

Inequalities in the Distribution of Primary Care Providers: Comparing Measles & Healthcare Disparity among Urban and Rural Areas

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ABSTRACT

Despite economic process and improved health outcomes over the past few decades, India still experiences striking urban-rural health inequalities. According to the Census Of India, 27.8 % of total population resides in Urban areas and henceforth 72.2% population resides in rural areas of the country. The aim of this study is to estimate trends in urban-rural disparities in self-care, outpatient, inpatient care utilization and measles vaccination. Complementing other papers in this Series, we argue for the application of certain principles in the pursuit of equity in health care in India. These are the adoption of equity metrics in monitoring, evaluation and strategic planning, investment in developing a rigorous knowledge-base of health systems research; development of more equity-focused process of deliberative decision-making in health reform, and redefinition of the precise responsibilities and accountabilities of key actors. The implementation of those principles, alongside strengthening of public health and first care services, provide an approach for ensuring more equitable health after India's population.

KEYWORDS: Healthcare, Rural, Urban, Primary, Patient

INTRODUCTION

India population is 17.7% among world population and India is among fast growing developed countries. The entire per capita government spending on healthcare in FY20 is ₹ 1,944, which is the same for all regions and states. But, still there's an enormous gap within the medical facilities among urban and rural areas. During this research topic, we'll emphasize the government healthcare policies and its implementation towards the welfare of a citizen. Among the marketing research, we found there's an enormous gap in medical facilities, equipment and practitioners.

Measles, a vaccine-preventable disease, primarily affects children in developing countries. Consistent with the planet Health Organization (WHO), measles may be a leading explanation for childhood mortality. Globally, measles fell 50% from an estimated 345,000 in 2005 to 110,000 in 2019. Estimates for 2025 indicate deaths fell further to 65,000 globally, with 77% of the remaining measles deaths in 2008 occurring within the South-East Asian region.¹ In 2010, faced with such a high mortality burden from a vaccine-preventable disease, the Indian government introduced a second dose of measles vaccine into its immunization program through a two-pronged approach: routine immunization in 17 states, and mass immunization campaigns targeting children aged between 9 months and 10

years in 14 other states with historically low immunization uptakes. The campaigns were implemented between 2010 and 2013, targeting over 134 million children – a huge undertaking by any standards and one among the most important mass immunization campaigns ever conducted. There's evidence suggesting that measles vaccination coverage has increased only slightly or maybe stagnated in some provinces within the previous couple of years.

Impact of Medical Expenditure on Household well being

Does the health expenditure cost an equivalent to every household? This remains a serious policy concern in many of the developing countries including India, where household OOP payment for health care may be a significant part of the entire health expenditure. The high OOP spending on health often results in catastrophic levels of paying for healthcare to several households and pushes them into poverty. The proportion of households facing catastrophic OOP health payments during 2004–2005, as measured by Ghosh was 15.4% and therefore the range varies as less as 3.5% in Assam to 32.4% in Kerala

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Table1: Health care spending on monthly household income

	Health care spending (%) on monthly household income		
	Any morbidity	Short term	Long term
All India	6.02	4.43	1.59
Place of residence			
Metro	1.13	0.67	0.46
Other urban	3.57	2.42	1.15
More developed village	7.73	5.72	2.01
Less developed village	6.87	5.18	1.69
Income			
Lowest quintile	14.53	11.15	3.38
Second quintile	4.53	3.27	1.26
Third quintile	2.44	1.74	0.7
Fourth quintile	1.44	1.02	0.42
Top quintile	0.65	0.37	0.28
Social groups			
High caste Hindu	5.13	3.65	1.48
OBC	7.59	5.66	1.93
Dalit	5.32	4.06	1.26
Adivasi	3.88	2.78	1.1
Muslim	4.84	3.88	0.96
Other religion	9.19	4.36	4.83

Since private health facilities that provide specialist services are mostly found in urban areas, the onus of providing access to specialist services in rural areas primarily lies with CHCs. India spends a little extent of its financial plan on human services. Expanded budgetary designations to National Rural Health Mission prompted altogether improved wellbeing results: the vast majority of this improvement happened in rustic zones, diminishing wellbeing imbalances. Nonetheless, generally speaking budgetary assignments to medicinal services stay low, around 1% of total national output (GDP), limiting ideal upgrades.

Urban Vs Rural Medical Infrastructure

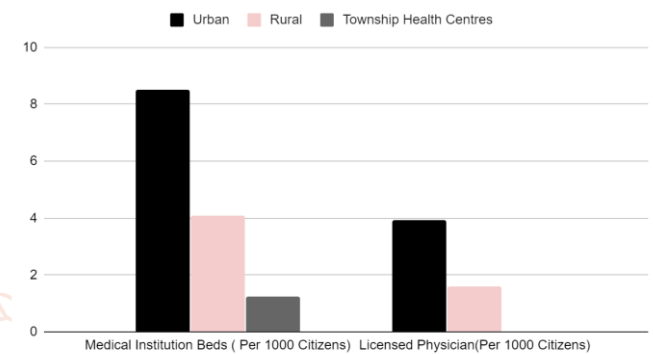


Fig2: Medical Infrastructure (Urban vs Rural)

Current Trends

Government health services in rural India are mainly provided through a three-tier hierarchy of publicly funded health facilities, with community health centres (CHCs) – 30-bed, 24 × 7 rural hospitals that serve about 120,000 people – at the highest, primary health centres (PHCs) within the middle, and health sub-centres (HSCs) at rock bottom. While HSCs and PHCs provide essential healthcare services, the CHC provides specialist services and acts as a referral centre for the PHCs and HSCs in its catchment basin.

