## REVIEW ARTICLE

# DISADVANTAGED RURAL HEALTH – ISSUES AND CHALLENGES: A REVIEW

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## ABSTRACT

Disadvantaged rural health reflected by significantly higher mortality rates in rural areas which indicate less attention paid by the government. The issue of health disadvantage to the rural area in the country is far from settled. The public expenditure on health in India is far too inadequate, less than 10% of the total health budget is allocated to rural area where 75% people live. In spite of rising budgetary provision, many of the rural populace dies without any medical attention.

Access to high quality health care services plays an important part in the health of rural communities and individuals. Resolving the health problems of rural communities will require more than simply increasing the quality and accessibility of health services. Until governments begin to take an 'upside-down' perspective, focusing on building healthy communities rather than simply on building hospitals to make communities healthy, the disadvantages faced by rural people will continue to be exacerbated.

Underutilization of existing rural hospitals and health care facilities can be addressed by a market-centered approach, and more effective government intervention for horizontal and vertical hospital integration. Tele-healthcare, Mobile Health Units and Community-based health insurance are proven helpful in rural areas. Autonomy enjoyed by women and exposure to media also has a significant impact on maternal health care utilization.

Accessibility to health facilities is a critical factor in effective health treatment for people in rural areas. Location–allocation models prescribe optimal configurations of health facilities in order to maximize accessibility.

**Keywords**: Rural, health expenditure, equity, public expenditure

The health of India's citizens have improved significantly since it gained independence from Great Britain in 1947 thanks largely to public-health efforts that have nearly doubled life expectancy while halving infant mortality rates. It mentions that India's public-health system eradicated smallpox and guinea worm[1], and fighting hard against polio and measles. [1]

However, the urban - rural health differences have received less attention in the entire course of action. On average, urban populations in modern-day periods live longer than do rural populations, and with the exception of HIV/AIDS, exhibit healthier levels across a range of indicators.[2]

In the period when centralized planning was accepted as a key instrument of development in the country, the attainment of an equitable distribution was considered one of the main objectives. Despite this conscious focus in the development process, the attainment of health status differs significantly across urban and rural areas as shown in Tables 1.

**Table 1: Comparison of Vital rates among urban and rural India[3]**

| Vital Rates, 2010 | Rural | Urban |
|---|---|---|
| Crude Birth Rate | 23.7 | 18.0 |
| Crude Death Rate | 7.7 | 5.8 |
| Infant Mortality Rate | 54.7 | 33.7 |
| Under Five Mortality Rate | 66.0 | 38.0 |
| Percent of deaths where medical attention received before death | 29.7 | 48.9 |

Part of the advantage to urban area is thought to be a function of environmental factors, such as better equipped and a greater concentration of health facilities, and part a function of individual factors, such as characteristics among urban dwellers that relate to better health, like higher levels of income and education. Yet, the issue of health advantage in the country is far from settled.[2]

Discussion on rural/urban differences in health in developing countries usually considered issues that affect non-elderly populations, such as communicable

diseases, infant mortality, reproductive health, and traffic-related injuries and deaths. However, rural/urban discrepancies in health problems typical among older people have been almost completely ignored.[4] The issue, however, is of importance and becoming more so for a number of reasons, not the least of which is the rapid population aging occurring in much of the developing world.[4] A rise in older adults means increasing proportions of budgets devoted to this segment of society, bringing their health needs to the forefront of policy.

The total expenditure on health in India is estimated as 5.2% of the GDP; public health investment is only 0.9%, which is by far too inadequate to meet the requirements of poor and needy people.[5]

Successive 5-year plans allocated less and less (in terms of per cent of total budget) to health as pointed out by Kinsella et al[6] and Langmore et al[7]. A major share of the public health budget is spent on family welfare. While 75% of India's population lives in rural areas, less than 10% of the total health budget is allocated to this sector. Even here the chief interest of the primary health care is diverted to family planning and ancillary vertical national programs such as child survival and safe motherhood (CSSM) which are seen more as statistical targets than as health services. According to one study, 85% of the PHC budget goes on personnel salaries. The lack of commitment to provide health care for its citizens is reflected in the inadequacy of the health infrastructure and low levels of financing, and also in declining support for the various healthcare demands of the people; especially since the 1980s, when the process of liberalization and opening up of the Indian economy to the world markets began. Medical care and control of communicable diseases are crucial areas of concern, both in terms of what people demand as priorities as well as what existing socioeconomic conditions demand.

