technology, information providers etc. One of the most vital requirements of healthcare are doctors in rural areas but India is facing a 64% shortage at present. A shortage of more than 12,300 specialists should be a cause for concern. Moreover, there are vacancies for 3,880 doctors in the system along with the need for 9,814 health centers. [3] Unnerving. The facts are out there, but, we aren't getting any close to a solution. By the end of this paper, after looking at the key indicators of health in India, we will discern the existing disparities, we will gain cognizance into the rural-urban imbalance existing in our country currently. The health industry has been expanding, but we will set a contrast and see whether it is really helping rural India grow.

We will observe Uttar Pradesh, one of the poorest states in India that is under high focus and compare the results with one of the general category states for example; Karnataka. Comparison with Karnataka or any one of the general category states will help set a benchmark. A field of possibilities and potential, if I may. It will give us a coherent view of the current situation. Then, we may find answers to whether there is any hope left for rural India.

PROMISING HEALTHY INDIA

First off, we need to understand the healthcare system that currently exists in rural parts of India. Essentially, the rural healthcare system is divided into three tiers; Sub Centres, Primary Healthcare Centres (PHC), Community Healthcare Centres (CHC) as seen in Figure 1. At a rudimentary level, there is a need for PHCs and CHCs in the rural healthcare system.The PHCs have a capacity of serving roughly 20,000 people in tribal and hilly region and about 30,000 in the plains. Whereas, CHCs holds an extent to serving 80,000 people in tribal and hilly regions and about 120,000 in the plains.[4]

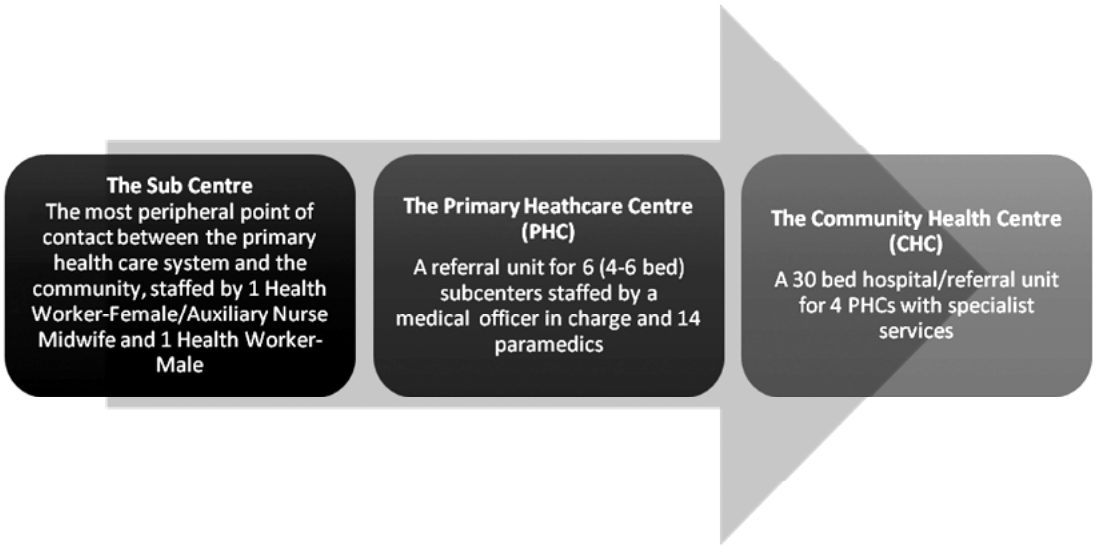

Figure 1: Healthcare Infrastructure in Rural India

However, according to the National Rural Health Mission (NRHM), there are some staggering finds about our current healthcare system. The rural population has a supply of doctors that is six times lower than that provided to the urban population. The ratio of rural beds provided in relation to the population is even lower when compared to the urban population; 1:15. For each bed provided to the rural population, there are 15 for the urban population. Only a mere 34% of rural population has access to preventive medicines and 31%, an even more trifling number, have to travel more than 30kms to get the required medical care. Even the existing PHCs aren't fully equipped; 3,660 lack an operation theatre or a laboratory or both. The existing labs in PHCs, 39% are without a lab technician at present. Half of the specialist's post that is, obstetricians, pediatricians, and gynecologists; in PHCs as well as CHCs are vacant. An even more staggering statistic is that there is a deficit of 70.2% of specialists in CHCs. In rural areas, infectious disease still sway the morbidity pattern at a much higher rate than that in urban areas; 40% for the former while only 23.5% in the latter. As a nation, the odds are pretty much against us in this case.[5]

