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Trivialization of Health Care Scenario in Rural India: A Sociological Concern

Dr. K. Bhavani Shankar
Assistant Professor (C), Dept. of Sociology, Nizam College, Osmania University, Hyderabad, Telangana, India

Abstract

"Health is not everything but everything is nothing without Health"

Globalization is a key challenge to public health, especially in developing countries, but the linkages between globalization and health are complex. India alone accounted for nearly one-fourt of the world's poor, highest number of maternal deaths & under-weight children and one-third of the world's under-weight children. Currently India spends on health less than one per cent of its GDP. The effort to meet & exceed the Millennium Development Goals (MDGs) in India by 10th & 11th five year plans. Article 25 of the Universal Declaration of Human Rights unequivocally states that "the preservation and promotion of health is one of the most basic human rights". India, despite being a signatory to the "Alma Ata Declaration" (1978), which aimed at "Health for All" by 2000. Women being the focus of all the health programmes, the strategy of the government to include rural women and more precisely the local women in the infrastructure at the root level needs to educate women with health literature and improve their health consciousness. However, disparities between rural & urban areas to access health care services were alarming, the challenge of quality health services in remote rural regions has to be met with a sense of urgency. Thus, the "Health is at the Bottom of In-Justice".

Introduction: Even After 64 years of Independence, a number of urban and growth-orientated developmental programs having been implemented, nearly 716 million rural people (72% of the total population), half of which are below the poverty line (BPL) continue to fight a hopeless and constantly losing battle for survival and health. The policies implemented so far, has not concentrate on equity and equality, which have widened the gap between 'urban and rural' and 'haves and have-nots'. Article 47 of the Indian Constitution states that the "the State shall regard raising the level of nutrition and standard of living of its people and improvement in public health among its primary duties".

The successive Five-Year Plans laid down the policies and strategies for achieving these goals. Primary Health Centers were established in rural areas from 1952 onwards. Rural people in India in general, and tribal populations in particular, have their own beliefs and practices regarding health. Some tribal groups still believe that a disease is always caused by hostile spirits or by the breach of some taboo. They therefore seek remedies through magic-religious practices. On the other hand, some rural people have continued to follow rich, undocumented, traditional medicine systems, in

addition to the recognized cultural systems of medicine such as: Ayurveda, unani, siddha and naturopathy, to maintain positive health and to prevent disease.

Rural Inequality of Health Status in India: Article 25 of the Universal Declaration of Human Rights unequivocally states that "the preservation and promotion of health is one of the most basic human rights". India, despite being a signatory to the "Alma Ata Declaration" (1978), which aimed at "Health for All" by 2000. About 75% of health infrastructure, medical man power and other health resources are concentrated in urban areas where only 27% of the population lives. However Communicable diseases like Contagious, infectious and waterborne diseases such as diarrhea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections dominate the morbidity pattern, especially in rural areas. And, Non-Communicable diseases such as cancer, blindness, mental illness, hypertension, diabetes, HIV/AIDS, accidents and injuries are also on the rise. The health status of Indians, is still a cause for grave concern, especially that of the rural population.

Globalization is a key challenge to public health, especially in developing countries, but the linkages between globalization and health are complex. The process of globalization not only includes opening up of world trade, development of advanced means of communication, internationalization of financial markets, growing importance of MNC's, population migrations and more generally increased mobility of persons, goods, capital, data and ideas but also infections, diseases and pollution. The wider view equals globalization with the notion of "Vasudhaiv Kutumbakam" (the whole world is one family).

Due to early marriage of women and early pregnancy (below 18 years of age). More then (Fifty-Eight per cent) of deliveries are conducted at home by an untrained traditional birth attendant. Only 30% of women had postnatal checkups. Two distinct types of health status have been in evidence, the 'Rural–Urban'. There are also other divides such as 'Rich–Poor', 'Male–Female', 'Educated–Uneducated', 'North–South, 'Privileged–Under Privileged', etc.

Rural-Urban Divide in Health Services in India

Sl. No.	Characteristics	Rural (per 1000 population)	Urban (per 1000 population)
1.	Hospital Beds	0.2	3.0
2.	Doctors	0.6	3.4
3.	Public Expenditures	Rs. 80, 000	Rs. 5, 60, 000
4.	Out of Pocket	Rs. 7, 50, 000	Rs. 1, 150, 000
5.	Infant Mortality Rate (IMR)	74/1000 Live Births	44/1000 Live Births
6.	Under Five Mortality Rate (U5MR)	133/1000 Live Births	87/1000 Live Births
7.	Births Attended	33.5%	73.3%
8.	Full Immunization	37%	61%

Source: Jhilam Rudra De (2008)

To improve the prevailing situation, the problem of rural health is to be addressed both at macro (National and State) and micro (District and Regional) levels. This is to be done in an holistic way. A paradigm shift from the current 'Bio-Medical Model' to a 'Socio Cultural Model', which should bridge the gaps and improve quality of rural life, is the current need. The *"Bhore Committee*

(1946)" was not only the last colonial legacy but also become *the first policy statement on health care in independent India.*

Central budget allocations for health have stagnated at 1.3-2% of total Central budget. In the States it has declined from 7.0% to 5.5% of State health budget. Consider the contrast with the Bhore committee recommendation of 15% committed to health from the revenue expenditure budget.

