A CRITICAL STUDY ON CAUSES OF MAJOR RURAL HEALTH CARE INEQUALITIES IN INDIAN CONTEXT

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ABSTRACT:

Health inequalities can be understood with societal disparities in health and healthcare, focusing on income to include markers of deprivation like income, gender, religion, wealth, employment, poverty, and occupation that distress health and the quality of life. For analytical study of spatial development, research on health inequalities has become one of the central pillars. Socio-economic background plays an important role in distribution of inequalities. Poverty and education are the most significant controlling factors of health inequality. Literacy rate among women is very less in rural India which considered as major obstacle in acquiring health goals. Since the last decade income inequality has become the centre of attraction of research for understanding health inequality of India. The study mainly can prove to be of great help for the policymakers, academician, research scholars and teachers to understand the causes of health inequality among the people. The amazing fact, therefore, that the inequality analysis of rural health services has become a topic of widespread interest. This work aims to study the causes of major rural health care inequalities in India.

INTRODUCTION:

A critical study of rural healthcare inequalities in India reveals that the primary causes originated from a complex interplay of factors including a severe shortage of healthcare professionals in rural areas, inadequate infrastructure in public health facilities, poor patient transportation connectivity, low socio-economic conditions, limited health care awareness, and a lack of financial accessibility, all contributing to significantly poorer health outcomes compared to urban areas.

Food, cloth and shelter are three basic necessities of human life. To avail these three basic things human health is most important factor for the development of any region. These crude indicators are very much associated with health and economic development. As a result

‘Health is wealth of nation’ is common and famous saying. According to Mahatma Gandhi, “It is health that is real wealth and not pieces of gold and silver.” Health as a form of human capital is an input for the further development. This will be solved if government takes decision to reduce remoteness of rural area with the development of infrastructural, transport, educational development. If government introduces the policy that every health staff will have to serve at least few years in rural area or intensive scheme for serving in rural area, there will have a rescue from the problem. The present health care infrastructure, like village Dai, ASHA, para medical staff, sub centers, health centers, rural health centers, Primary health centers, Block primary health centers etc. of India are not well distributed. The village dwellers are not properly aware about the health-related issues and knowledge.

The development of any country or society depends on the wealth and human resources play a vital role on this development. The amount and quality of human resources depend on health status of human being. Now a days most important challenge in the society is to keep good health of the people. This is possible only when health care services are available at all levels in the society, especially for rural low-income or BPL households. Before independence, the government has extended all kinds of help to keep the health of every people in good condition. Therefore, with the increase in the number of health care facilities, the infrastructure and health care system have been improved. The health status of the society is much better than the previous health standards due to easy and convenient public health services. Rural doctors and professionals in rural areas are also very quick to improve our health status, and are always striving to improve Allopathic, Homeopathy and indigenous health system (AYUSH)) of India.

The National Rural Health Mission (NRHM) was launched on 12th April 2005, to provide accessible, affordable, and quality health care to the rural population, especially the vulnerable groups. The key features to achieve the goals of the Mission include making the public health delivery system fully functional and accountable to the community, human resources management, community involvement, decentralization, rigorous monitoring & evaluation against standards, the convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators. NHM Components are RMNCAH+N, Health Systems Strengthening, Non-Communicable Disease Control Programmes, Communicable Disease Control Programme,

Infrastructure Maintenance. After the implementation of Ayushman Bharat programme strengthening of Sub Centres and Primary Health Centres are being done by converting them into Health and Wellness Centres to deliver comprehensive Primary Healthcare services through these Centres. SCs and PHCs are proposed to be converted into Health and Wellness Centres in the phased manner.

The term inequality means difference in size or degree or lack of equality. In our society there have many inequalities in social status, wealth or opportunity in different stages. We are here only to consider the health care related inequality. Though the term inequality is much broad, here we will consider only the inequality of health unit related health care. So, when we papered it would be excluded. We are only confined the attention which is very much related to the health parameter. Health inequality is the disparity of health status or distribution health resource between people or group where they live (WHO, Glossary). This is mainly due to dissimilarity of society. In the society there, we see many groups of people are living in a definite area as their race, religious and caste and economic status. All this group performs own customs and ethics to maintain their life. So, by nature it differs from man to man how they manage their health. It differs not only individually but also in state, national, and international level.

