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Developmental Disparities in Rural Health Care: Distant Dream to Achieve Universal Health Coverage in India

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Abstract

There is always a health gap striking between rural and urban, advantaged and marginalized section of society while accessing and utilizing health care services. This research paper tries to throw some light on the disparities and challenges faced by healthcare service recipients (rural community people) as well as healthcare service providers (Government Healthcare system like PHC and Rural Hospital). The study reveals that majority of the healthcare services in the remote & tribal 'padaas' lack health centres, medical doctors, and medical equipment. Adding to it, the shortage of trained medical professionals especially lab technicians, pharmacist and nurses and non availability of essential medicines to poor patients adversely affects access to and utilization of health care service, thus making Universal Health Coverage a distant dream to achieve in India.

Keywords: Healthcare, Access, Utilization, Coverage, Development, Rural health

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Introduction

Recent High Level Expert Group (HLEG) report on Universal Health Coverage (UHC) for India is a landmark health policy document which emphasizes the central role of public services in ensuring universal access to healthcare for all (Baru, 2012). It defines 'Universal health Coverage' as *Ensuring equitable access for all Indian Citizens, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider, of health and related services* (Planning Commission, 2011). Worldwide experience has shown that providing Universal healthcare is feasible and affordable depending upon political will, government commitment and allocation of resources to enhance access to health for all (Singh, 2013).

Government of India being signatory of Millennium Development Goals (MDGs) pledged to meet MDGs by 2015 (Nayak et al, 2005) and oblige to provide universal access to healthcare services free of charge by any health-care service provider, public or private, by laying down minimum standards and appropriate regulatory mechanism (MOHFW, 2009). Out of fifteen core targets of MDGs, eight are directly linked to healthcare and other focus on social determinants of health, i.e., achieving universal education, gender equality, empowering women, ensuring food security, eradicating poverty and ensuring environmental stability (Travis et al, 2004). Therefore consideration of social determinants and other related factors in overall global developmental agenda clearly affects overall universal access to healthcare in country.

It is true that a lot has been achieved by the government flagships programs e.g. NRHM, Janani Suraksha Yojana, Rashtriya Swasthaya Bima Yojana and initiatives like 'Jan Aushadhi Program'. But still there are certain areas and sections of the society which are far behind and where the benefits of these schemes are not reaching to the needy.

Rural Health Care System

Primary health care forms an essential part of the national health system based on Bhore committee (1946) recommendations with extensive focus on component of 'Minimum needs programme' (Duggal, 2001). Since 1948, Bhore Committee recognized the 'district' as a unit of planning, administration, implementation and delivering the services to address vast rural-urban disparities in the existing health services. (Ibid)

At national level, despite impressive economic stability and political commitment towards inclusive development, India is one of the countries with lowest government spending on health at approximately 1.2 percent of GDP (Planning Commission, 2011). Most of spending on availing healthcare services is an out of pocket expenditure and is increasing day by day in cost. The government healthcare infrastructure is mostly overcrowded or provides substandard services due to which common man in India avail most of the curative services from private sector which constitute 72 percent of the total expenditure on health in the country (MOHFW, 2011).

Launch of National Rural Health Mission (NRHM) in 2005, flagship programme of United Progressive Alliance (UPA) government has again placed centrally rural health care in the developmental agenda of India with an aim to carry out necessary health sector reforms by flexible finance support with community involvement and participation (Bajpai et al, 2010). The NRHM with lot of changes and innovations in the mechanisms, strategies, planning, budgeting and plan of implementation of different healthcare programs has been successful to bring change in enhancing access and utilization of healthcare services by rural communities to some extent.(Ibid)

However, despite the well defined structure and function of three tier level of health system in rural areas pre and post NRHM, closer analysis reveals the real picture of underserved condition of rural health service system with poor doctor to population ratio, unequal bed to population ratio, inadequate training of staff, inequitable distribution of services and rural to urban migration of medical professionals leaving rural health centres (Jhunjhunwala 2011).

Situational context referred above, is currently being felt in the villages of Karjat Block of District Raigad of Maharashtra. Therefore, this research paper tries find out various factors responsible for the disparities and challenges faced by healthcare service recipients (rural community people) as well as healthcare service providers (Government Healthcare system like PHC and Rural Hospital) and contributes in terms of bringing in depth understanding for taking policy decisions to make significant changes in the present scenario of rural health care.

