



Research Article

Rural healthcare situation in India: The malaise continues

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SUMMARY : After independence the government adopted a welfare state approach and envisaged a national health system in which the State were required to play a leading role in determining priorities and financing for providing health services to the population (Bhore Committee Report, 1946). The New Economic Policy of 1991, has resulted in high growth rate trajectory of 9 % for India, however, this rapid economic development has not been accompanied by social development particularly the health sector. Health sector has been accorded very low priority as is evident from low allocation of resources by the government. Public expenditure on health in India is less than 1 per cent of Gross Domestic Product (GDP), one of the lowest across the globe. The worst affected due to this policy are poor especially residing in rural areas, who have meagre financial resources and dependent on public healthcare facilities.

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BACKGROUND AND OBJECTIVES

India is home to about 315 million poor people and 74 per cent of these reside in rural areas. Moreover, the concentration of poverty among landless agricultural labourers, marginal and small farmers accounts for nearly 50 per cent of total poor in India (Kumar *et al.*, 2011). According to National Crime Bureau nearly 1,83,000 farmers have committed suicides due to indebtedness in India in the last two decades. The most concerning fact is that cases of farmer suicides due to indebtedness were reported from states like Maharashtra, Andhra Pradesh, Karnataka, Kerala and Punjab which were considered to be agriculture prosperous states.

In recent studies on agrarian distress it was found that healthcare expenditures have been significant in causing or increasing the indebtedness of farmers, which has in turn been a proximate cause of rural suicides. According to National Sample Survey Organization (NSSO, 2005), credit taken for healthcare facilities was identified as one of the major component of total credit acquisition by marginal and small farmers, as nearly 41.6 per cent of total credit acquired by

these category of farmers was for healthcare purposes.

Therefore, to have a better insight into this problem the present study was undertaken with following objectives to assess the public healthcare scenario and its consequences especially in rural areas of India and to highlight the reasons for existing health care situation in rural India.

RESOURCES AND METHODS

The present study is secondary data based collected from government reports/ publications such as World Development Report, Human Development Report, reports of Union Ministry of Health and Family Welfare, the National Planning Commission and National Rural Health Mission, etc., journals, internet, newspaper etc. for evaluating the healthcare scenario in rural areas of India.

OBSERVATIONS AND ANALYSIS

The results obtained from the present investigation has been discussed under following sub-heads :

KEY WORDS :

Health parameters, Infant mortality rate, Maternal mortality rate, Privatized healthcare, Healthcare institutions

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Economic growth vs. development:

The comparisons of certain economic and health indicators of India with some other countries of the world were made (Table 1). India's performance in terms of size of the economy (GDP) and average annual growth rate (1990-2007) of 4.5 per cent is quite commendable and better than developed economies of the world such as USA (2.0 %) and UK (2.4%) but its performance in terms of health parameters is not comparable even with south Asian small economies like Sri Lanka and Bhutan (Table 1). Health parameters like life expectancy at birth in years are 64.4 which is lowest among other south Asian countries such as Sri Lanka (74.4), Pakistan (67.2), Nepal (67.5) and Bangladesh (66.9). The infant mortality rate of India is 54 per thousand live births where as in Sri Lanka it is only 13, China it is 18, Bangladesh it is 43 and Nepal it is 41 per thousand live births. Similarly, maternal mortality rate per 1 lakh births is 450, which is even higher than Pakistan (320), Bhutan (490) and Sri Lanka (58). In India only 47 per cent of births are attended by skilled workers where as in Sri Lanka it is 99 per cent and in China it is 98 per cent (HDR, 2010). Moreover, India has nearly 76 per cent population living below US \$ 2 per day which is more than countries like Bhutan (49.5%), Pakistan (60%) and Sri Lanka (39.7%) (Human Development Report, 2009

and 2010). From this comparison it is clear that inspite of outstanding economic growth the poor performance of health related parameters are responsible for low HDI ranking for India. One of the reason for poor health status of India is its lack of financial commitment to health sector as evident from total government expenditure on health (as % of GDP) which is lowest among all south Asian countries except Pakistan. Moreover, per capita public expenditure on health in India (in US\$) is also less than countries like Bhutan, China and Sri Lanka (Table 1).