KEY CAUSES OF RURAL HEALTHCARE INEQUALITIES IN INDIA:

Healthcare Workforce Distribution:

- Shortage of Doctors and Nurses: A large concentration of medical professionals in urban areas leaves rural regions severely understaffed, limiting access to basic healthcare services.

  As of July 2024, the doctor-to-population ratio in India is around 1:836, which is better than the WHO standard of 1:1,000. However, the demand for doctors exceeds the supply in many parts of the country, especially in rural areas.

Infrastructure Deficiencies:

- Limited Healthcare Facilities: Inadequate number of primary health centers, community health posts, and specialized hospitals in rural areas.

As of November 2023, India's hospital bed-to-population ratio was 1.3 beds per 1,000 people. This is far below the World Health Organization's (WHO) recommended ratio of 3 beds per 1,000 people.

- As on 31st March, 2021, there are 156101 and 1718 Sub Health Centres (SHC), 25140 and 5439 Primary Health Centres (PHCs) and 5481 and 470 Community Health Centres (CHCs) respectively which are functioning in rural and urban areas of the country.
- According to RHS-2021 report, there is a shortfall of 83.2% of Surgeons, 74.2% of Obstetricians & Gynecologists, 82.2% of Physicians and 80.6% of Pediatricians. Overall, there is a shortfall of 79.9% specialists at the CHCs as compared to the requirement for existing CHCs.
- 20937 Health Worker (Female)/ANM is in-positioned at PHCs. There is 20.6% posts vacant and shortfall of 30.8% of HW (F)/ANM at PHC, out of the total requirement at all India level.

Socioeconomic Factors:

- Poverty and Low Income: Limited financial resources prevent rural populations from accessing necessary medical care, often leading to delayed treatment or forgoing healthcare altogether.
- Low Literacy Levels: Lack of health awareness due to low education levels hinders preventive healthcare practices.

Accessibility Issues:

- Poor Transportation Networks: Inadequate road infrastructure and limited public transport options make it difficult for rural residents to reach healthcare facilities, especially during emergencies.

Systemic Challenges:

- Inadequate Public Funding: Insufficient government funding for rural healthcare infrastructure development and workforce training.

Specific Health Concerns in Rural Areas:

- Maternal and Child Health Issues: High maternal mortality rates, inadequate antenatal care, and malnutrition among children due to limited access to healthcare.

- Communicable Diseases: Higher prevalence of infectious diseases like malaria, tuberculosis, and vector-borne illnesses due to poor sanitation and hygiene practices.
- Non-Communicable Diseases (NCDs): Growing burden of chronic diseases like diabetes, hypertension, and cancer with limited screening and management facilities.

Major Causes of Health Inequalities:

If we desire to build up a developed nation, there should be equity among wealth, power and income between the population and group. But practically that are not happened in any society. Even in developed country discrimination is an inevitable situation in every circumstance. We are only confined the attention which is very much related to the health parameter. Health inequality is not desirable in any society, as we have right equal social justice in health condition. However, the health inequality is evitable. This is not miraculously but due to normally socially control. All the parameter like education, employment, income, race, religious, caste and gender are the controlling factors of health inequality in general or individual. As all these parameters unevenly distributed within or between every country, so the discrimination of health status is an unavoidable result for various income group of peoples.

INCOME:

It is one of the prime creators of health inequality in overall population. Income is not equal in each people. It varies between person to person e.g. age, sex, disability, and quality of work. All these are determiner of their workforce, which ultimately comes from their education, social and cultural status. Apart from this, women, young people, retardant people earn very low than others. The women work as a homemaker, maidservant and agricultural field like paddy field, tea garden as a soft worker, for their income level is not so high as male workers; young people are working at various factory, agricultural field and various shops as a child labor in condition with day payment or mid day meal. Therefore, their income is also very low. Above all there are miserable condition of retardant people in earning side as they are not able to do any work easily, so the employers try to avoid them maximum time. On the other hand, educated, physically bold person is working in various fields according to their ability. They earn more money as their status.

Higher the income level, higher will be the health status of the people we know it. Many studies have revealed that there is a proportional relationship between income and health. Higher the income higher the health status and lower the income lower the health status. Higher income group easily can get services and buy the commodities, which help to get for better health of them. Therefore, the health inequality is automatically come with the differences of income. Lower income led to the poverty of the people as a result these people are naturally poor health due to lack of nutritious food, hygienic practises and good services at the time of emergency.