Disparities between Urban & Rural

	Crude Birth Rate (per 1000)	**Crude Death Rate (per 1000)**	**IMR (per 1000 Live births**	**Prevalence of Anaemia Among Children (6–35 Months) (%)**	**Prevalence of Anaemia among Pregnant Women (%)**
Urban	19.1	6.0	40	75.7	54.6
Rural	25.6	8.1	64	81.2	59.0
Total	23.8	7.6	58	79.2	57.9

Source: Ministry of Health & Family Welfare (GOI), 2006 and NHFS 3, IIPS (2005–06).

Unfinished Targets of Communicable Diseases: Apart from the above, there remains a vast unfinished burden in preventing controlling or eliminating other major communicable diseases and in bringing down the risk of deaths in maternal and peri- natal conditions. Endemic diseases arising from infection or lack of nutrition continue to account for almost two thirds of mortality and morbidity in India.

1. India accounts for more than 20% of global maternal and child deaths, and the highest maternal death toll in the world estimated at 138,000.
2. Infant Mortality Rate (IMR) in India was 67.6 in 1998-99 and has come down to 57 in 2005-06. Kerala heads the progress made so far with an IMR of 15/1000 births. Uttar Pradesh has the worst IMR in the country of 73/1000 births.
3. Maternal Mortality Rate (MMR) is currently 4 deaths per 1000 births.
4. India accounts for the largest number of maternal deaths in the world.
5. 79% of the children between the age of 6-35 months, and more than 50% of women, are anemic, and 40% of the maternal deaths during pregnancy and child-birth relate to anemia and under-nutrition.

Unfinished Targets of Non Communicable Diseases: Three major such diseases viz., cancer cardiovascular diseases and renal conditions– and neglect in regard to mental health conditions - have of late shown worrisome trends. Cures for cancer are still elusive in spite of palliatives and expensive and long drawn chemo- or radio- therapy which often inflict catastrophic costs. In India cancer is a leading cause of death with about 1.5 to 2 million cases at any time. Over 15 lakh patients require facilities for diagnosis and treatment. CVD cases and Diabetes cases are also increasing with an 8 to 11 % prevalence of the latter due to fast life styles and lack of exercise. It is acknowledged that the only way of handling mental health problems is through including it into the primary health care arrangements implying trained screening and counseling at primary levels for early detection.

Disease Burden

Disease/Health Condition	Estimate of Cases/lakh	Projected number (2015) of Cases/lakh
Communicable Diseases		
Tuberculosis	85 (2000)	NA
HIV/AIDS	51 (2004)	190
Diarrhoeal Diseases	760	880
Malaria and other Vector Borne Diseases	20.37 (2004)	NA
Leprosy	3.67 (2004)	Expect to be Eliminated
Otitis Media	3.57	4.18
Non-Communicable Conditions		
Cancers	8.07 (2004)	9.99
Diabetes	310	460
Mental Health	650	800
Blindness	141.07	129.96
Cardiovascular Diseases	290 (2000)	640
COPD and Asthma Others	405.20 (2001)	596.36
Injuries—deaths	9.8	10.96
Number of Hospitalizations	170	220

Source: Bulletin of Rural Health Statistics in India, Special Revised Edition, MOHFW (GOI), 2006

Health Infrastructure: The launch of NRHM has provided the central and the state governments with a unique opportunity for carrying out necessary reforms in the health sector. The strengthening and effectiveness of health institutions like SHCs/PHCs/CHCs/Taluk/District Hospitals have positive consequences for all health programs health infrastructure. The health care infrastructure in rural areas has been developed as a "Three Tier System". In the hierarchy of rural public health facilities, community health centers (CHC) comes first under which the primary health center (PHC) and finally the sub health centers whom the women health volunteers (WHVs) work.

Sub Health Centers: It is the first contact point between the community & Public.-health System manned by an ANM (Auxiliary Nurse Midwife) and a male health worker. Each sub health center covers a population of 3000-5000; there is a provision of Rs. 10000/- fund per year to each Sub center. Availability and flexibility in utilizing the fund for improving the services as per local needs will empower the ANM and the PRI (Panchayati Raj Institution).

