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A Comparative Study on Healthcare Challenges In Urban And Rural India

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Abstract

The healthcare sector, both public and private, in India are in booming peaks when it comes to generation of revenue and creation of employment opportunities Now, the rural and ethnic population of India experiences significant health disparities in safety and quality living status when compared to the country's overall population (Ncbi.nlm.nih.gov, 2018). The disparities are predominantly characterized by a higher incidence of disease, higher chances of untreated disability, larger mortality rates, lower life expectancies and of course higher rates of pain, trauma and suffering.

Key Words: Public Health, Pain, Morality Rates and Disease

Introduction

The healthcare sector, both public and private, in India are in booming peaks when it comes to generation of revenue and creation of employment opportunities. The Indian healthcare segment is anticipated to grow about three-fold generating 8.6 trillion by the year 2022 (Chakraborty, 2018, p.7). While the private sector stringently focusses on the urban localities, the primary necessities of healthcare in rural India as well as in urban regions are funded and aided by the government. Although in 2018, the number of arrivals of medical tourists in India has perpetuated growth by 20% to 25% (about 1.07 million; it was 0.98 million in 2017), there prevail a plethora of critical and long-standing challenges and severities that call for immediate strategic and sustainable development through policy-level interventions. While 27% of the country's population has access to 75% of highly developed urban healthcare infrastructure, the remaining 73% population is concentrated in rural, suburban and ethnic communities who are being deprived of minimum healthcare facilities(Chokshi*et al*., 2016, p.S11). There is sound and steady growth, progress and revenue flow in the private realm, while the treatment adversities and service quality degradation in the public front is alarming. The underpinned challenges mostly include poor functioning infrastructure, under-staffed facilities, scarcity of medicines and medical equipment, lack of health professionals, lack of educational facilities and professional exposure, lack of capital and recurring financing and so on (Mullen *et al*., 2016, p.57). This helps in picturing the shortcomings faced in the urban healthcare context.

Now, the rural and ethnic population of India experiences significant health disparities in safety and quality living status when compared to the country's overall population (Ncbi.nlm.nih.gov, 2018). The disparities are predominantly characterized by a higher incidence of disease, higher chances of untreated disability, larger mortality rates, lower life expectancies and of course higher rates of pain, trauma and suffering. The risk factors for health disparities in rural India are indicated by the presence of lower socioeconomic status, geographic isolation, limited access to healthcare specialists and subspecialists, higher rates of health risk behaviours and limited job opportunities (Nolan, 2015, p.73). In addition to this, this inequality becomes intensified with slimmer chances for rural residents to access personal health insurance facility or employer-provided health insurance coverage. Furthermore, because of monetary issues most people in rural India suffer from the public (limited) or private transport options, unskilled or semi-skilled paramedics, misled in the hands of quacks, mistreated with unscientific medical practices, zero readiness towards emergencies, intense poverty and poor literacy rate (Rob and Talukder, 2013, p.28). The shortcoming becomes more emergent if statistics are presented. The practising guidelines and standardised service criteria as laid down by the

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Indian Public Health Standards (IPHS) so far have been adhered by only 16% Community Health Centres (CHCs), 13% Primary Health Centres (PHCs) and 11% sub-centres in the rural and suburban India. This can be translated to only one state-run hospital in a region covering 90,000 people where only one doctor or health professional is available for every 10,000 people (Ncbi.nlm.nih.gov, 2014). The medical infrastructures in the urban area of India have received comparatively successful reforms and developments under government initiatives than in the rural spectrum sustaining 70% of the population (Nolan, 2015, p.79). Despite the existing setup for infrastructural health care and medical service in urban India is on the momentum of the right track, the availability of quantitative and qualitative care facilities is a far cry if compared against the prescribed norms of the World Health Organization. The pressure on the urban medical settings due to the rising medical visits by the ruralites only speaks as evidence for the immense crisis that goes incomparable to any other social sector. Around 86% of the rural population, the majority of which might have to travel far above than 100 km to avail themselves a required health care facility, come to urban hospitals and nursing homes in anticipation to get cured, to have a second chance at life and to end their health sufferings (Chokshi*et al*., 2016, p.S11). While in the absence of insurance, 70% to 80% of the mounting cost towards medical service is borne by them out of pocket that can mostly land them into poverty or debt-trap, the non-availability of basic drugs has increasingly been one persistent problem in both the rural and urban healthcare spectrums of India. A significant portion of urban-rural differences is determined by better access to private sector health services as well as general inpatient and outpatient care. In 2014, 47.5 percent of births (compared to 24.1% belonging to the rural population), 69.4% of outpatient care received for reported illness in last 15-days (compared to 62.5% belonging to the rural population) and 18.1% of health insurance benefits receiver (compared to 14.1% belonging to the rural population), belonging to the urban population were done in private facilities(Mullen *et al*., 2016, p.76).