Methodology for Research Study

The research study was accomplished in the rural areas of Karjat Block in Maharashtra from October 2011 to April 2012 with main aim to determine the factors affecting utilisation of primary health care services along with identification of challenges with the existing health system from the perspectives of both service recipients and service providers.

This paper is based on the field based observation & findings from the cross-sectional study conducted in pocket of selected ten villages under Kadav Primary Health Centre (PHC) and Kalamb PHC in Karjat. The research methodology utilizes mixed method approach with collection of quantitative data followed by qualitative data for in-depth exploration of information. Data is collected utilizing semi-structured interviews and focus group discussions with total sample of 120 respondents comprised of marginalized disadvantaged community people like elderly, women and people with disabilities as a primary respondents and other key stakeholders like Panchayat members, Primary Health Care staff, ICDS workers and officers from Government and Non Government organizations as secondary respondents respectively.

Pretested semi-structured interview schedule and focus group discussion guide was used to collect the information from heterogeneous group of primary respondents selected using cluster sampling. Ten villages were selected randomly under the total population served by Kadav and Kalamb PHC. From each of these villages, twelve primary (service recipients) were selected randomly comprising total sample of 120 respondents.

Consecutively, secondary respondents from the same villages in three groups were also interviewed to get their insights on challenges to rural health care provision.

The interview schedule contained various sections having query related to demographic information, household socio-economic status, morbidity for specific illness, type of treatment received and barriers faced by them in access to and utilization of healthcare services. Three focus group discussions were also conducted for in-depth exploration of the reasons of poor utilisation of public health services in the study area.

Study Area and Study Population

Study was conducted in the Karjat block of Raigad district of Maharashtra. Raigad district is one of the most populated districts of the Adivasi (Scheduled Tribe) community in the Konkan region of Maharashtra. Karjat is well known for its tribal population called 'Katkari' which is prominent and concentrated in different parts of the Karjat block.

Almost 86 percent of the block jurisdiction is rural areas which do not seem to provide adequate livelihood opportunities for majority of population, resulting in selective male out-migration. Most of them get absorbed by developing industries in Mumbai and adjoining northern towns of the district. Others work as landless agricultural laborers in the rural areas. The overall socio-economic conditions of the area reveal the poor situation in the region.

At the Karjat block level, one sub district hospital in Karjat town, one rural hospital in Matheran, six primary health centers and twenty eight sub centers are available spread across to cover total population of 2.5 Lakh residents.

However, the health levels and attainment in the community are low. It was observed that the reason for poor health rests in the relative inaccessibility of health services. The Sub district Hospital located near Karjat Station is an ideal place for treatment for all needy cases, but not so because of its defunct man power, under utilization of medical equipments and poor management. Whereas Private medical services with adequate healthcare facilities exists,

instilling faith in needy cases for their availability in spite of their high cost charges and medicines.

Key Findings and Discussions

Out of 120 respondents, 95 had history of illness at their household in last one year. Out of 95 who had an ill member during last one year, 69 approached government health facility i.e PHC or district hospital for the treatment and 26 sought private care. We then explored the satisfaction among those who sought care at government facilities. The results showed that around 82 percent of the treatment seekers were un-satisfied by the care provided at the PHCs or District hospital (Fig 1).

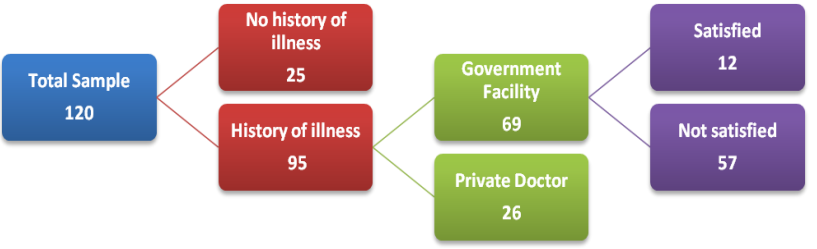

Fig 1: Utilization pattern and satisfaction among the service recipients

To get the view of the community regarding their health services, a holistic approach was adopted and all the respondents were asked their experiences with the health care services. Special emphasis was given on those cases who were unsatisfied with the care they were provided at the government facility. Table 1 below provides the reasons highlighted by the respondents for poor utilization or their dissatisfaction for the care provided at these facilities.

Multiple reasons were mentioned by the respondents affecting the utilization of the public health service system. The major reason which was mentioned by the respondents was unavailability of the doctors at the PHC. Other major barrier which came into focus was accessibility to health facilities in terms of lack of transportation facilities and remote location of the facilities from the villages. Other factors which were highlighted equally were poor quality care, inappropriate care, non availability of other medical staff like

pharmacists and lab technicians and medicines and rude behavior with the poor patients.

