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CONTENTS

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STATEMENT OF THE PROBLEM

OBJECTIVES

HYPOTHESIS (ES)

RESEARCH METHODOLOGY

RESULTS & DISCUSSION

FINDINGS

RECOMMENDATIONS/SUGGESTIONS

CONCLUSIONS

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CARE FOR INDIA: TACKLING URBAN-RURAL DISPARITIES: URBAN VS. RURAL ACCESS TO HEALTHCARE SERVICES IN UTTAR PRADESH

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KAMALA NEHRU COLLEGE
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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 effects. We hope to find a probable way forward.

KEYWORDS
healthcare services, healthcare system.

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) survey, 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 spends.

Many a times India has been criticized for having one of the emerging world's most ramshackle 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] Around three-fourth of the health infrastructure in India – including doctors, specialists, and other healthcare resources – are concentrated in the urban cities where only 27% of India's population resides[2]. There is no doubt that there is a chronic lack of proper health services for the rural population. The majority of the healthcare indicators which we will come across further down the study, show the sad state of affairs in the rural healthcare system in India. Policymakers often argue that there is a close relation between gender inequality and unequal access to healthcare. Multiple pregnancies, preference for sons, inability to take a stance against the family, and underlying patriarchal social mores – have impacted on the health of women, including maternal mortality, infant mortality, low birth weight, ante-natal anemia among others. We will touch upon this argument later in this study.

It is of utmost importance to ensure proper medical care as well as preemptive care facilities. In fact, it is mentioned regularly in every 5th year plan but somehow the plans all end up being shelved and every year economists come up with new death statistics. So the question to ask is;

Where are we going wrong?

1. Rama Baru and other co-writers of "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 elements; availability, affordability and accessibility. Furthermore, they have explained the inequities in preventative and curative services. The factors affecting inequities are of importance as the government can take the lead in changing the circumstances. They play an essential role in the way forward.
2. "Humanity is first and foremost a stomach" – Mac OrlanJean Dreze 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.
3. 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 children and grandchildren of the poor will remain impoverished, regardless of their potential and hard work. Why?

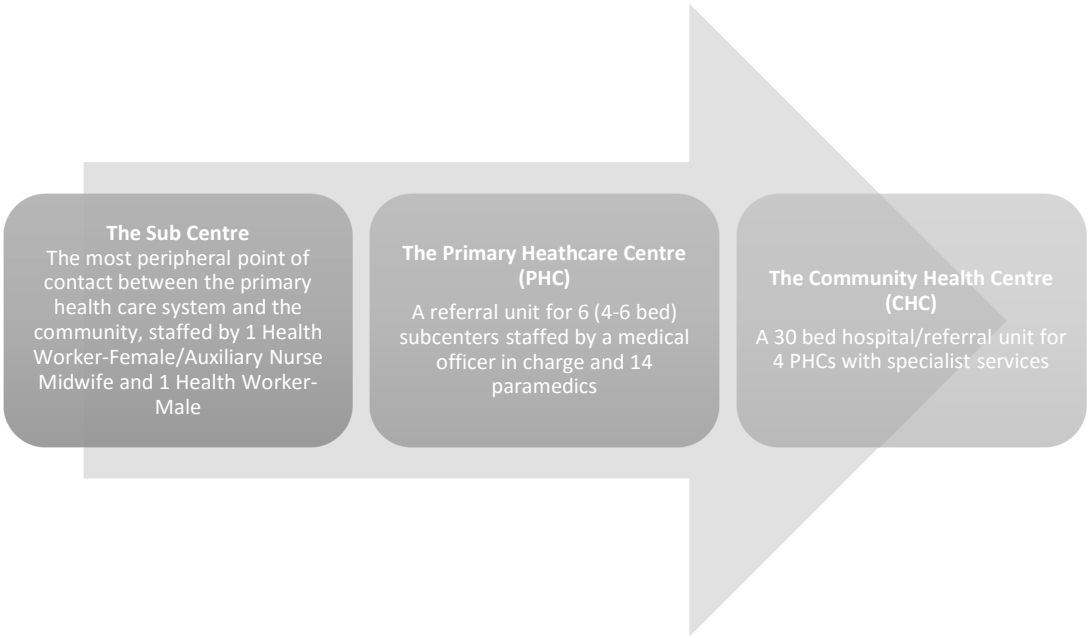
The healthcare industry currently holds a wide range of services like hospitals, pharmaceutical companies, drug manufacturers, diagnostics and device manufacturers, and health technology and information providers. One of the most critical requirements for healthcare in rural areas is doctors. Doctors and medical specialists are an integral component of the Indian healthcare system but rural India is currently facing a 64% shortage of doctors. Rural India faces a shortage of more than 12,300 specialist doctors. There are vacancies for 3,880 doctors in the rural healthcare system along with the need for an astounding 9,814 health centers. [3] The facts are out there, but, we aren't getting any close to a solution.