Again, in rural situations, where a few hospitals and nursing facilities are available to suffer from numerous pitfalls. Now and then a deaf ear is turned to the patients and their relatives. It is not surprising that the patients and their families become victims of exploitation, fraud, misguidance, malpractices, unequal treatment and unfair judgement, debt traps as well as unskilled and unscientific practices leading to death, deformity and degenerated conditions. As the care users remain ignorant of their rights, they are sent to various tertiary care hospitals where they get into more deafening quandaries and financial quagmire where they are often subjected to get cheated by middlemen, fraudsters and unethical health workers. In most scenarios, only two to three doctors are designated at each hospital where they mutually shift and alter their duties barely for one to two days each week while the rest is left to be managed by short-staffed nurses, junior doctors, vocational trainees and pharmacists.

The notions of mirroring the agglomerationdichotomy areinexorably associated with urban and rural health advantages, disparities and penalties. In the 19th century, during the historicalIndustrial Revolution, the rapidly rising populations of cities faced worse health conditions than the rural counterparts of India. A reversal of differences in health conditions between rural and urbanized India, however, can be observed in terms of hygiene, improved sanitation, medical technology, reduced poverty and better access to nutritious foods by the early 20th century(Mullen *et al*., 2016, p.88). In currently developing countries, household surveys generally show that, although with Despite significant and drastic inequalities present within urban populations, the health and nutrition indicators reflect better average health conditions in the urban areas than in the rural areas. This urban health advantage can be attributed to higher average incomes in urban areas compared to rural areas, improved hygiene and sanitation conditions as governments establish services in growing cities, and better access to health care services (Rao and David, 2015, p.e729).In 2012, for example, the average under-five mortality rate in Indian urban areas stood at 32.0per 1,000 which is 45 percent lower if being comparedto that of the rural areas (a rate of 58.0 per 1,000). As per 2014's service utilization indicators, the 89.2% of births at the urban health facilities and that of 79.6% amongst the rural

population drove down the urban-rural difference to just 12% (it was 251% at the rural level between the period 1992 to 1993)(Mullen *et al*., 2016, p.88). Again, service utilisation is determined by individual household income and economic status – both in urban and rural areas. The service utilization indicators for 2014 show that 85.2% of birth cases belonging to urban households of the poorest quintile occurred in health facilities, while it was 74.9% for rural households of the poorest quintile(Mullen *et al*., 2016, p.92). Similarly, at the poorest quintile, there prevailed large differences in the urban-rural fertility rate, antenatal care utilization, vaccination coverage and contraceptive use while the variance in the child malnutrition rate was not equally large.