Table 1: Reasons for poor utilization and dissatisfaction from government services

Factors	(percent)
Non availability of doctors	22 (18.3%)
Transportation	20 (16.6%)
Long distance and time required to reach health centres	18 (15%)
Poor healthcare services	19 (15.8%)
Inappropriate care	15 (12.5%)
Non availability of other medical staff and medicines	16 (13.3%)
Rude behaviour with the poor patients	10 (8.3%)

After collecting quantitative information, detailed thematic analysis was done to get an in-depth understanding of various factors and the dynamics among them. This was done to find out the implications of the identified factors on the health care utilization by the rural population.

The various themes emerged from qualitative data has been illustrated in Table 1 which comprises of the factors affecting the rural health care service delivery system. It has been classified into three broad headings of facility factors, community and institutional factors.

Table2 Barriers in Access to Health care

Facility factors	Community factors	Institutional factors
• Transportation • Long distance and time required to reach centres • Poor healthcare services • Inappropriate care	• Social and cultural restrictions on women's mobility • Women's lower income • Limited information about the health needs	• Higher authorities control over decision making • Lack of Health budget

Facility factors	Community factors	Institutional factors
• Non availability of medical staff and medicines • Lack of adequate facilities for disadvantaged groups	• No information about the health rights • No information about the availability of services	• Perceptions & local treatment sought • Stigma and discrimination in healthcare settings

Factors affecting rural healthcare service delivery and their implications on health care utilization:

The factors have been categorized into two categories- 1. Societal and Individual Determinants, and 2. Health Service System Determinants.

Societal and Individual Determinants

Poverty-Increase in population, disintegration of families and migration of male members to the urban areas, subdivision and fragmentation of land holding, heavy load on land, traditional methods of cultivation, unemployment and other factors are responsible for poverty and different health needs of this segment of the population which indicates that any restructuring of health systems at their level should consider all these determinant factors.

Lack of educational facilities- Lack of education and ignorance has contributed to the development of avoidance, superstitions, traditionalism in these communities which in turn has lead to ignorance, unawareness, poor utilisation behaviour and lack of faith on the public health facilities.

Caste and class differences interacting with geographical factors- As Karjat is one of the most populated blocks having Adivasi (Scheduled Tribe) community in the Konkan region of Maharashtra, it also becomes a geographical area where these vulnerable populations suffer from multiple deprivations. The people from higher caste are residing in close proximity with each other and have better access to health or other public infrastructure but the people from lower caste reside in relatively inaccessible

regions. Therefore institutional health facilities provided by the government often remains underutilised as these populations largely suffer from not only physical exclusion but social exclusion as well.

Occupation- Agricultural labour in the villages and migrated casual labours in the urban areas are the poorest and most underprivileged. Inability to meet out of pocket health care expenditure from their meagre sources of income is a matter of concern and hence need urgent attention for some public provisioning as per the prevalent situations.

Geographical factors- Availability of hospital beds is directly linked to the degree of isolation/remoteness of area. The more isolated the area, fewer are hospitals beds available. So the people living in outskirts such as tribal population of Karjat block become underserved and excluded. The time, money and opportunity cost which they lose for the day for seeking care make them highly vulnerable to ignorant health related behaviors.

Existing health facilities- Curative healthcare facilities in these areas are over ten times less than in urban areas. According to the respondents, the quality of infrastructure of public health services is usually poor forcing people to go to nearby city like Mumbai if they seek high-quality care. Majority of the health services in the remote & tribal 'padaas' lack health centres, medical doctors, and medical equipment. Shortage of trained medical professionals especially lab technicians, pharmacist and nurses and non availability of essential medicines is common phenomena.

In spite of the fact that Alibag is located in extreme eastern coastal part of District Raigad, it exists as a major central nodal centre for each and every service in the district. The cases referred from Karjat hospital/health centres has to travel three hours long journey to reach District hospital and spend out of their pocket approximately Rs.200 per visit to Alibag. Rural people end up spending more on treatment as they have to incur direct and indirect costs in terms of loss of daily wages, transportation costs etc.

Health Service System Determinants

Interviews with the service providers and critical analysis of three tier level of District Health system of Block Karjat of District Raigad highlighted the issues and barriers faced at each of its level. Some of the issues which were identified as faced by service providers in effective health care service delivery are described in the Table 2 below.