In spite of rising budgetary provision and actual expenditure on the rural health care services, 11% of the rural populace dies without any medical attention.[8] Use of institutional medical services is still very low (just 14.75% of the reported death cases had used any sort of institutional health care before death).[8] In same study researchers reported that 74% of the populace of rural West Bengal dies after receiving non-institutional means of treatment.[8]

It is well known that rural communities do not have access to the same range of healthcare services as urban communities and that health status is poorer in rural areas. As models of health service delivery are changing from treatment and illness prevention to wellness models, health providers are under increasing pressure to re-engineer healthcare services to rural and remote areas in a climate of shrinking resources and community skepticism.[9]

Access to high quality health care services plays an important part in the health of rural communities and individuals.[10] This fact is reflected in efforts by governments to improve the quality of such services through better targeting of funds and more efficient management of services.

Government experience difficulties in attracting and retaining doctors in rural area and it has long been recognized as a contributing factor to the relatively higher levels of morbidity and mortality in rural areas.[10] Studies suggest that resolving the health problems of rural communities will require more than simply increasing the quality and accessibility of health services.[10] Health and well-being in such communities relates as much to the sense of community cohesion as it does to the direct provision of medical services. Over recent years, that cohesion has diminished, undermined in part by government policies that have fuelled an exodus from small rural communities to urban areas. Until governments begin to take an 'upside-down' perspective, focusing on building healthy communities rather than simply on building hospitals to make communities healthy, the disadvantages faced by rural people will continue to be exacerbated. Much of what is known was also summarized by the National Research Council's Panel on Urban Population Dynamics.[11]

Well networked health care system access to healthcare in rural areas is far from satisfactory.[12] In the current scenario, 75% of the qualified consulting doctor's practice in urban, 23% in semi-urban (towns) and only 2% in rural areas where as the vast majority of population live in the rural areas. Hospital beds/1000 people are 0.10 in rural as compared to 2.2 in urban areas. Further, a vast proportion of north and north-eastern region of country lie in hilly terrain and some territory in remote islands making healthcare reach impossible to such far flung areas.

Shorter duration Medical Degree rather than the standard MBBS has been suggested[13] in the country like India. The specialist topics can be excluded in the degree, such as kidney transplantation and angiography. The graduates of this degree allow to practice in rural areas only. Even a distant learning programme to rural health professional by use of modern technology provide rational, less time consuming and less costly ulternative.[14]

Underutilization of existing rural hospitals and health care facilities is also a common phenomenon. Many a time rural patients bypass local rural hospitals despite the availability of comparable medical services. The general conditional logit analysis of data on patients and hospitals suggests that hospital characteristics (size, ownership, and distance) and patient characteristics (payment source, medical condition, age, and race) influence rural patients' decisions to bypass local rural hospitals.[15] A market-centered approach, and more effective government intervention for horizontal and vertical hospital integration may lead to better utilize rural health care institutions.[15]

Moreover, Tele-healthcare concept and its advantages are no longer unknown to the country. Both government and private agencies are venturing into it. Few Indian companies are being capable of providing

hardware and software solution for telehealth care. Products of reputed overseas telehealth industry have their presence. Efforts are directed towards setting up standards and IT enabled healthcare infrastructure in the country.

Community-based health insurance is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor.[16] Studies show that in poor environments, insurance programs can work: (mutual health organizations) have a higher probability of using hospitalization services than nonmembers and pay substantially less when they need care. However, the analysis revealed that while the schemes achieved to attract poor people, the poorest of the poor remained excluded.[16]

Difficulty to access medical services and the increasing cases of diseases prompts the government the need to provide medical services by Mobile Health Units (MHU). The beneficial contribution of MHU to the rural and tribal people and its ability to serve patients has been documented.[17]

Government of India has started National Rural Health Mission with a goal to provide quality health care to isolated rural communities in India. Chatterjee et al[18] try to look at how India's government is aiming to improve rural health care and he concluded that India has the best and the worst in health care: a poor public health-care system as well as state-of-the-art private hospitals.

Various socio-economic and community level factors play vital role in determining the antenatal and maternal health care utilization pattern. Based on the National Family Health Survey analysis it was shown that autonomy enjoyed by women and exposure to media has a significant impact on maternal health care utilization even after controlling for other attributes, particularly their education and household economic status.[19] Availability of a rural health facility in the village and other community level programme propagates the utilization of health care.[19]

Accessibility to health facilities is a critical factor in effective health treatment for people in rural areas of lesser-developed countries like India. In many areas accessibility is diminished by the lack of all-weather roads, making access subject to weather conditions. Location–allocation models have been used to prescribe optimal configurations of health facilities in order to maximize accessibility[20], but these models are based on the assumption that the underlying transport network is static and always available. Essentially, past work has ignored the potential impacts of improvements to the transport system in modeling access.

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