We will look at Uttar Pradesh, one of the poorest states in India, in order to understand the current scenario and 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. The rural healthcare programme in India, structured in the three tiers below, has a basic need for Primary Healthcare Centres (PHC) and Community Health Centres (CHC). These PHCs can serve approximately 20,000 people in tribal and hilly areas and around 30,000 people in the plains, while the CHCs can serve approximately 80,000 people in tribal and hilly areas and around 120,000 people in the plains. [4]

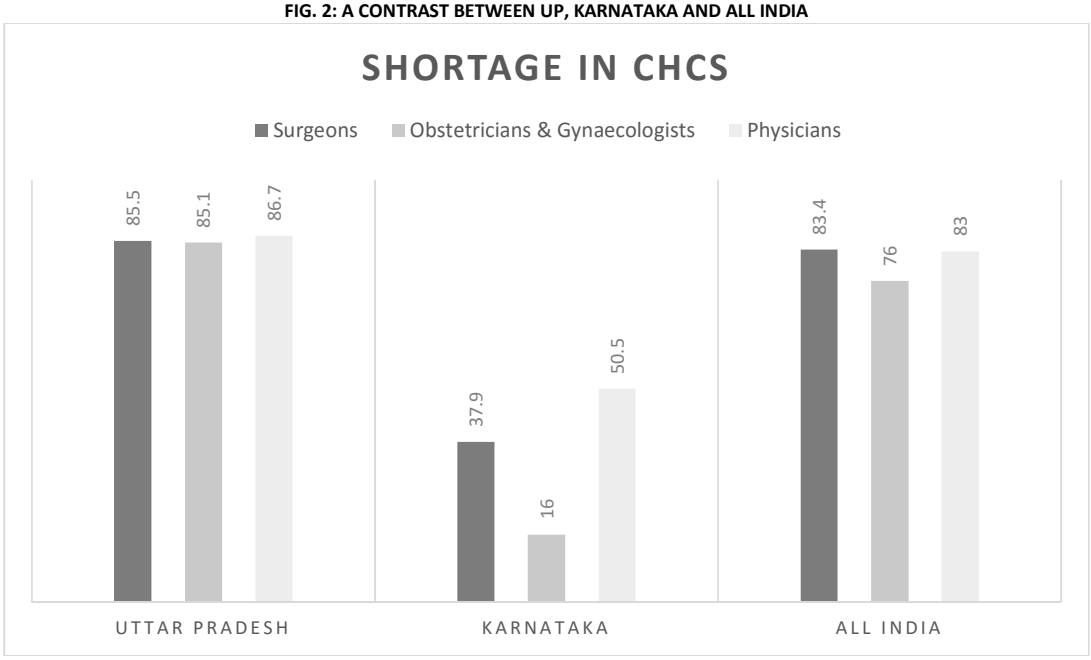
FIG. 1: HEALTHCARE INFRASTRUCTURE IN RURAL INDIA



However, according to the National Rural Health Mission (NRHM), there are some staggering finds regarding this subject. That is, the ratio of rural population to doctors is six times lower than in urban areas. The ratio of rural beds vis-à-vis the population is 15 times lower than in urban areas. 66% of the rural population in India lacks access to preventive medicines. 31% of the rural population in India has to travel over 30 km to get needed medical treatment. 3,660 PHCs in rural India lack either an operation theater or a lab or both. 50% of the posts for obstetricians, pediatricians, and gynecologists in PHCs or CHCs are vacant. There is a 70.2% shortfall of medical specialists in CHCs. 39% of PHCs are currently without a lab technician. Infectious diseases dominate the morbidity pattern in rural areas: 40% in rural areas vis-à-vis 23.5% in urban areas. As a nation, the odds are pretty much against us in this case. [5]

But, wait, there's more. According to the latest Rural Health Statistics 2015 released by Ministry of Health and Family Welfare, there is an 83% of specialist medical professionals in CHCs. In case of Uttar Pradesh, it is a whopping 85.5% compared to mere 37.9% in Karnataka. India bears the world's greatest burden of maternal, newborn and child deaths. 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.