Primary Health Center: PHC is the first contact point between village community and the Medical Officer, the PHCs were envisaged to provide an integrated curative and preventive health care to the rural population. A PHC covers a population of 20000-30000. The PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as referral unit for 6 Sub Centres. It has 4-6 beds for patients.3 Staff nurses ensure round the clock services. Out patient services are strengthened by AYUSH doctors, over and above the medical officers posted at the PHC.

Community Health Center: The NRHM aims at ensuring a functional 30-bedded rural hospital at the CHC level to provide 24x7 hrs hospital services with seven medical specialists including a Surgeon, Physician. Gynecologist, Anesthetist and Pediatrician supported by 21 paramedical and other staff including 9 staff nurses. It is a referral Unit for PHCs. A CHC covers a population of 90000- 120000. A separate AYUSH set-up also is provided in every CHC. The population coverage norms depend upon whether the center is in a hilly, tribal, difficult area or in the plains.

Women Health Volunteers (WHV). Also called as the Accredited Social Health Activist (ASHA), a central functionary of NRHM is appointed for every 1000 population.

Health Care Infrastructure and Gaps

As per Population	Present	Required	Shortfall
Sub Health Centers (SHCs)	1,46,026	19,269	60,762
Primary Health Center (PHCs)	23,236	4,337	2,948
Community Health Center (CHCs)	3,346	3,206	205

Source: Bulletin of Rural Health Statistics in India, Special Revised Edition, MOHFW (GOI)

At the end of 2000, India alone accounted for nearly one-fourth (364 million) of the world's poor, highest number of maternal deaths & under-weight children and one-third of the world's under-weight children. Infant & maternal mortality rates are worse than those in some countries of sub-Saharan Africa. Currently India spends on health less than one per cent of its GDP, which is less than in countries like Sri Lanka & Sierra Leone. The effort to meet & exceed the Millennium Development Goals (MDGs) in India is a stated objective in many of the key policy documents of the country, including the 10th & 11th five year plans. The year 2007 marked the mid-point of the period agreed by the UN Member states for the achievement of the MDGs.

Sale/Commercializing Health Services in India: The 'Western Models' system, which is highly selective, institutionalized, centralized and top down, not by oversight but by design, and which treats people as *"Objects rather than Subjects"*. Hospitals in major cities are in many cases run by business houses and use corporate business strategies and hi-tech specialization to create demand and attract those with effective demand. Health care arrangements generally evolve under the influence of at least *four component factors* viz., A) population health status B) Health infrastructure and its management (public and private) C) Fairness in financing costs of care, and D) Differing health perceptions of people , professionals and planners. As an open democratic society India had always been influenced by the dominant international paradigms on health care be it PHC or District health systems approach or WHO or UNICEF or World Bank, are leading to *two consequences*. First the technocratic paradigms received from donors as part of aid have periodically redirected public health priorities in direction of efforts, in terms of unit costs and in manpower deployment, because *foreign funding was often accepted as an addition to*, and not an integral part of, domestic health sector planning. Second, some vertical programs underestimated the biological consequences of mass intervention in *drug resistance.* In a market economy, health care is subject to three links, none of which should become out of balance with the other 1) The link between state and citizens' entitlement for health, 2) The link between the consumer and provider of health services and 3) The link between the physician and patient.

While 75% of India's population lives in rural areas, less than 10% of the total health budget is allocated to this sector. In the case of medical research, a similar trend is observed. While 20% of research grants are allocated to studies on cancer, which is responsible for 1% of deaths, less than 1-

2% is provided for research in respiratory diseases, which accounts for 20-30% of deaths. Doctors practicing in the private sector are sometimes accused of prescribing excessive, expensive and risky medicines for diagnosis and treatment. Private independent practices – and to smaller extent hospitals, dispensaries, nursing homes etc - are seen as markets for medical services. About 67% of all hospitals, 63% of all dispensaries and 78% of all doctors in India are in the private/corporate sector.

Government Involvement: Improvement in the health status of the people has been one of the major thrust areas for the social development programs of the country. The dream of healthy India can only be fulfilled when the rural health is taken care of. Rural India is characterized with low literacy rate and high rate of vulnerability to diseases both communicable and non-communicable. Starting with the *Bhore committee recommendations 1940***,** the government of India has laid foundations of comprehensive rural health services through the concept of public health care. In compliance with the National Population Policy, (NPP) 2000 and National Health Policy, (NHP) 2002, and the recent Millennium Development Goals (MDG), in which out of the Eight Goals three of them are health oriented goals. The target of meeting the Millennium Development Goals (MDG) were also kept in the mind as the goal under National Rural Health Mission (NRHM) as, NRHM addresses two of the major health problems identified in UN millennium project. MDGs are eight goals to be achieved by 2015 that respond to the world's main development challenge. India is one of the 189 nations, who adopted the millennium declaration which was signed by 147 heads of states and governments during the UN millennium summit in September 2000.