Furthermore, "India bears the world's greatest burden of maternal, newborn and child deaths" - World Health Organization. The latest Rural Health Statistics 2015 released by Ministry of Health and Family Welfare shows that there is an inadequacy of 83% for specialists in CHCs in India. Uttar Pradesh has a whopping shortage of 85.5% compared to a much lower statistic, 37.9%, in Karnataka.

To add to that, there is 76% shortage of obstetricians and gynecologists in CHCs nationwide, In Uttar Pradesh, again the numbers are high; 85.1% while Karnataka has only a mere 16% shortage. We can see the staggering difference in the facilities provided. Many factors play a role in causing these inequities and the statistics show an alarming situation, but, we are yet to put in adequate resolve and resources into the matter.

Specialized medical treatment has proven to be perverse in rural India which had propelled rising number of people to much expensive private sector. 58% of hospitalized treatment in rural Indiawas

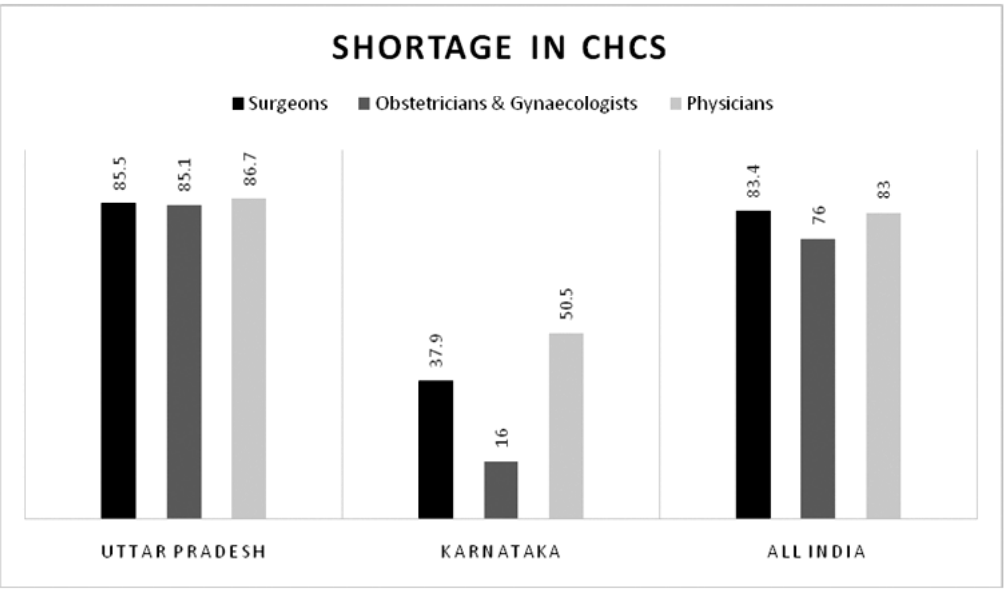

Figure 2: A contrast between UP, Karnataka and All India

undertaken by private hospitals while in urban India, 68%, according to the Key Indicators of Social Consumption on Health 2014 survey carried out by National Sample Survey Office (NSSO). [6]

KEY INDICATORS: WHAT STORY DO THEY TELL?