However, all time high societies have not enjoyed good health for their food habits and high-risk job and long term uninterrupted mentally work load. They are physically weaker than the poor people who work in the field but the poor people forced to damage their physical health without good food and rest from work. So both are sufferer from the income level and led to the health inequality.

TAX:

It has a great impact on distribution of household income, public fund and purchasing power of population. It recycling through income tax, national insurance, council tax, and indirect tax through each and every commodity which parched by the population.

Tax system is used as to fulfil of Government fund as well as equity in income of overall people of a country or nation. Ultimately, that will reduce the inequality of health. There is some difference between the direct and indirect tax. As the daily needed goods are the same indirect taxation for both rich and poor people, this led to the rise of income inequality. Other hand direct tax may be reducing the income inequality, as the taxation is proportion to their income. In our society, drugging is one of major problem. Though it is individual cost matter but the prices of drug is the most controlling factor to consume it. If the cost value of tobacco and alcohols has been increased with taxation then it may be possible to reduce to take it. Therefore, taxation on unhealthy product may be reducing the health inequality.

EMPLOYMENT:

It is also another significant factor for health inequality in the society. The nature and availability of job, whether it is permanent or temporary, agriculture or industry, education or health, communication, or information technology, public or private is the matter of uneven

distribution of wealth, income and power. There are so many differences in between and within all these sectors in availability, risk and wage earning capacity. Therefore, no risk, higher earning people enjoy better health than the high risk, lower income people. In this way, employment determined the health inequality in the society.

WEALTH:

The natural resource is unevenly distributed throughout the world. So automatically, the wealth is not equally handed over the population. It may be in the form of money or other assets, which provide extra benefit the people. In this way depending upon wealth; our society is bifurcated as rich and poor. In the society, rich man has opportunity to live with good health as they have enough wealth to get healthy food, housing complex, clean water. Moreover, poor people cannot bear the fresh food, house, clean water, and sanitation; as a result, their health condition is very worse. So poverty is concern with poor health in every society and health inequality is inevitable.

POWER:

Physical, mental and social is not visible According to "Conceptual Framework for Action on the Social Determinants of Health" of WHO, they recognize four types of power. These are following

a) Power over – It is where one can dominate other.

b) Power to – It is that power; one can form and revoke the system of hierarchies.

c) Power with – It is the combined power of association or institution.

d) Power within – It is the personal strength.

POVERTY:

It means when the basic needs of man such as food, cloth and shelter are not occupied with their individual income, and then it may be called poverty. It is one kind invisible demarcation line, above which they can live very well and bellow which they have to spend a painful life. However, the line of poverty is not same in all the country of the world. It is different from place to place as their local economic base level. Normally in all the country has their specific dead line of poverty. In India this line is called PL (poverty line) Line. The men who belong below this line are called BPL and above the line, it is called APL. The situation of BPL people is very worse. They have no individual land for built up the house,

no money for food and clothing. They just live with minimum requirement and some time they have to compel fasting. In this situation, their health condition is very poor and decayed. So there is high inequality in health between the BPL and APL people.

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INFRASTRUCTURE INEQUALITY:

It is mainly due to Governmental plan, all the facility like building constriction, doctors, nurse, and any other modern devices are recommended for city / town area. Usually the numbers of building, nurse doctors are concentrated in the urban area than the rural area. Where the sub divisional office is situated, that is functioning multi work sector. So many people comes from the rural area to complete their various work and also officer, doctors all these categories of men started to live in that area for all kind of facility.

Health depends upon the geographical location, climate, and social culture and food habits. As poor, not enough money to get basic needs of food. Every day it is uncertain to gather food. Even some get one time meal; it may be during day or night time.

On the other hand, as rich are healthy, slim due to dieting, exercise and hygienic practices. In the village who are working in the field every day, they are naturally physically strong and slim. They do not have any digest problem because they take fiber food unlike any fat and physical hard worker. Some time they intake protein, but its cost compels them to take normal vegetable and their own product. So villagers are free from all kinds of gastric disease. But the villagers are normally suffer from water borne diseases from dirty and unclean environment and other malnutrition diseases. This is the normal situation of the village people.