Deaths due to curable diseases:

As a consequence of poor health care facilities, precious man-hours of works and human lives are lost due to small curable ailments due to non availability of the timely medical services. According to government estimates in India nearly 66204 persons died due to tuberculosis in 2008 (Table 5). Similarly deaths due to diseases like diarrhoea (2875), snake bite (1508), pneumonia (3817), respiratory infections (5321) and malaria (1055) were significant (NHP, 2009). Moreover deaths due to unnatural causes *i.e.* falls, poisoning, accidents etc. could have been easily avoided with timely and affordable healthcare facilities.

Table 1 : Comparison of economic and health parameters of some countries

Sr. No.		USA	UK	China	India	Sri Lanka	Bhutan	Pakistan	Bangladesh	Nepal
Economic parameters										
1.	Annual GDP (in billion US\$)	14591.4	2674.1	4327	1159.2	40.6	1.3	164.5	79.6	12.6
2.	Av. annual growth rate in % (1990-07)	2	2.4	8.9	4.5	3.9	4.2	1.6	3.1	1.9
3.	HDI ranking of 2010	4	26	89	119	91	-	125	129	138
4.	Population living below US\$ 2 / day	-	-	36.3	75.6	39.7	49.5	60.3	81.3	77.6
5.	People having sanitation facility (in %)	100	100	44	33	91	70	59	39	35
6.	People having improved water source (%)	100	100	77	86	79	62	91	74	90
Health parameters										
1.	Life expectancy at birth (in years)	79.6	79.8	73.5	64.4	74.4	79	67.2	66.9	67.5
2.	Infant mortality rate (per 1000 births)	7	5	18	52	13	54	72	43	41
3.	Maternal mortality rate (per 1 lakh births)	11	8	45	450	58	440	320	570	830
4.	Under five mortality rate (per 1000 births)	8	6	21	69	15	81	89	54	51
5.	Children under weight for age (in %)	-	-	7	46	29	19	38	39	48
6.	Births attended by skilled workers (in %)	99	99	97	43	96	-	31	13	19
Immunization of children (in %)										
1.	Against T.B.	-	-	86	75	99	99	82	99	87
2.	Against measles	93	82	86	58	99	93	78	81	74
3.	Probability of not surviving 40 yrs (in %)	-	86	6.2	15.5	5.5	14.2	12.6	11.6	11
Health expenditure										
1.	Public expenditure (as % of GDP)	7.1	5.6	1.9	1.1	2	3.3	0.8	1.1	2.0
2.	Private expenditure (as % of GDP)	8.5	1.1	2.9	4.1	2.3	1.2	1.8	2.2	4.1
3.	Total govt. expenditure on health (in %)	19.1	16.5	9.9	3.4	8.3	7.3	1.42	7.4	9.2
4.	Per capita expenditure (in US \$)	7285	2992	233	109	179	188	64	42	53

Source: Human Development Reports 2009, HDR 2010

Table 2 : Trends in health expenditure in India (GDP at market price with 1993-94 base year)

Year	Health Expenditure as % of the GDP		
	Revenue	Capital	Total
1950-51*	0.22	NA	0.22
1960-61*	0.63	NA	0.63
1970-71*	0.74	NA	0.74
1980-81*	0.83	0.09	0.91
1990-91*	0.89	0.06	0.96
2000-01*	0.86	0.04	0.90
2001-02*	0.79	0.04	0.83
2002-03*	0.82	0.04	0.86
2003-04*	0.86	0.06	0.91
2004-05	-	-	0.96
2008-09	-	-	1.01
2010-11	-	-	0.89

Sources: *Ghuman and Mehta (2009); Economic Survey of India (2011)

But the reliability of death figures by government sources is quite doubtful as according to World Health Organization (WHO) nearly 15,000 persons in India die annually due to malaria (Anon., 2010). Similarly, in a recently released report of International Vaccine Access Centre, India was placed at top position with nearly 1.6 million child pneumonia deaths which is nearly 25 per cent of the total pneumonia deaths of the world (Tandon, 2010).

Moreover, certain diseases of new ages are also posing serious challenge to country's health with reported cases of coronary heart disease (over 60 million patients), diabetes (45.8

million patients), HIV (42.4 million people) and cancer (over 1 million patients) increasing at alarming pace (Table 6).