The figure of 2005 as published by the Union Ministry of Health and Family Welfare indicates a shortfall of 50% Community Health Centers (CHCs), 16% of Primary Health Centers (PHCs) and 12% for sub-centres. In simpler terms, there are only 3346, 23,236 and 146,026 CHCs, PHCs and sub-centres existing in India (Ma and Sood, 2008, p.31). As of 2005, the report suggested that 49.7% of sub-centres, 78% PHCs and 91.5% CHCs are in acute need of additional buildings for 60,762 more sub-centres, 2948 more PHCs and 205 more CHCs (Chakraborty, 2018, p.5). This also insinuates the improper utilisation of capital and human resources through an enhanced idle time of health care workers and heavy loss of daily wages as more and more PHCs and CHCs are set up at a far distance from the rural and suburban areas. An inimical positioning when transport and financial options are limited has only driven poor population from rural India to reach out for private health care practitioners. This is how poor and marginal Indian population stay left out and unregistered from accessing affordable and relatively much cheaper medical services at their village and township localities (Assets.kpmg, 2015). The reluctance of the Indian government in spending from the gross domestic product towards the health care sector stands at only 0.9%. While only 0.5% of the rural enjoy basic sanitation facilities, the average spending of the household income towards availing health care stands at 14%. Even bare minimum spending of 1.3% in a poor household in Tamil Nadu to spending about 37% in Rajasthan's Jalore exhibit the reluctance towards health priorities(Chakraborty, 2018, p.9). A major amount of the total population is rigged and affected by serious health ailments being deprived of basic sanitisation and safety requirements deriving from multiple socio-economic (polluted water, degrading living conditions) and political (ungenerous government, political motives) issues.

This above discussion so far reflects well that there exists a high level of use of health care services in both the Indian urban and rural settings. The public sector health professionals receive a fixed remuneration but all consultation charges should either be free or be nominally priced. The majority of these public-sector doctors are mandated to be qualified with a six-year bachelor degree in medicine and surgical education(Rao and David, 2015, p.e730). However, as most patients continue to seek care services in the private front, it can be seen that the private professionals come from a variegated range of backgrounds starting from a bachelor degree of medicine and surgery to various low-cost and unscientific degrees based on traditional systems of medicine (for instance, Ayurveda or Unani). Furthermore, the professional education of medicines is also available in the form of distance education (such as courses offering only six months of so-called training to courses that come with no medical training at all) and medical practitioners and physicians promoted by most popular and trusted health and fitness brands. An earlier survey showed that that public providers account for only 8 out of every 100visits from rural households for health check-up and a major of 70 out of every 100 visits are catered by unqualified private providers (Ncbi.nlm.nih.gov, 2013). Again, about 70% of the urban households pay visits to various private-sector health care providers leaving the rest of the 30% are reaching out for various public centres and hospitals for primary health care. Thus, in nutshell, statistically, 14% pay visits to any urban private-sector providers and another 31.5% opt for care providers with no or minimal training. Again, about 43.6% might end up receiving care service from providers with some dependable training whileremaining 24.8% are entrusted with care providers

having a sound understanding of the subject at hand and professionalknowledge on medicinal and surgical properties (Ncbi.nlm.nih.gov, 2013). This report further highlighted that the recurring requirement of visiting a healthcare professional in rural Madhya Pradesh is too common – more than half of the households claim to send at least one member to avail primary medical care in the preceding month. Again, the average household visits to the health care provider in the urban Delhi is reported to be 2.1 times a month which is equivalent to more than twenty-five times of visits in a single year (Ncbi.nlm.nih.gov, 2013).