Table 3 Health Service System Determinants

Level of administration	Issues faced in effective health care service delivery	Barriers in achieving Universal health coverage
District : Raigad District Civil Hospital, Alibag	• Lack of coordination between Civil Surgeon and District Health Officer for integrative health services. • Discontinuation of existing health services • Lack of Block specific and village specific initiatives e.g. District health action planning • Lack of attempts to address complaints and issues in timely manner • Lack of convergence of national health programs like National Leprosy Control program and Blindness Control Program at planning level. • Lack of focus on prevention of disability but rather on curative care	• Reluctance to converge and professional ego, Lack of effective communication system • Delay in release of funds from the state and discontinuation of funds from International funding sources for such robust action planning • Accountability for funds and Lack of training on how to use health care funding to execute plans at lower levels • Geographical Location of Civil hospital in Alibag (3 hours journey by local transportation with one way fare of Rs. 100/- per person).

Block : Karjat Sub District Hospital of Karjat manned by one medical Superintendent, and three MBBS	• Lack of medical infrastructure and underutilization of resources available in Rural Hospital. • Disparities in providing services to tribal population • Unavailability of doctors on regular basis • Lack of specialist services and manpower • Lack of funds to initiate new need specific health programs	• Inequitable distribution of man power, resources and infrastructure • Geographical location and Inaccessible transportation services • Reluctance of medical professionals to work in extreme rural areas • Lack of transparency in management of funds
PHC Kadav/Kalamb and Village level sub centre	• Lack of specialist services and manpower at PHC and sub centre level for proper referral. • Non availability of drug kits • Poor compliance to medical treatment.	• Faith in local healers/private doctors and poor faith on Government medicines and treatment.

Some of the common issues which are identified at the grass root level of health service delivery at PHCs are described as below:

Human resources

a. Staffing- According to the Indian Public Health Standards (IPHS) norms, there should be 3 medical officers (M.O) at the PHC out of which one should be AYUSH. But in most of the PHCs in Karjat, there are either 1 or 2 M.O and both are not from MBBS background. Moreover, qualified medical and paramedical staff is not willing to work in the rural areas because of the professional, personal and social reasons. This explains the shortfalls and delays encountered by the PHCs in timely recruitment of staff as well as the non-availability of specialist services at PHC level.

b. Working- Most of the times, only one of the medical officers is present in PHC and work on rotation basis. This problem is further compounded by bureaucratic procedures and practices relating to postings and transfers of medical and paramedical staff. There is lot of deputations of the staff from one place to another leading to the disturbances in the functioning of PHC and double burden on the other staff.

c. Duty hours & Absenteeism- Being IPHS upgraded PHC, the PHC should be 24X7, but it is being observed that this condition has not been fulfilled. Due to lack of effective supervision, the absenteeism rate was found to be high in sub centres and in PHCs. Most of the times, the PHC staff come late and leave early from the PHC or remain absent from the duty in between. Along with this, there is no mechanism to trace and find out how honestly or how long ANMs or ASHA work in the field.

d. Shortage of Essential drugs and Consumables- There is shortage of generic drugs along with shortage of essential kits eg. RDT for malaria, kits for Sickle cell anemia, drugs (anti-hypertensive and anti-diabetic), vaccines (Hepatitis B) and contraceptives which leads to the huge wastage of other efforts, money and resources which is being put on the program. It acts as a major factor in poor delivery of services and making people to look for alternate choices or returning back without treatment.

Financial System

Under the NRHM, special emphasis has been given to certain activities which are very important for the fulfillment of ultimate goals of this mission. These activities include IPHS up-gradation of PHC and SCs, RKS strengthening and effective utilization of untied grants. Although maximum grants are given for these activities but neither of these activities had full utilization of grants or more than 75 percent of expenditure. Sometimes mis appropriation of funds at higher level leads to lack of funds for emerging health care need inspite of will of medical administrators at grassroot levels.

The Village Health Committee members are not given enough training apart from initial orientation on how to plan financial activities as per the needs of the community. Moreover, it was

realized that even huge money which has been put on IPHS up gradation of PHC has been not effective as there is gross under utilization of these infrastructure. Rogi Kalyan Samiti which was supposed to raise the funds after one time grant allotment is not doing so in practice.

Referral Mechanism

Referral system and feedback are not smooth when real time implementation on ground takes place. Once the patient is referred from PHC to District hospital, there is no mechanism to track the patient.