The health care divide :

When it comes to healthcare, there are two India's, the country that provides high-quality medical care to middle class/high class Indians and medical tourists, and the rural India where the majority of the population lives (i.e. nearly 70 %). Moreover, It is ironical that limited or no access to quality healthcare is available in areas where nearly 60 per cent of people are living below the national poverty line, 300 million people survive on less than a dollar a day, and more than 50 per cent of all children are malnourished (EMR, 2007). Furthermore, only 25 per cent of the Indian population has access to Western (allopathic) medicine, which is practiced mainly in urban areas, where two-thirds of India's hospitals and health centers are located. In rural India there are 0.2 hospital beds per thousand persons as against 3.0 in urban areas. Similarly in rural areas there are only 0.6 doctors per 1000 persons, which is as high as 3.4 in urban areas. The rural population who work in most hazardous atmosphere and live in abysmal conditions like unsafe and unhygienic birth practices, unclear water, poor sanitation, and sub human habitats which pose serious challenge to public health. Rural-urban health disparities are equally pronounced on account of outcome of health services for instance Infant Mortality Rate (IMR) in rural areas in 74 per one thousand live births which is about 44 per thousand live births in urban areas. Similarly Under-Five Mortality Rate (U5MR) is 137 per thousand live births in rural areas and 87 per thousand live

Table 3 : Healthcare inequalities in India

	Rural areas	Urban areas
Healthcare inequalities area wise		
1. Hospitals (per 1 lakh persons)*	0.36	3.6
2. Dispensaries (per 1 lakh persons)*	1.49	3.6
3. Hospital beds (per 1000 persons)	0.2	3.0
4. Doctors	0.6	3.4
5. Public expenditures (in Rs. '000)	80	560
6. Out of pocket (in Rs. '000)	750	1150
7. Infant mortality rate (per 1000 births)	74	44
8. Under five mortality rate (per1000 births)	133	87
9. Births attended (in %)	33.5	73.3
10. Full Immunization (in %)	37	61
**Health care inequalities income wise		
	Among rich 20 % population	Among poor 20%population
1. Infant mortality rate (per 1000 births)	0.97	38
2. Under-five mortality rate (per 1000 birth)	141	46
3. Full immunization (in %)	0.64	0.21
4. Birth attended by skilled workers (in %)	0.84	0.16
5. Children under weight for age (in %)	27	68

Source: * EMR (2007), De (2008), ** HDR 2010

Table 4 : The availability and requirement of rural health institutions in India (in numbers)

Particulars	SC 's	PHC 's	CHC 's
1. Availability			
Up to March 2008	1,46,036	23458	4276
Tenth plan targets (2002-07)	8669	1714	2565
Achievement of targets (up to Mar 07)	6630	224	938
2. Requirement*			
As per 2008 population estimates	1,60,263	26711	6678
As per 2015 population estimates	1,75,563	29260	7315
3. Coverage			
Av. rural population covered by one	5084	31652	173641
Av. rural area (sq.kms) covered by one	21.35	132.95	729.26
Av. villages covered by one	4	27	149
4. Basic facilities			
Institutions without buildings	57812	1212	148
Institutions without electricity	47932	3122	-
Institutions without water supply	48176	2160	-
Without all weather motorable road	17268	1625	-

Source : Rural Health Statistics, 2009 ; * National Health Profile 2009

births in urban areas (Table 3).

Moreover, rural public health system continues to suffer from the same malaise as earlier – less in number, poor facilities, not enough doctors and nurses, inadequate medicine supplies, poor maintenance etc. which makes medical facilities through government health services inadequate, non qualitative and not available at times. There are less number of sub centres (SC's), primary health centres (PHC's) and community health centres (CHC's) than their actual requirement in the rural areas. According to Indian Public Health Norms (IPHS) there should be one SC for 5000 people (3000 in hilly areas), one PHC for 30,000 people (20,000 for hilly areas) and one CHC for 1,20,000 people (80,000 for hilly areas). But in rural areas there are only 1,46,036 SC 's against the requirement of 1,60,263 according to population estimates of 2008 (NHP, 2009), 23458 PHC 's against the requirement of 26711 and 4276 CHC 's whereas 6678 are required. Moreover, the number of health institutions in rural areas have not increased according to tenth plan target which highlights poor commitment of the governments towards health. The actual requirement of medical institutions on the basis of projected population estimates of rural areas (as per NHP, 2009) for the year 2015 were much higher i.e. nearly 1,75,563 SC 's, 29260 PHC 's, and 7315 CHC 's are required which outstrips the actual availability of these institutions. Similarly due to less number of public health institutions than their actual requirement, these institutions in rural areas are overburdened both in terms of area and number of persons dependent. One PHC covers nearly 132.95 sq. kms whereas one CHC's caters to 729.26 sq. kms of area which sounds unbelievable. Moreover, 57812 SC's, 1212 PHC 's and 148 CHC 's were having no building at all. Even some of

the basic facilities in these government health institutions are not available such as electricity in 47932 SC 's and 3122 PHC 's and water in 48176 SC 's and 2160 PHC 's (Table 4).