Infant Mortality Rate (IMR) indicates, much like a barometer, the country's populace's health status. In that way, it's also a vital gauge of human development. However, IMR remains a blatant concern around the world despite growth in technology and medical science. India aims to reduce the cause dramatically in the coming years. According to the Sample Registration Survey of India (2012), we have the following figures:

We have successfully reduced the IMR from 50/1000 live births (2009) to 42 in 2012. However, it is far from reaching the individual target of having 27/1000 by 2015 as shown in Figure 3. [8]Note the gap in

Table 1
Key Indicators of Health; Rural vs Urban

Mortality Indicators	*Total*	*Rural*	*Urban*
Crude Death Rate	7.0	7.6	5.6
Percentage of infant deaths to total deaths	13	14.2	8.6
Percentage of deaths of less than one week to total infant deaths	53.3	55.0	42.9
Under-five Mortality Rate	52	58	32
Infant Mortality Rate	42	46	28
Neo-natal mortality rate	29	33	16
Early neo-natal mortality rate	23	25	12
Late neo-natal mortality rate	6	7	4
Post neo-natal mortality rate	13	14	12
Still Birth	5	5	5

[7] Source: Sample Registration System, 2012 - figures at a glance, India

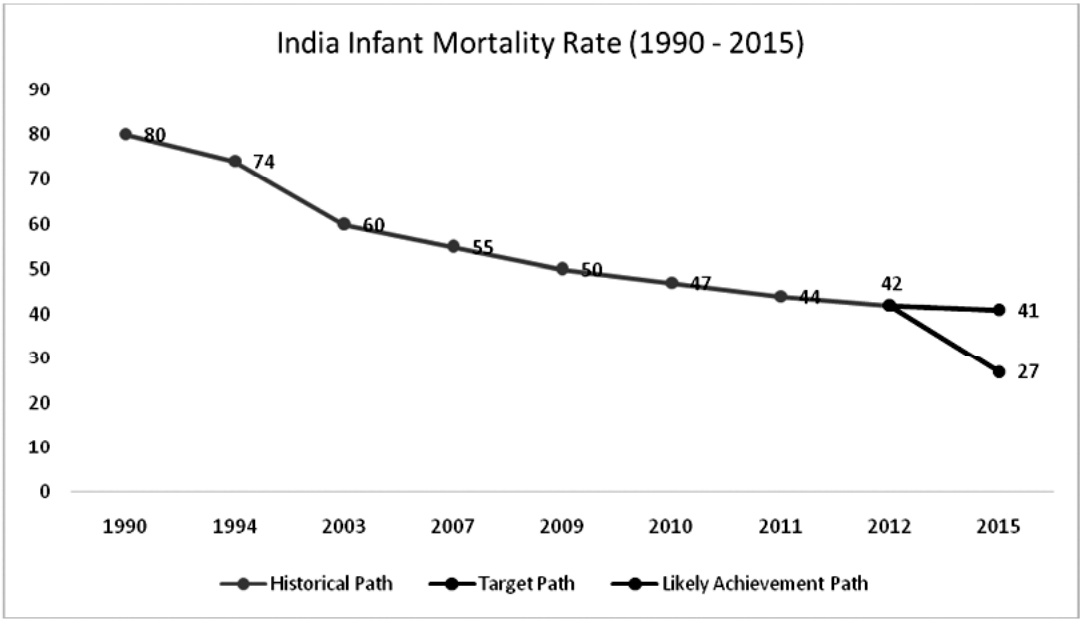

Figure 3: Infant Mortality path over the years

IMR between the rural population and urban population; a clear indication of how unequipped the system is. There are steps being taken to fortify the statistics, new plans and policies being set in place by the Ministry of Women & Child Development, but, I feel there is insufficient enactment.

Around 300,000 infants across India die within 24 hours of being born. The highest number in the world. In most cases, the cause of death is preventable such as low birth weight, prematurity, asphyxia, birth trauma etc. It is a worrisome figure because while India constitutes nearly 30 states, 9 of them rank very lowin terms of their child health and maternal statistics. Uttar Pradesh is one of them while Karnataka isn't. These nine states cover 48% of our nation's populace and 59% of the births and even then the mortality rates are so high. [9]

In Figure 4, we can see that 62% of maternal deaths are accounted for by these nine states. Maternal health is one of the most pressing challenges that India faces and efforts are being made.

