



Review Article

## POOR MEDICAL CARE IN RURAL AREAS OF UTTAR PRADESH: PERCEIVED REASONS AND STRATEGIES FOR IMPROVEMENT

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This paper seeks to evaluate quantity and quality of service delivery in rural public health facilities under National Rural Health Mission in Uttar Pradesh. On appropriate and feasible measures, the former is assessed on the static and dynamic condition of physical infrastructure; by the numbers of paramedical, technician and medical staff employed, as well as figures for attendance and gender breakdown; by the supply, quality and range of drugs; by availability and usage of decentralized untied and maintenance funding of centres; and by actual availability of laboratory, diagnostic and service facilities. Quality is defined in relation to the condition of the above tangibles, as also supplemented by subjective data on intangibles, such as patient satisfaction, gathered from the exit interviews.

**Keywords:** National Rural Health Mission, Uttar Pradesh, Rural public health

### INTRODUCTION

The past twenty years have brought enormous changes and growth to parts of India. Globalization has afforded enormous opportunities to many of its citizens living in urban areas. However, the situation is not as bright in rural India which makes up over 70% of the population of India.

When measuring health, the three factors that are considered most informative about standards

of living are mortality, morbidity, and life expectancy. These measures allow us to examine rates of life, death and disease in an area and enable us to draw conclusions about the state of health care in any given area. For rural and urban areas of Uttar Pradesh some important indicators are shown in Table 1.

The data in table 1 tell us that there is an urgent need to improve the quality of health care in rural

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**Table 1: Important Indicators of Healthcare in Uttar Pradesh (2009)**

Indicators	Rural (%)	Urban (%)
Population	71.3	28.7
Birth Rate	24.1	18.3
Death Rate	7.8	5.8
Infant Mortality. Rate	55.0	34.0
Natural Growth Rate	16.5	12.6

*Source: SRS Bulletin, January 2011, Sample Registration System, Office of Registrar General, India*

areas if India wishes to provide desirable health care to all its citizens.

## THE CURRENT INFRASTRUCTURE OF HEALTH CARE

Government of India has created, at least in theoretical terms, a very intricate infrastructure to provide health care to its rural population. It is as follows:

1. Sub Centers (SC): Most peripheral contact points between primary health care system and the community, manned by ANM (Auxiliary Nurse Managers).
2. Primary Health Care Centers (PHC): A reference unit for 6 sub centers with 4-6 beds, manned by a Medical officer in Charge and 14 subordinate paramedical staff.
3. Community Health Centers (CHC): A 30 bedded hospital/Referral unit for 4 PHCs with specialized services.

The plan looks fine on paper but the reality is far different. The PHCs and Sub-Centers either don't exist or, if they exist, find themselves severely under-staffed and undersupplied.

According to a national study only 38% of PHCs have the necessary manpower and only

31% have critical supplies. Physician: patient ratios are 6 times lower in rural areas and physician: bed ratios are 15 times lower.

It seems that very little has changed between the India of 1980s and the India of 2011 when it comes to the poor state of health care in rural India. An attempt is made in this paper to test this very hypothesis.

## Survey

A survey was conducted in six rural areas of District Fatehpur in Uttar Pradesh, all of which lie within a perimeter of 50 km. from Fatehpur city. The survey, which was conducted in February 2007, shows the approx distance, population, literacy rate, professionally qualified manpower, per capita income, number of primary health care centers, number of registered medical practitioners, and the number of drug stores in each area. Simultaneously, a comparison was made with what existed of the same variables, in these villages, 28 years back; i.e. in 1982. Figures for both years are exhibited in Table 2.

## DISCUSSION

As can be seen from the above table the healthcare scene has not changed significantly during the last 25 years. Despite tall claims from the Provincial and Central Ministries of Health as well as local and cabinet level politicians, the situation remains as grim as before. What exists in Uttar Pradesh can equally be applied to most Indian states. Barring a few enlightened states such as Kerala, Tamilnadu, Goa, and Karnataka, most Indian states do not consider healthcare a priority issue and spend comparatively very little on it.