On the other hand, it is totally opposite situation for the city life. They suffer from obesity due to their food habits because they intake high amount of fat and fast food. Usually they work in the office, there is no any physically hard work only mental pressure. Therefore,

the maximum city dweller is suffering from Obesity. In the urban area during summer and rainy season, it is dangerous due to Dengue and other mosquito borne diseases.

It we look at the world scenario then we find that people of polar area naturally taller and physically stronger than any other low latitude area. Because tempered and cold areas are free from formation of bacteria. However, in equatorial region there is a high growth rate of bacteria. Around the sea area or island area all the people have giant figure due to easily accessible of sea protein, mainly sea fish. In this way in the world spatial variation is reflected in human figure with physical environment, weather, socio-economy and culture, food habits and also different of wealth.

EFFECT OF HEALTH INEQUALITIES:

Health programme of the study area is not satisfactory as there we find many registered RMP doctor and quake doctor. They are the main source of village level doctors. In the villages there have RMP or cowage doctors who provides all kinds of treatment to the people. They do even small portion of surgery like tumor, carbuncle abscess without local anesthesia. As these types of doctors are easy accessible in village and they serve in door to door, so the each and every villager are delighted for getting the treatment in hand.

I) First of all, the villagers are not educated. Therefore, they are not able to go to the town.

II) As they are very poor, they cannot provide as much money, which is required for the treatment.

III) These people are very much they cannot lay bare the patient problems to the doctors.

IV) There are many problems for remote, poor, illiterate people, the broker or agent or intermediary who convinces them to assure / ensure for better treatment easily traps them. So, this agent enlists the patient's name where the agent can get their percentage of incentives of per patient from the doctors or the nursing home.

V) Another is the major problem of distance for the higher hospital.

GOVERNMENT INITIATIONS:

Rural health care services are standing based on infrastructure of health care system. In rural area health centres mainly Sub health center, Primary health center and Community

health centres are predominantly work for health care services. But the numbers of all these centres are not sufficient for providing the health care services to the rural people. According to the IPHS (Indian Public Health Standard) there are huge shortage of sub health centers, Primary health center and Community health centers.

At present Government is providing various financial supports like free of cost Ambulances for transport to health care centre, cash is paid for purchase of drugs and others nutritional foods, thus institutional delivery has increased than the home delivery. As a result, the women health care after delivery has enormously increased. Government provides numerous facilities regarding health service. But still there is facing health inequality in India. Over time, social lifestyle and economic infrastructure of the people are changing. Gradually, inequality in society is manifested in the health and delivery of various services.

ROLE OF GOVERNMENT SCHEMES:

Now a day government has given more emphasis on the health sectors, so various schemes and project has introduced for the development of health of the people of the country. Rural people depend on the public health center for their treatment in any circumstances. Though there does not have sufficient infrastructure of the health centers like doctors, nurse, beds (hospital), medicine, modern devices for various tests etc. So, the people are not getting sufficient medical services from the nearest health centers. Not only is that but the health center not evenly distributed throughout the district. The number of the health centres is not adequate with population ratio (according to Indian Public Health Standard). Above all, over population is the major problem of the India. In present time various plan and programme have been provided by the local as well as state and central government for the development of the health status and health care infrastructure. But people still face many obstacles that hinder development.

At present it is very difficult to maintain expenditure of health care of the individual family in the study area as well as country and the state. According to the World Bank reported: “Irrespective of income class, one episode of hospitalization is estimated to account for 58 per cent per capita annual expenditure, pushing 2.2 per cent of the population below the poverty line. Even more disconcerting is the fact that 40 per cent of those hospitalized had to borrow money or sell off assets.” Hence government should provide support to the people for the treatment of some chronic and acute diseases. Though there is everything free in

public health center, mainly in Primary Health Sectors, but these sectors are not sufficient for designated treatment as per IPHS. So, the people are forced to take the treatment in the private sector but there is much more cost that goes out of ability.

CONCLUSION:

Different types of discriminates based on caste and religion, education, occupation, income are found in India. The rural area is not prosperous in wealth or income than urban area, so there is poor condition in education, health status and health infrastructure. As most of the plan and project of government are done which are mainly urban oriented, so the rural area is facing lack of infrastructure, doctors, para medical staff, new modern laboratory device, medicine etc. As the rural area is far away from the urban area, so the accommodation and modern facility is not available as one gets in urban area. So, the Doctors and Nurses don't like to go to the health centres of rural areas.