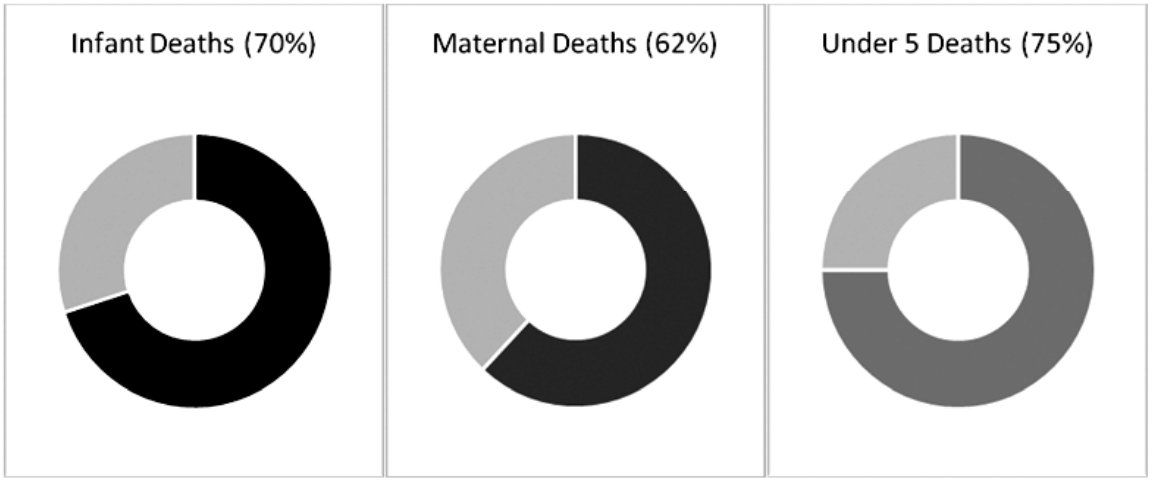

Figure 4: Mortality proportion in the nine states

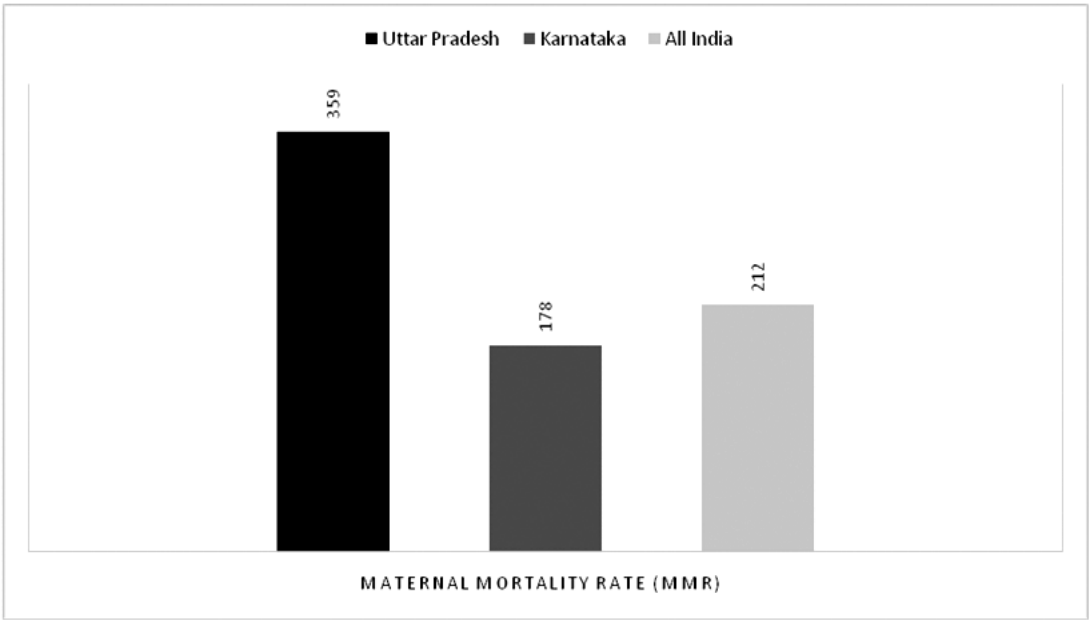

Figure 5: Maternal Mortality Rate in Karnataka, Uttar Pradesh and All India (2009)