Effective Planning and Clarity of Planning Procedure

Even though in NRHM, the responsibility for planning and implementation has been decentralized to village and PHC level (through Rogi Kalyan Samiti and Village Health Committee), it is realized that even though reports and recording is done at PHC but it is not been utilized and analyzed effectively for planning and priority setting at village level. The participation of the grass root level workers and their understanding about the importance of effective planning and their involvement in planning is found to be low.

Inter-sectoral coordination and Convergence

Inter-sectoral cooperation is very much important for the betterment of health services in India. Coordination with other departments like education department for School Health program and water department for water quality management program is found to be less rigorous.

Communication and Delegation

Regarding management of health services at PHC level, various problems relating to suitability and honesty of personnel, coordination of work of different health functionaries, field logistics and facilities, infrastructural support and services, sectoral coordination with organizations related to health etc., have been noticed. The monthly review meetings and field visits are the two main mechanisms through which the Ministry of Health (MOH) keeps track of the work progress. However, the monthly meetings

held at the PHC were, by and large utilized for compiling various reports and very little time were devoted to program planning.

Capacity Building

There is no regularity in terms of planning and conducting training sessions. When some new program is launched, training sessions are organized for the staff but after that there is hardly any regular follow up or evaluations to measure the impact of training sessions. Most of the times training is for either ASHA or ANM, with rest of the staff remains untrained which hampers the effective service delivery with similar enthusiasm. This creates a wider gap between the one who got training in specific domain and the one who has the authority to translate and utilize the training while planning for action plan.

Focus on Curative services rather than prevention

Prevention of disability and its conversion into a lifelong handicap is something which needs to centrally focus in all planning and capacity building of medical staff. But this is missing in most of health programs as hardly any programs are catering to the disability specific needs of rural needy cases either in terms of early screening and intervention for disabled cases.

Conclusion

To meet healthcare needs for people in Indian context is complex phenomenon where socioeconomic inequities produce multiple crosscutting issues (race, gender, caste, class, religion and disability) exposing people to health-damaging conditions and differential vulnerability. These socio-economic inequities prevailing in rural community are major factors that demand restructuring of healthcare service system.

Country like India has to rethink and re plan effectively to address the "Developmental Divide" between the rural and urban to realize its objective within set time targets. Therefore to achieve the goal of universal health coverage, government action and community involvement must play integral roles in ramping up efforts to meet the MDGs and overall inclusive development of nation. The realization of goal of achieving Universal health coverage for India

is still at a utopian stage and requires rigorous efforts to provide accessible and affordable healthcare to all disadvantaged population of country.

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References

Baru, R. V. (2012). A limiting perspective on universal coverage. *Economic and Political Weekly*, *47*(8), 64-66.

Planning Commission. (2011). *High level expert group report on universal health coverage for India* (No. id: 4646).

Singh, Z. (2013). Universal health coverage for India by 2022: a utopia or reality?. *Indian journal of community medicine: official publication of Indian Association of Preventive & Social Medicine*, *38*(2), 70.

Nayak, N. C., & Basu, A. (2005). Meeting Millennium Development Goals in India: Rhetoric and Realities'. *Globalisation and Rural Development: Understanding New Development Paradigm. New Delhi: Commonwealth*.

Mohfw. (2009). GOI Working Draft, Version Jan – 09. National Health Bill-2009, 10

Travis, P., Bennett, S., Haines, A., Pang, T., Bhutta, Z., Hyder, A. A., & Evans, T. (2004). Overcoming health-systems constraints to achieve the Millennium Development Goals. *The Lancet*, *364*(9437), 900-906.

Duggal, R. (2001). Evolution of Health Policy in India. *Mumbai: Centre for Enquiry into Health and Allied Themes*.

Ibid Article 2.

Ministry of Health and Family Welfare. (2011). *Annual Report to the People on Health*, Government of India

Bajpai N, Sachs J.D, Dholaki R. (2010). *Improving Access & efficiency in public health Services: Midterm evaluation of India's NRHM*, Columbia University, Sage Publishers Organizational Structure of Health care System and Hospital Administration.

Jhunjhunwala, A. (2011). *Can ICT make a difference to Healthcare Case Study*: Rural India

Maigavkar P.D. (1981). "*Rural Health Care: The Jamkhed Project*", Centre for Policy Research, New Delhi.

Mishra S, Duggal R, Lingam L, Pitre A. (2010). *A Report on Health Inequities in Maharashtra*, prepared by SATHI for Maharashtra Health Equity and Rights Watch Implemented in collaboration with CEHAT & TISS.