Moreover, acute manpower shortages also exist in these institutions as there exists a shortage of 12825 doctors in CHC's (i.e. nearly 75% shortage), 2581 radiographers (60.4% shortage), 14848 laboratory technicians (53.5% shortage), 6778 pharmacists (24.4% shortage) and 103199 health workers (35.3% shortage) which severely affects the services of these institutions (Table 7).

Table 5 : Deaths due to curable diseases (in numbers)

Diseases	Deaths reported in 2008	Deaths reported in 2009
1. Tuberculosis	66208	-
2. Respiratory infections	5321	2813
3. Pneumonia	3871	2813
4. Snake bite	1508	1162
5. Diarrhea	2865	1762
6. Malaria	1055	1068
7. Rabies	259	260
8. Japanese encephalitis	684	774
9. Viral hepatitis	536	584
10. Unnatural causes	3,18,316	-

Source: National Health Profile 2009;

*Estimated value from last five years data.

Health expenditure in India:

In the pre-liberalization period of independent India, the health expenditure as percentage of the GDP increased as a whole from 0.22 per cent in 1950-51 to 0.96 per cent in 1990-91.

Table 6 : Future projections of some diseases (in numbers)

Diseases	No. of reported cases in 2009	Projection for 2015
1. Coronary heart diseases	4,69,68,695	6,15,22,343
2. Diabetes	3,76,71,965	4,58,09,149
3. HIV aids	3,38,40,000	4,23,16,522*
4. Cancer	9,79,786	10,60,889
5. Tuberculosis	15,33,309	*17,10,677
6. Influenza H1N1	25912	*1,05,232

Source: National Health Profile 2009

Surprisingly, it has further witnessed decline during the post economic liberalization period from 0.96 per cent in 1990-91 to 0.91 per cent in 2003-2004. Health care has never been an important election campaign issue except in 2004, when United Progressive Alliance (UPA) promised to raise healthcare expenditure to 2 to 3 per cent of GDP. But in their second tenure at the Centre they managed to take public health spending barely to 1 per cent of GDP in 2008-09 budget, no where close to their target of achieving 2-3 per cent of GDP. Interestingly, the national budget of India for fiscal 2010-2011 was announced when food inflation was over 22 per cent and the allocation for health was Rs. 251.54 billions which is barely 0.36 per cent of the projected GDP. The overall national health budget as a proportion of the GDP is clearly on a downward trajectory hitting a low of 0.89 per cent of GDP (Table 2).

The meagre resource allocation to health sector has adversely affected both access and quality of health services. The unequal access to health services is reported across strata and location *i.e.* urban and rural areas in India.

Privatized healthcare in India:

Health expenditure is highly unequal across the globe. As is to be expected, the developed countries spend the most on health per person. Developed countries accounted for less

than 20 per cent of the world's population but were responsible for almost 90 per cent of the world's health spending. Therefore, 80 per cent of world's population spent only 10 per cent of the total expenditure on health which includes people in the Asia-Pacific as well as African and Latin American countries (EMR, 2007). In India after more than 60 years of independence and number of urban and growth oriented development programmes, nearly 750 million rural people (70% of the total population) in India continue to fight constantly losing battle for survival and health as nearly 70 per cent of all deaths and 92 per cent deaths from communicable diseases occurred among the poor sections of society because 80 per cent of the health expenditure in India is privatized whereas in developed societies more than 80 percent health expenditure is borne by the exchequers (Kurian, 2010).