Eight Millennium Development Goals:

1. Eradicate extreme poverty and hunger
2. Achieve Universal Primary Education by 2015
3. Promote gender equality and empower women
4. ***Reduce Child Mortality by 2015***
5. ***Improve Maternal health by 2015***
6. ***Combat HIV/AIDS, Malaria and other diseases by 2015***
7. Ensure Environmental Sustainability
8. Develop a global partnership for development.

The various health programmes introduced by the government for rural health like IMNCI, (Integrated Management of Neonatal and Childhood Illnesses), RCH (Reproductive Child Health - 1997-2004), Jeannie Suraksha Yojana (JSY) under the XI Five Year Plan (2007-201.2) and the National Rural Health Mission (NRHM) (2005-2012) are focusing on improving the child and women health. Rural India is infected by communicable diseases which are Water borne:-sector borne, airborne and by sexual transmission.

Community Intervention: The National Rural Health Mission (NRHM) has been envisaged as a focal point of all the programs targeted to improve the health of rural people in India. The transition from curative measures to preventive measures plays a vital role in eradication of both communicable and non communicable diseases. People need to be educated at large regarding hygiene and sanitation, preventive measures, procuring safe drinking water etc. arid this is possible, only when it is done by involving the community. Women being the focus of all the health programmes, the strategy of the government to include rural women and more precisely the local women in the infrastructure at the root level needs to educate women with health literature and improve their health consciousness. Government of India, realizing the importance of women

especially the rural women has come up with the Health programmes where the child and women are focused on.

Time-Bound Goals for the Eleventh Five Year Plan:

1. Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births.
2. Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.
3. Reducing Total Fertility Rate (TFR) to 2.1.
4. Providing clean drinking water for all by 2009 and ensuring no slip-backs.
5. Reducing malnutrition among children of age group 0–3 to half its present level.
6. Reducing anemia among women and girls by 50%.
7. Raising the sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17.

Pattern of Health Budget as % of Total Budget (Rupees in Crores)

Five year plans	Total plan investment	Health budget	Health budget as % of total budget.
I	1960.0	65.02	3
II	4672.5	140.8	3
III	8576.5	225.9	2.6
Annual plan(1966 – 1969)	6625.5	140.2	2.1
IV	18778.2	335.2	2
V	39426.2	760.8	1
VI	975500	1828.1	1
VII	180000.0	3392.9	1
VIII	220000.0	3842.2	1
IX	254500.0	4000.5	1
X	300000.0	4500	1.5
X1	21,113.33	4,000	1.5

Source: Ministry of Health & Family Welfare (GOI)

Missions Vision: The National Rural Health Mission (2005-12) seeks to provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and weak infrastructure. These 18 states are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, and Madhya Pradesh. Nagaland, Rajasthan. Sikkim. Tripura, Uttaranchal and Andhra Pradesh.

1. The Mission is an articulation o commitment of the Government to raise public spending on health from 0 9 percent of GDP to 2.3 percent of GDP.
2. It seeks decentralization of programme- district management of health.
3. It seeks to improve access of rural people especially poor women and children, to equitable affordable, accountable and effective primary health care.

A significant allocation has been an increase of Rs. 2,057 crore over the proposed Rs. 12,070 crore in the interim budget for National Rural Health Mission (NRHM).

Conclusion: Thus, the "*Health is at the Bottom of In-Justice*". It is in this context that we should ask the question as to how far and in what ways has politics been engaged in health care. The 'Magical' year of 2010 AD has come to an end. 'Health for all by 2010 AD' remains as a distant mirage and

the slogan has been rephrased as 'Health for all in 21st Century'. Primary health care, as a paradigm, has been lost on the way. The failure of the 'Alma Ata Declaration' in fulfilling its objectives to shift resources from urban to rural scene, reiterates the urgency of looking for alternative strategies at the national and local level. The problem of rural health is to be addressed both at the macro (national and state) and micro level (district and regional), in a holistic way. A comprehensive revised National Health Policy addressing the existing inequalities, and work towards promoting a long-term perspective plan exclusively for rural health is the current need. It is unfortunate that while the incidence of all diseases are twice higher in rural than in urban areas. Even minimum health facilities are not available to at least 175 million of rural and tribal people, and wherever services are provided, they are inferior. While the health care of the urban population is provided by a variety of hospitals and dispensaries run by corporate, private, voluntary and public sector organizations. Much has been achieved in the last 62 years. It is nation's moral, legal & constitutional responsibility to promote, restore or maintain the health status of its population through meticulously designed policy, plans & programs.

However, disparities between rural & urban areas to access health care services were alarming. The dream of healthy India can only be fulfilled when the rural health is taken care of. The challenge of quality health services in remote rural regions has to be met with a sense of urgency. The urgent need is to transform the public health system into an accountable, accessible and affordable system of quality services.

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