In a developing country such as India there is huge inequality in healthcare distribution although

**Table 2: Comparative Figures for Some Healthcare Indicators in Six Rural Areas of District Fatehpur, 1982 and 2011**

Name of Village	Approx. Distance from Fatehpur (km.)	Population		Literacy Rate		Professional Manpower		Per capita Income in (Rs.)		No. of PHCs		No. of RMPs		No. of Drug Stores	
		1982	2010	1982	2010	1982	2010	1982	2010	1982	2010	1982	2010	1982	2010
Sathigawan	45.0	1500	8300	25%	75%	1.0%	10.0%	1300	7500	0	0	0	4 *	0	7
Salehpur	44.0	1200	6000	16%	65%	0.1%	1.0%	800	6000	0	0	0	0	0	0
Rampur	44.5	700	5200	19%	65%	0.1%	1.5%	600	6500	0	0	0	0	0	0
Chand pur	49.0	3500	10,000	17%	60%	0.2%	2.7%	675	6737	1	1	1**	1**	0	2
Kaushalpur	48.0	900	3,000	45%	80%	5.0%	12.0%	2000	9000	0	1	0	0	0	0
Buranda	42.0	550	4,000	12%	65%	9.0%	1.8%	300	4300	0	0	0	0	0	0

Note: \* Having no medical degree; \*\* Not an MBBS — possibly BAMS.

nearly 73% of Indians lives in rural areas, more that 75% of Indian doctors are based in cities. The Indian government spends just 0.9% of the country's annual gross domestic product on health and little of this spending reaches remote villagers, where the health workers feel that they become professionally isolated and outdated if stationed in remote areas.

In addition, poor Indian villagers spend most of their out-of-pocket health expense on travel to the specialty hospitals in the city and for staying in the city along with their escorts. A recent study conducted by the Indian Institute of Public Opinion found that, 89% of rural Indian patients have to travel about 8 km. to access basic medical treatment, and the rest have to travel even farther. (Sharma, 2000).

47% of India's children below the age of three are malnourished, almost twice the statistics of sub-Saharan African region of 28% (David, Oct 11 2009; and *The New York Times*, 2009). World Bank estimates this figure to be 60 million children out of a global estimated total of 146 million

(Chaudhuri, 2011) reported by Sam Mendelson). Although India's economy grew 50% from 2001–2006, its child-malnutrition rate only dropped 1%, lagging behind countries of similar growth rate (Simon Robinson, 2008)

Diseases such as dengue fever, hepatitis, tuberculosis, malaria and pneumonia continue to plague in India due to increased resistance to drugs (Samir Chaudhuri, 2011). India finally developed a *totally drug-resistant* form of tuberculosis (Robinson Simon, 2008). India is ranked 3rd among the countries with the most number of HIV-infected. Diarrheal diseases are the primary causes of early childhood mortality (Goldwert Lindsay, 2012). These diseases can be attributed to poor sanitation and inadequate safe drinking water in India (HIV/AIDS, 2011).

Given the state of the public facilities, the main sources of health care are private practitioners and traditional health healers. However, such practitioners are largely untrained and uneducated According to a recent study, about 41% of these in the private sector who called themselves

doctors said they had no medical degree, 18% had no medical or paramedical training at all, and 17% had not even passed their secondary school examinations. In 68% of visits to private practitioners patients were given an injection and in 12% patients were given a drip, compared with 32% and 6% in government facilities. Only 4% of visits to private facilities led to a laboratory test for diagnosis (Sanjay Kumar, 2004).

The study also showed that an average 45% of medical or paramedical personnel were absent from government run sub-centers and 36% were absent from the larger primary health centers. The sub-centers were closed 56% of the time during their regular opening hours, at unpredictable times, discouraging people from walking an average of 1.4 miles from their village. While patients should be getting free medicines at the public facilities, this was not always the case. Hence poor people rely less than better-off patients on the public facilities.

These studies paint a fairly bleak picture: villagers' health is poor; the quality of public service is abysmal, private providers—unregulated and, for the most part, unqualified—provide the bulk of health care in rural India, specifically in UP.

## CONCLUSION AND RECOMMENDATIONS

One of the main reasons behind the poor state of Healthcare delivery in rural areas of U.P. is lack of awareness among the masses living in the villages. This stems from lack of real education (not mere literacy) among the rural folks, which in turn leads to superstitions, blind faith and inertia. Hence, efforts should be made to educate

people, in the real sense and not simply make them literate.

Accountability is another aspect which must be observed if any progress is to be made on this front. At present nobody—whether a village level health worker, Auxiliary nurse, compounder, PHC physician, or CMO, is held accountable for what he/she does or does not do. This must stop. Rural Health care workers must be taken to task if found inactive or incompetent.

A system of effective reward or punishment must be put in practice for those who are performing well as opposed to these who are not.

Only by following these simple guidelines we can transform the state for healthcare delivery system in rural UP from the current state of abysmally poor to a state of moderately fair or at best, satisfactory.

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