RECOMMENDATIONS:

- Increase Public Investment: Allocate more funds to improve rural healthcare infrastructure, equipment, and workforce training.
- Incentivize Rural Healthcare Providers: Offer attractive salary packages, housing allowances, and career advancement opportunities to retain healthcare professionals in rural areas.
- Community-Based Initiatives: Empower local communities through health education campaigns and community health workers to promote preventive healthcare practices.
- Telemedicine: Utilize telemedicine technology to connect rural patients with specialist care in urban areas.
- Strengthening Rural Health Infrastructure: Develop comprehensive network of primary health centers, community health posts, and mobile health units to improve accessibility.
- The public health facilities infrastructure was not up to the mark as per Indian Public Health Standards. The IPHS compliance of services at various levels of public health facilities requires holistic approach in upgrading basic infrastructure, human resource, and other supportive services.

- The State and District health authorities should be focus on Anaemia Mukt Bharat programme to reduce anaemia among the Children, Adolescent, ante natal and post-natal, it brings down maternal and child deaths through achieve SDG goal-3.
- The Rashtriya Bal Swasthya Karyakram (RBSK) is a program that screens children for health issues and provides early intervention. The RBSK programme requires to be strengthened in the districts and states.
- Health workforce needs professional training programs then enhance their high-quality health care approaches among ASHA, ANM, Staff nurse, Para medical staff and Doctors.
- Overall, a significant shortage of Specialist Doctors was observed among the districts and states. Therefore, specialist doctors' recruitment need on regular and NHM basis to District Hospital, Sub District Hospital and Community Health Centres.
- Quality Certification are to be improve and focus on quality assurance on NQAS, Kayakalp, MusQan, LaQshya, and District level Quality assurance Committee (DQAC).
- Improve patient feedback system in all public health facilities in all districts and states.
- Need to enhance lab investigations up to mark in all public health Facilities in Chittoor District.

REFERENCES:

1. Aditi, I., Gita, S. & Piroska, O., Inequalities and Intersections in Health: A Review of the Evidence in Gita Sen and Piroska Ostlin edited Gender Equity in Health.
2. Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. Soc Sci Med 47(10): 1513-27.
3. Dasgupta, M. (2005). Public health in India: Dangerous neglect. Economic and Political Weekly. December 3, 2005. P: 51-59.
4. Duggal, R. & Amin, S. (1989). Cost of Health Care: An Household Level Survey in an Indian Dstrict. Foundation for Research in Community Health, Bombay.
5. Mills, A. & World Health Organization (1990). Health system decentralization: concepts, issues and country experience. Geneva, World Health Organization.
6. Sen, Gita & Aditi, I. (2000). Health Sector Changes and Health Equity in the 1990s in Raghuram, Sobha (eds.) Health and Equity-Effecting Change. Technical Report

Series 1.8. Humanist Institute for Cooperation with Developing Countries, Netherlands.

7. Joe W, Mishra US, Navaneetham K. Socio-economic inequalities in child health: Recent evidence from India. Glob Public Health. 2009:1–16. doi: 10.1080/17441690903213774.
8. Sen G, George A, Ã–stlin P. Engendering international health: the challenge of equity. Cambridge, Mass.: MIT Press; 2002.
9. Tang S, Meng Q, Chen L, Bekedam H, Evans T, Whitehead M. Tackling the challenges to health equity in China. The Lancet. 2008; 372(9648):1493–1501. doi: 10.1016/S0140-6736(08)61364-1.
10. Evans T, Whitehead M, Diderichsen F, Bhuiya A, Wirth M, editors. Challenging inequities in health: from ethics to action. Oxford; New York: Oxford University Press; 2001.
11. Gaudin S, Yazbeck AS. Immunization in India 1993–1999: wealth, gender, and regional inequalities revisited. Soc. Sci. Med. 2006; 62(3):694–706. doi: 10.1016/j.socscimed.2005.06.042.
12. Harper S, King NB, Meersman SC, Reichman ME, Breen N, Lynch J. Implicit value judgments in the measurement of health inequalities. Milbank Q. 88(1):4–29. doi: 10.1111/j.1468-0009.2010.00587.x.