FIG. 2: A CONTRAST BETWEEN UP, KARNATAKA AND ALL INDIA



Such statistics show that specialized healthcare treatment in rural India is difficult, which has driven rising number of people to costlier private healthcare. In rural India, 58% of hospitalized treatment was carried out in private hospitals, while in urban India the figure was 68%, according to the Key Indicators of Social Consumption on Health 2014 survey carried out by National Sample Survey Office (NSSO).

KEY INDICATORS: WHAT STORY DO THEY TELL?

A country's infant mortality rate (IMR) is considered as a barometer measuring health status of its people. In that way, it's also a vital indicator of human development. But despite advancements in technology and medical science, IMR remains a marked concern around the globe, including India, where the cause is one the nation aims to dramatically reduce by next year. According to the sample registration survey of India (2012), we have the following figures:

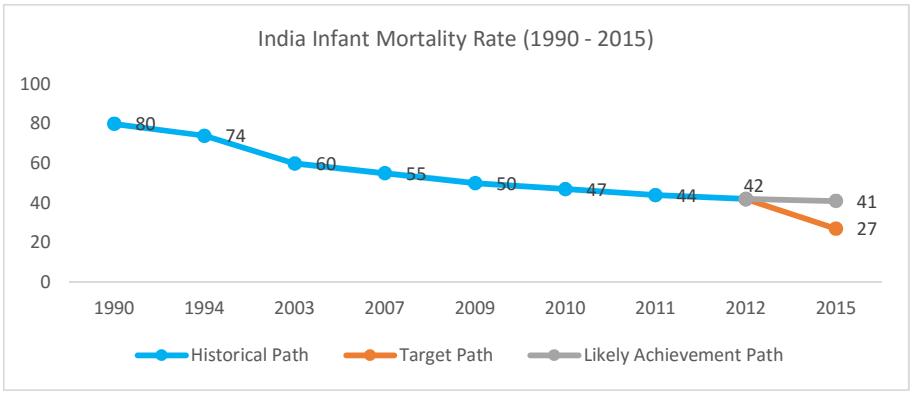
TABLE 1

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]

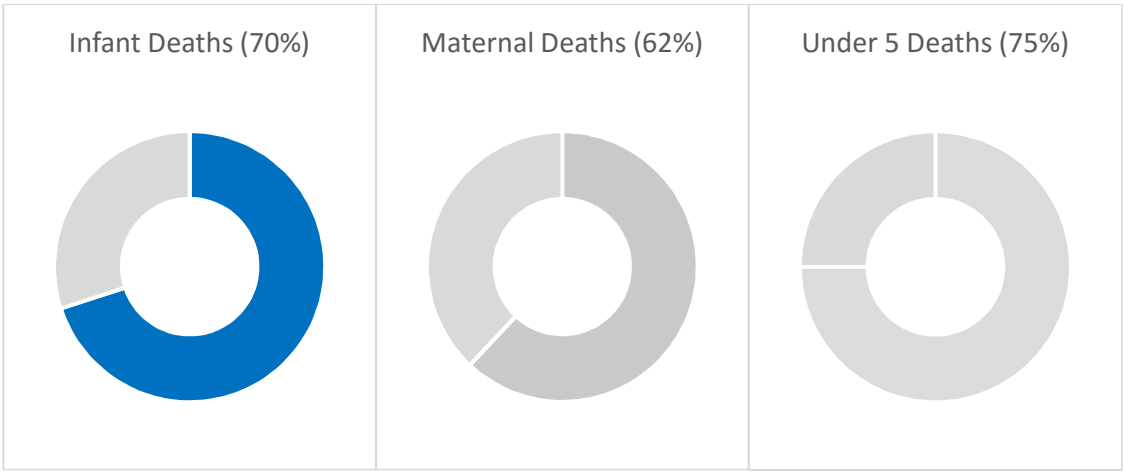
India has reduced its IMR from 50 per 1,000 live births in 2009 to 42 in 2012, but the country is far from reaching its individual goal of having an IMR of 27 by 2015. [8]