However, the promise that our nation had made to bring down maternal mortality rate from 390 in year 2000 to 109 by 2015 has been broken. Approximately 47,000 pregnant women or new mothers die each year and yet again, in most cases, cause of death is preventable such as hemorrhage, sepsis and anemia.[10]

The challenges faced by mothers living in rural areas are different than the ones faced by mothers living in urban areas. In rural areas, as mentioned earlier, there are less resources such as doctors, nurses etc. available and therefore, there is a low fraction of institutional deliveries. This paucity of health infrastructure that is essential for pre and post-partum care leads to an increase in MMR. Unawareness and misconceptions surround pregnancy and childbirth practices. Delivering a child at home is a common phenomenon, plus, lack of hygiene constitutes a threat to both; mother and child.Institutional delivery curbs maternal mortality and other complications. National Family Health Survey – III shows that the percentage of births that took place under institutional care was only 40.8%. In rural areas, it was less than half (31.1%) of that in urban areas (69.4%). Births that were assisted by a doctor or nurse or other health personnel nationwide was 48.8%. Rural population again faces a significant hitch with only 39.9% while urban population was at 75.3%. Mothers who received postnatal care from a doctor or nurse or other health personnel within 2 days of delivery for their last birth nationwide was only 36.8%, in rural areas 28.5%, and in urban areas 60.8%.[11] Despite the efforts, the gap between the facilities provided in rural areas and in urban areas is wide. In Uttar Pradesh, the delivery care has the following distribution:

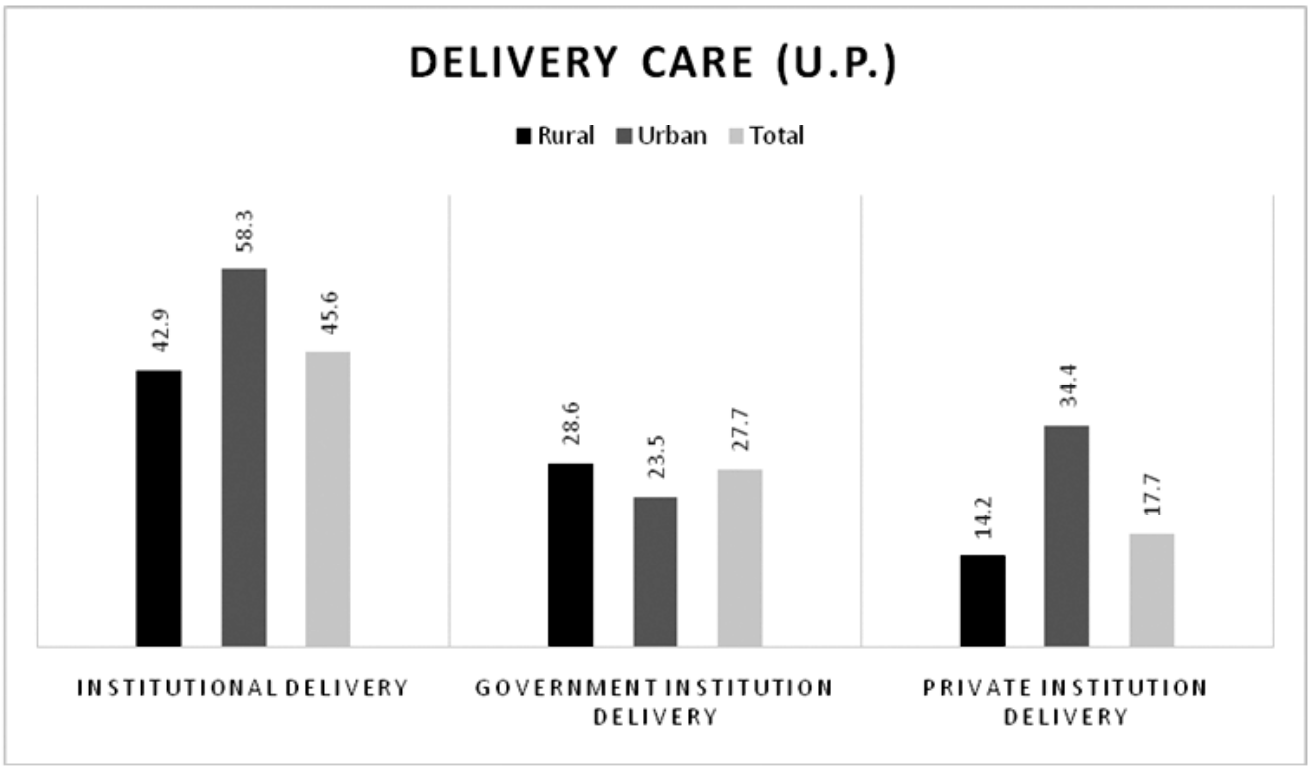

Figure 6: Institutional delivery distribution (left to right); overall, government institution, and private institution[12]

***Source*: http://www.censusindia.gov.in/vital_statistics/AHSBulletins/AHS_Baseline_Factsheets/U_P.pdf**

JOURNEY TILL NOW

Janani Suraksha Yojana (JSY), launched in 2005, works towards reducing the level of maternal mortality and neonatal mortality. Under this scheme, each eligible woman is taken care of from the time of her pregnancy. Pregnant women that belong to households below the poverty line and are above 19 years of age are eligible for up to two live births. JSY takes the responsibility of providing the necessary supervision on a regular basis. Every pregnant women registered under the scheme receives help in form of cash, antenatal care during pregnancy, institutional care pre and post-partum. Once we have a look at the journey of JSY through the years, we can see that there was a sharp decline in MMR rate in 2003-06 as compared to that in 2001-03. With this pace, we might actually be able to bring down the maternal mortality rate to 139 from 212 next time around.[13]

JSY was taken forward with the help of a huge network built by Accredited Social Health Activists (ASHA). The ASHA identifies a pregnant woman as a beneficiary and staystill the woman delivers in a health institution. ASHAs are encouraged for every pregnant woman they tend to till the health institutions so it's not just the mothers. It's a step forward to ensuring that preference for sons and failure to beget sons, and familial pressure doesn't strip women of any say in their health.

Here, Uttar Pradesh as well as Rajasthan, both high focus states, experienced a drastic raise in the number of institutional deliveries in rural areas.

According to AHS, one in 25 children nationwide don't receive any vaccine at all.[15] Universal Immunization Programme is working towards tackling the same problem by providing free vaccines.