In this context, based on the scenarios discussed above, a few recommendations might be drawn. Firstly, reducing the financial burden on individual consumers that come with out-of-pocket health care payments. A radical shift towards the prepayment mechanisms from the out-of-pocket payment policies can help to eliminate financial catastrophe to a large extent. India can follow Europe's move in nationalizing or socialising insurance aids.This should be made mandatorily free of cost and widely acceptable specifically for a rural and suburban population who are dwelling at BPL or below poverty line (Jaysawal, 2015, p.31). For urban areas, the government can encourage for availing private insurance schemes as could be seen in the United States. Thus, it is recommendable that India should tick for both public and private insurance models. These models can be customised according to the distinct needs of the country into adapted versionsconsidering the wide and diverse needs. Also, the country should consider deploying an HMO model for vertical integration of health insurance provisionas well as health care containing minimum costs (Assets.kpmg, 2015). Secondly, the reduction of overutilized services is achieved by shifting away from various regulated price structuring and contracts coming with the fee-for-service requirement. Hence, India should tryassigning separatepolicies for governing drug prescription and drug dispensing. It should also put alternative reimbursement mechanisms in place. India might follow the example ofMedicare's prospective payment model in the United States (Rao *et al*., 2014, p.497). Nevertheless, ensuring the high quality of care requires any country to conduct quality assessment alongside critical and constructive evaluation should be welcome as an integral part of the overall healthcare system. Thirdly, India should try enhancingaccess to health care for the people who are financially incapable or succumbing to poverty. The supply induced demand forspecific health care services in India are overutilized. This is necessarily why a lot many from the disadvantaged and underserved populations face adversities and death risks because of lack of access or critical financial problems. Henceforth, India should strive towards allocating resources optimally to set up a promising and high-functioning primary health care infrastructure facilitatingbasic preventive and curative care options. Fourthly, India should consider building the rightcapacity that can help it addressand monitor various emerging diseases (such as Obesity, HIV, Dengue, Covid-19 and so on). Thus, India can improve the horizontal and vertical coordination between itspublic branches in the major areas of contamination and spread of any kind of communicable disease through preliminary surveillance and control. Maintaining a fair and transparent view of medical data and progressis essential to ensure ethical and reliable conduct. For this, India must develop a stronger surveillance system that encourages more and more investment of resources in the health care system while catering to routine primary care needs seamlessly (Assets.kpmg, 2015). Lastly, India must strive to build a framework where the capabilities of individual hospitals are matched with the local needs.However, India has intrinsically suffered from an inefficient system of health care delivery system. This systemhas led to setting up health care facilities abundantly in overly concentratedurban areas and comparatively far more slimly in the rural and remote areas. Therefore, it is recommendable for the country to device strategies and policies that will ascertain adequate allocation of capital and human resources towards the primary facilities of basic preventive and curative care. This will immensely help several lower-tier clinics and low-scale community hospitals continue to eliminate sickness by co-existing with the public sector and make continuous improvement.Also, critical attention towards the improvement of access to care in the rural areas should be obtained through social welfare measures of education, immunization, screening,

vaccination and transportation assistance. The government of India through its flagship program called the "National Rural Health Mission" has raised funding to improve the delivery of health care and diagnosis, particularly in rural areas. Since then the rural health care services have achieved thrice as much growth as spending went up to 304 billion rupees (in the US, $5.54 billion) in the year 2011 to 2012 (it was 100 billion rupees or $1.83 billion in US equivalent in 2005 to 2006) (Assets.kpmg, 2015). Nevertheless, despite better spending, large geographic disparities continue to linger the poor health status of the Indian population. The sharp differences as present between the two different geographical siteswithin the same country have been depicted in a study. It showed that the infant mortality rate in Madhya Pradesh in the year 2010 stood at62 per 1,000 births as compared to 30 per 1,000 births in the urban Delhi (Bassi*et al.*, 2018, p.117).

Conclusion

India, since antiquity, has been the first state to recognisethat national health care is a uniform right of its citizens. In the present scenario, however, Indian rural and urban health care facilities are severely submergedwith a crisis that could not be compared with any other social sector.Thus, it is highly recommended that India must strive tirelessly towards the encouragement and development of a culture of professionalism in the regime of health care driven by the motto of improved quality care and health care for all. Undoubtedly, the existing facilities require more and more detailed and critical consideration and evaluation to ensure resources are invested and better management is in action. The role of collective awareness shared responsibility and informed choice are foundational stones for an equitable and reliable health care system. In the 21st century, if an individual falls seriously ill and due to lack of knowledge or exposure to education, such backward community peopleseek for ways to cure through the superstitiousmeans of witchcraft and hermits, then a country fails to ensure sustainable development. Again, in the absence of government-funded care options, they might head toward the urban setup and end up placing themselves in the trap of money lenders creating a worse situation of lifelong financial adversity.

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