FIG. 3



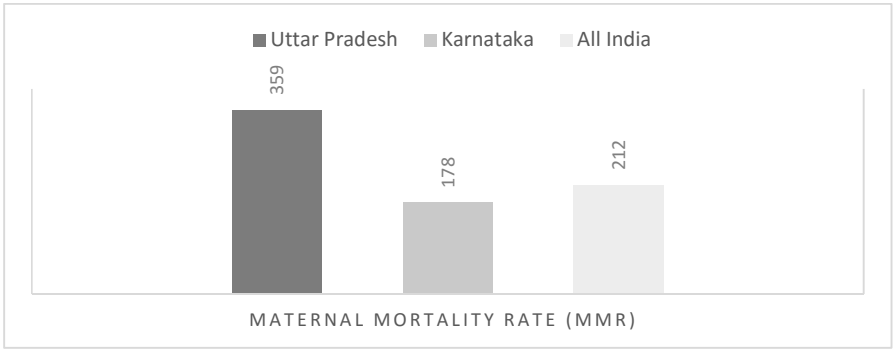
Around 300,000 infants across India die within 24 hours of being born. Furthermore, the cause of death is preventable is majority of cases such as prematurity, low birth weight, asphyxia and birth trauma. It is in fact the highest number in the world. We should be worried because while India comprises of nearly 30 states, nine of them rank very low in terms of their maternal and child health statistics. Uttar Pradesh is one of them. These nine states cover 48% of India's population and 59% of the births and even then the mortality rates are so high. [9]

FIG. 4



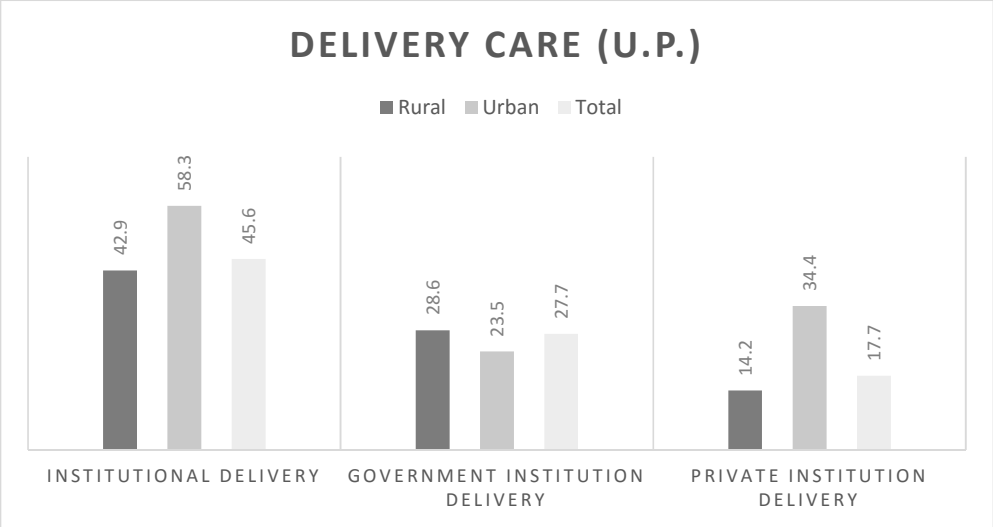
From above, we can see that these nine states account for 62% of maternal deaths. Maternal health is one of the most pressing challenges that India faces and efforts are being made. However, the promise that our nation had made to bring down maternal mortality rate from 390 in year 2000 to 109 by 2015 has been broken. Approximately 47,000 pregnant women or new mothers die each year by a majority of preventable causes, yet again, such as hemorrhage, sepsis and anemia. [10]