In India healthcare is dominated by private sector and private spendings. The private hospitals accounted for 82 per cent of India's \$30.5 billion expenditure on health care which is an extremely high proportion even by international standards. These private hospitals provide about 60 per cent of all outpatient care in India and as much as 40 per cent of all in-patient care. Moreover, it is estimated that nearly 70 per cent of all hospitals, 75 per cent of qualified doctors and 40 per cent of hospital beds in the country are in the private sector (EMR, 2007). The greater reliance on private delivery of health infrastructure and health services, therefore, means that overall these will be socially under provided and also inaccessible to the poor. It adversely affects current social welfare and labour productivity, and of course harms future growth and development prospects. India has the lowest ratio of public to private health expenditure among all south Asian countries including the poorest countries like Pakistan, Nepal and Bangladesh etc. (Table 1). Further, all the private expenditure in India (as in some other countries) is constituted by out-of-pocket expenses which is nearly three-fourth of total

Table 7: The shortage of manpower in rural health institutions in India (in numbers)

Manpower	Required	Available	Shortage
1. Doctors (PHC's)	23458	21564	1894 (8.8)
2. Doctors (CHC's)	17104	4279	12825 (75)
Physicians	4276	1126	3150 (73.7)
Obst. and Gynecologists	4276	1174	3102 (72.5)
Pediatrician	4276	866	3410 (79.7)
Surgeon	4276	1113	3163 (74)
3. Lab. Technician's (PHC's+ CHC's)	27734	12886	14848 (53.5)
4. Radiographers (CHC's)	4276	1695	2581 (60.4)
5. Pharmacists (PHC's + CHC's)	27734	20956	6778 (24.4)
6. Health workers (SC's) (male + female)	292072	188873	103199 (35.3)
7. Health Asst/ ANM's (PHC's) (male + female)	46916	35584	11332 (24.2)
8. Nurse/Staff nurse (PHC's+ CHC's)	53390	44936	8454 (15.8)

() figures in parentheses are %ages. Source : Rural Health Statistics, 2009

healthcare expenditure which reflects a trend of gradually increasing household expenditure on health care and is inherently regressive putting disproportionate burden on poor households who pay proportionately more on health than the rich. The increase in healthcare expenditure is especially notable in rural areas, where health now accounts for nearly 20 per cent of total household consumption expenditure which reflects the increasing indebtedness among rural inhabitants to ensure minimal health care as the worsening quality and spread of, reliable public health services, and the increase in user charges and other effective charges even in the public health system, makes people pay more for medicines, diagnostic procedures and surgical aids (Singh, 2010). The worse part is that the reasonably robust urban public health system has also begun to collapse with rapid private sector growth and expansion including the support of private health insurance. Thus the inadequate public investment in health sector by successive central governments actually led to the boom of private health care which has now jumped to 5.5 per cent of GDP. Since private insurance covers barely 2 per cent of the population, most of this expenditure is out-of-pocket indicating a huge burden on households who often have to sell assets or take loans for their hospitalization needs (Duggal, 2010).

Although Government of India has launched a new massive health policy known as National Rural Health Mission (NRHM) in 2005, with the objectives to improve the availability of and access of quality health care to people, especially those residing in rural areas, the poor, women and children (NRHM, 2005). The Central Government launch the National Rural Health Mission (NRHM) under which it proposed to increase public expenditure on health as a proportion of the GDP to 3 per cent from 1 per cent. But increased expenditure without appropriated policy reform is unlikely to deliver. Moreover, the pace of implementation of this scheme is very slow as Accredited Social Health Activist (ASHA) who are the key player, to work as an interface between the community and the public health system are less in number and the states have not made any arrangement for their training. In India as a whole out of the total 2,28,327 ASHA's proposed to be selected only 1,45,546 ASHA's were selected and in most of the states the progress of NRHM is very tardy (Garg and Nath, 2007). A government funded review of National Rural Health Mission (NRHM) revealed its slow progress due to problems in the implementation of the NRHM due to administrative constraints, governance issues, inadequacies in human resources as well as the poor investment in public health services in the recent past (Shrivastava, 2008). Furthermore, financial irregularities and large scale corruption in implementation of NRHM in almost all states, has raised doubts regarding efficiency of this scheme.

Conclusion:

After 60 years of planned development there is a serious mismatch in India between the declared objectives of universal health care through public health care system on the one hand and the actual level of public health expenditure on the other. This mismatch between objectives and resources is at the heart of the inadequacies and inequities of the health system prevalent in the country. The dismal performance of public healthcare system especially in rural areas of the country is inherently regressive putting disproportionate burden on poor households who doesn't have access to privatized healthcare system due to limited resources. To improve access and quality of health services among rural inhabitants, increasing public spending on health sector to at least 3 per cent of GDP and appropriated policy reforms are suggested. These additional resources should be used for creating and upgrading the healthcare infrastructure in rural areas, hiring manpower and providing health insurance to poor people. Policy reforms include taking measures for speeding up development works, time bound completion of programmes and keeping a check on absenteeism, and corruption.

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