It provides specialist services to affect surgical, paediatric, obstetric, and gynaecological emergencies through a team of healthcare professionals that has four specialist doctors (doctors with a postgraduate medical degree in specific areas), namely surgeon, paediatrician, obstetrician, and anaesthetist.

To understand the issues on the ground in urban and rural areas of west bengal, we conducted field research in Kolkata District, a small area in the eastern region of India. Kolkata or Calcutta, a third tier city, and encompasses a total of 72 towns, 527 towns and villages, and 2 townships. In Kolkata, we interviewed physicians, health administrators, and government officials to understand their healthcare needs and challenges.

The shortage and unequal distribution of a specialist workforce at the CHC level can have serious implications not just for maternal and child mortality but also for the standard of health service delivery at higher levels, like in-district or regional hospitals. Since the agricultural poor mostly believe publicly funded facilities for their healthcare needs, the shortage of specialists at the CHCs often forces them to either forgo treatment or avail specialist services from the private sector, which is infamous for its exorbitant fees. The shortage of CHC specialists may cause higher disease burden and mortality for the agricultural population, and it could also trap rural households into a vicious poverty cycle thanks to the high out-of-pocket expenditures faced when seeking medical aid.

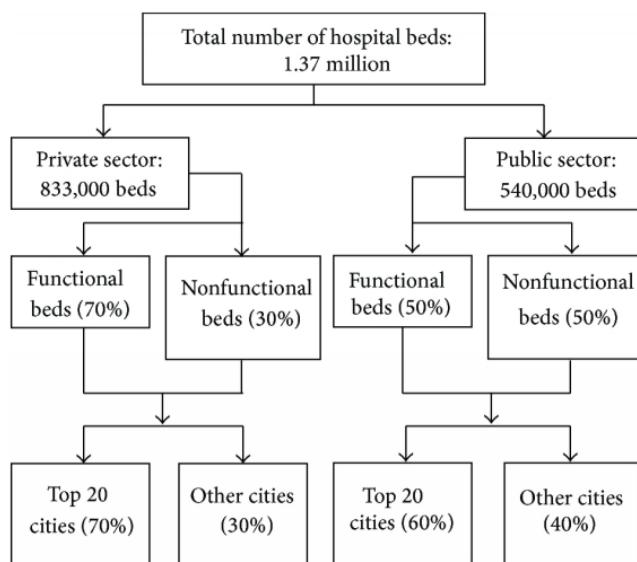


Fig1: Breakdown of number of beds among Private and Public Hospitals

Cross tabulation between Education of Household earner and Immunization status

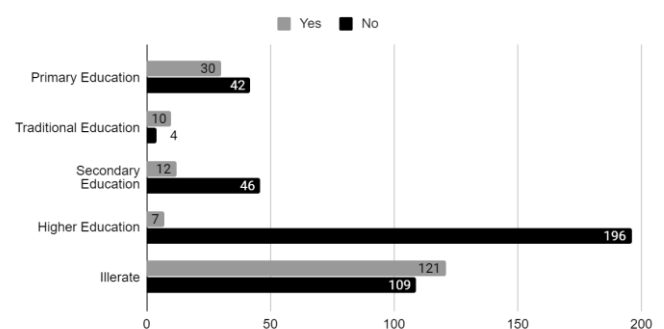


Fig3: Education of household earner and Immunization Status

Out of 577 children, females were 51.9% and males were 48.1%. Urban population was nearly 53% while the rural population was 47%. Most of the family earners were illiterate (40% n=230), followed by higher education (35.2% n=203), Primary (12.5% n=72) and traditional education like Madarsa (2.42% n=14). Monthly income of families ranged from Rs.2,000 to Rs. 31,000. Most of the family earners were private employed (41.7%), followed by labourers (25.6%) and government servants (32.7%).