FIG. 5



The challenge 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 proportion of institutional deliveries. This lack of health infrastructure that is essential for pre and post-partum care leads to an increase in MMR. The practices around pregnancy and childbirth remain steeped in unawareness and misconceptions. Delivering a child at home is a common practice and lack of hygienic practices poses a threat to both mother and child. According to NFHS-3, the percentage of births that took place under institutional care were 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/nurse/LHV/ANM/other health personnel nationwide was 48.8%. Yet gain, major setback for rural population with only 39.9% while urban population was at 75.3%. Mothers who received postnatal care from a doctor/nurse/LHV/ANM/other health personnel within 2 days of delivery for their last birth nationwide was 36.8%, in rural areas 28.5%, and in urban areas 60.8%. [11] Despite the efforts made by the government to better the circumstances, 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:

FIG. 6



[12]

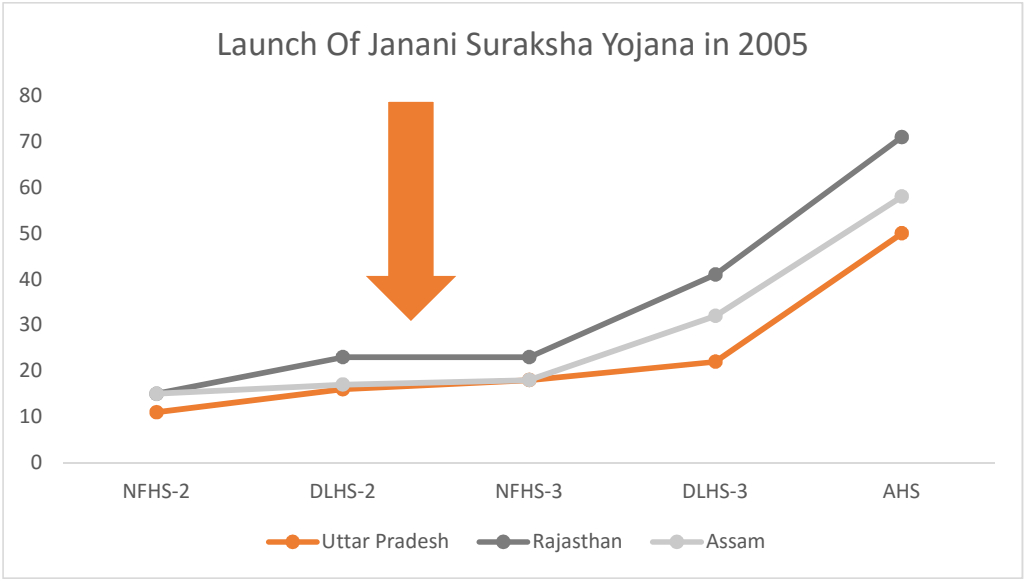
JOURNEY TILL NOW

In order to achieve the required level of reduction in maternal mortality and infant mortality, a scheme called Janani Suraksha Yojana (JSY) or Safe Motherhood Scheme was launched in 2005. Under JSY, each eligible woman is tracked from the time of her pregnancy and care is provided to her on a continuous basis. Every pregnant woman registered under the scheme receives at least three ante-natal check-ups including tetanus toxoid injections and IFA (iron, folic acid) tablets during the course of her pregnancy. During these interactions, she is encouraged by the health personnel to deliver in a health institution. 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]

Accredited Social Health Activists (ASHA) built a huge network across India which helped take JSY forward. The ASHA's role begins from identifying a pregnant woman as a beneficiary and lasts till the woman delivers in a health institution. And it's not just the mothers, but even ASHAs are incentivized for every pregnant woman they accompany to the health institutions. As literacy rates improve and cheaper health care is made accessible across the country, ASHAs, who at last count number over 9 lakh [14], hold the promise of bringing about a significant impact on the country's maternal mortality rate. 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.

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. However, one in three children are yet to receive 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?

FIG. 7



[16]

A PROBABLE WAY FORWARD

WHO 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] Different applications designed for monitoring the lifestyle, patient conditions, education, training and mass scale messaging for information are included in mHealth. The mHealth may be considered as a tool to support a healthcare practitioner for efficiency and quality of care as well as empowering a patient for self-care and monitoring.

In a hospital setup in urban and suburban areas mobiles already have significant presence. In day to day operations in a hospital both for clinical and administrative purpose, mobile phones have immense influence.

For rural population where healthcare infrastructure and skilled healthcare workers are hardly available, 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]

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 gap 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.

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