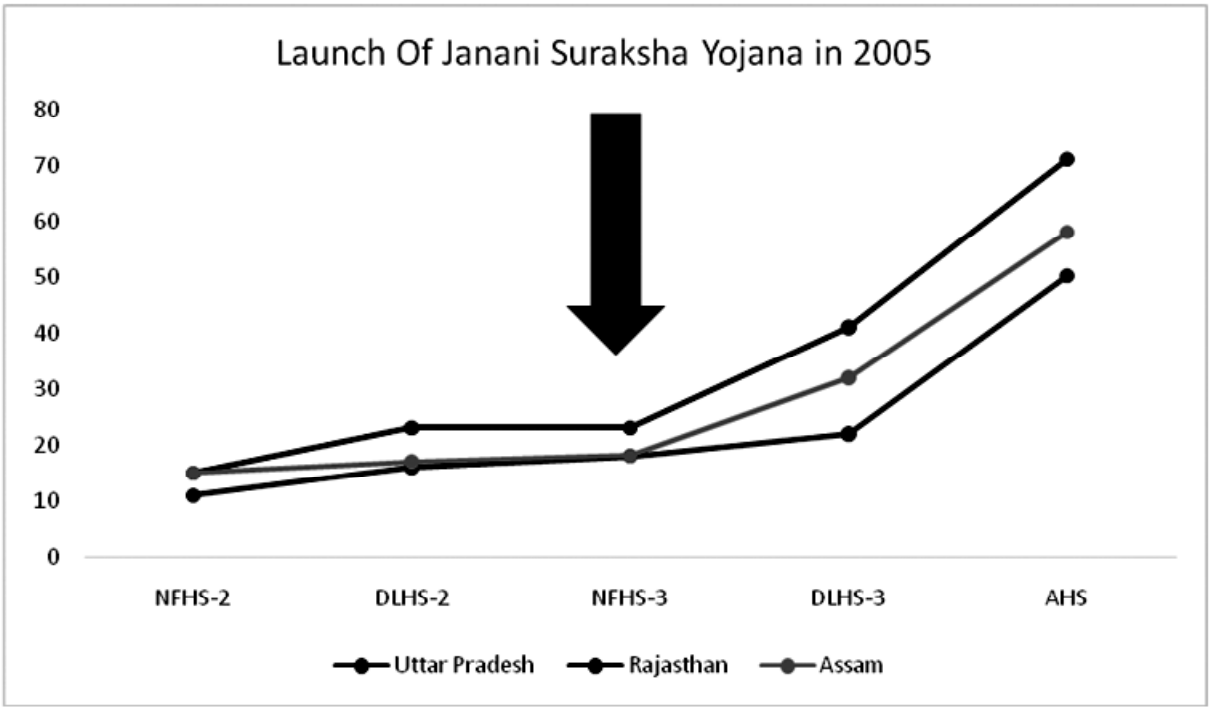

Figure 7: Increase in the number of Institutional Deliveries in rural areas after the launch of Janani Suraksha Yojana in 2005

***[16] Source*: http://www.nielsen.com/in/en/insights/reports/2014/delivering-with-care-.html**

However, 1 in 3 children are yet to be given all the vaccines made available. Making efforts towards reducing IMR will require actions that will impact chronic poverty, limited health access, and a lack of awareness. Problems that can't be tackled immediately. So, what do we do?

A PROBABLE WAY FORWARD

World Health Organization has defined "mHealth or mobile health as medical and public health practice supported by mobile devices, such as mobile phones, patient monitoring devices, different kind of Personal Digital Assistants (PDA), note pads and other wireless devices".[17]mHealth includes different applications designed for monitoring lifestyle, patient's condition, education, training and mass scale messaging for information. It may be considered as a tool to support a healthcare practitioner for efficiency and quality care as well as empowering a patient for self-care and monitoring.

In urban hospital set ups, mobiles already have significant presence. Mobile phones have immense supremacy in daily operations in a hospital for both; clinical and administrative purposes.

For rural population, by now we know that regular monitoring of vital signs is a very expensive affair. The urban subscriber base grew to 532.73 million while rural subscriber base reached to 371.78 million on March 31, 2014 from 342.50 million on March 31, 2013 and expected to further grow in next few years.[18]Good health of rural population is an asset and resource for the development of the country. Awareness about the health and diligent primary care by the rural population will enhance the productivity and also save expenditure on the healthcare. mHealth provides a great potential to address these issues apart from information dissemination, counselling and perhaps health condition monitoring.

CONCLUSION

The socially underprivileged are unable to access healthcare services due to geographical, social, economic or gender related distances. Keeping in mind that even after a rapid economic growth the gaps between rural and urban living conditions keep on widening, we need to take innovative steps to curb this difference. The key indicators of health have shown that India has one of the least developed healthcare systems and it is high time we approach innovative methods to tackle this problem. The mHealth approach may be one of those leading tools to spread awareness and therefore, deliver a better result in addition to the existing policies in place. mHealth provides an opportunity to transform healthcare delivery and empower patients to avail healthcare services anytime, anywhere.

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