Cross Tabulation between distance of CHCs centre and Immunization status

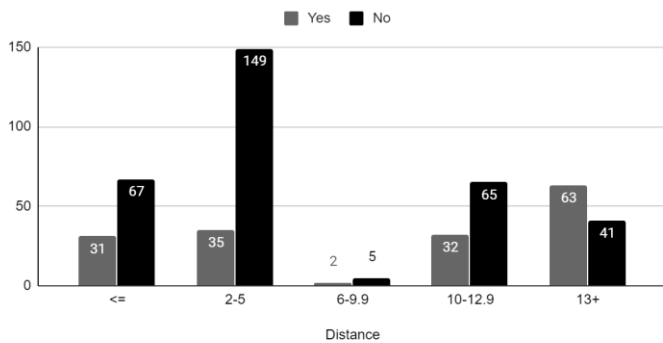


Fig4: CHCs centres distance in Km

The distance had no significant effect on Immunization status below 13km but it had a clear effect on immunization above 13 km (Fig 2). Similarly respondents who thought immunization wasn't of any benefit had a very low immunization status (25.5%) than the respondent's children who considered it beneficial (71.5%).

The lack of specialists in CHCs also forces the agricultural poor to hunt specialist services from higher-level, publicly-funded hospitals (such as district hospitals and medical colleges) or other CHCs in proximity. The influx of those patients who should be treated at their local CHC, into the higher-level facilities that are meant for complex and high cases or in other CHCs, often results in overcrowding, long queues, delays in treatment, and untimely deaths. The shortage or unequal distribution of the health workforce (for instance, specialists across CHCs) could also cause the ineffective use of physical infrastructure and equipment, rendering the invested infrastructure and equipment useless. Hence, it is vital to form sure that every one CHCs are equipped and staffed with a team of 4specialists, as recommended by the Indian Public Health Standards (IPHS).

Types of Hospital people visits

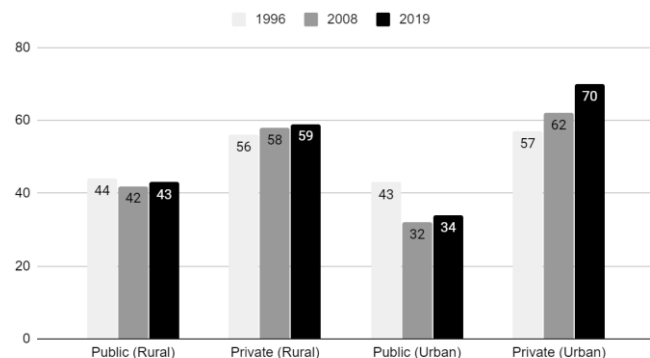


Fig5: Survey conducted in nearby locality by Top Medical Institution

This over-reliance on private hospitals allows hospitals to charge substantially more than government facilities. As

public health activists often point out, healthcare is not like any other consumable where the consumer can hold out for better prices. When faced with the prospect of a sick or dying relative, a person will choose expensive tests and procedures. Patients and families who are given choices between less and more expensive drugs, tests or procedures will choose the more expensive one, equating the higher price with better guarantee even though the more expensive drug, test or procedure may not be scientifically proven to be better.

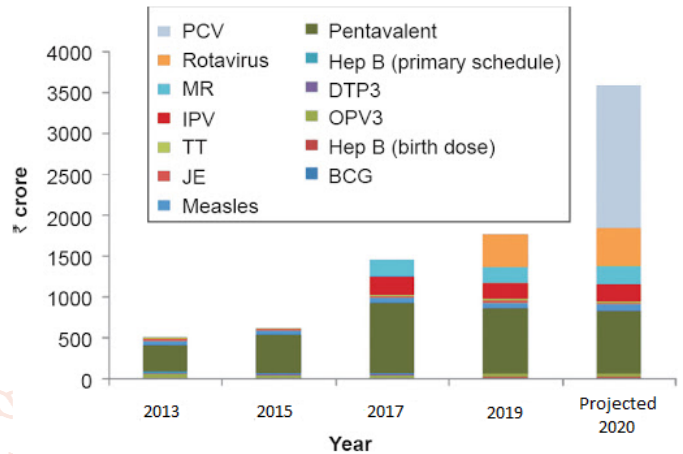


Fig6: Projected Trends of Vaccinations

Asset necessities for antibodies expanded from `511 crores (\$79 million) in 2013 to `3,587 crores (\$552 million) in 2020 as new immunizations were thought to be presented in the Program. The necessities will twofold from 2013 to 2020 if pentavalent immunization is turned out in all States and if IPV and MR antibodies are included. It will increment fundamentally again in 2020, if PCV is included.

Conclusion

Lack of awareness, low accessibility and misconception regarding immunizations and associated low literacy and poor socioeconomic conditions are the main causes of low immunization against measles. Government Policies related to medical facilities should be implemented in a more organized manner. There are worries that India's interests in the Pradhan Mantri - Jan Arogya Yojna (PMJAY) will advance auxiliary and tertiary social insurance, to the detriment of essential human services. The interview achieved proof and experience that will be useful for India to turn this around: helping the PMJAY reinforce as opposed to debilitating essential medicinal services.

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About Author:



Swaraj Agarwal is a senior in high school at La Martiniere for Boys, Kolkata, India. He is passionate about the intersectionality of sociology, economics, public health, and environmental science, and hopes to pursue these interests in college. He runs Micro Treasures, a social enterprise aimed at creating awareness about and supplying microgreens.

