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Rural-Urban Disparities : Health*

I shall briefly present the main points made by the authors of the invited and contributed papers and raise some critical issues for discussion. Deodhar's paper on 'Health Implications of Rural/Urban Disparities' makes one of the most original points; it concerns the perception on the part of the rural people of their own health problems, particularly the impact of the 'demonstration effect' of health strategy in the urban areas. Its contention is, "It will be difficult to prove new low-cost technologies to the rural population, large sections of which would look for the proof from the urban areas; something that is happening or seen in a town that has come to be established in peasant minds as proven and acceptable." The implication, in short, is that new low cost technologies should not be tried on rural people, just because they are poor. In this connection, let me refer to the government policy of integrating different systems of medicines in the new Health Guide Scheme formerly called the Community Health Volunteers Scheme. While nobody can find fault with the desirability of integrating various systems of medicines and, in particular, the indigenous systems like Ayurveda, Unani, Sidha, etc. this integration should be attempted at the highest level and not at the lowest level of the Health Guides in rural areas. It is well-known that the rural masses have more faith in the quick healing power of modern allopathic medicines and are reluctant to accept Ayurvedic medicines doled out by Health Guides or the PHCs, because they have come to view the allopathic to be superior to the Ayurvedic medicines. The question is not about the merits of the different systems, but about the *perception* of the people. Our field work in rural areas has revealed that even the practitioners of indigenous medicines were using allopathic medicines, including injections etc., in order to satisfy their rural patients.

*Organiser's statement on Health in the Plenary session of the VIII Conference of the IASP. *op. cit.*

The Statement on National Health Policy (1982). just released by the Government of India admits that "the existing situation has been largely engendered by the almost wholesale adoption of health manpower development policies and the establishment of curative centres based on the Western models, which are inappropriate and irrelevant to the real needs of our people and the socio-economic conditions obtaining in the country. The hospital-based disease and cure-oriented approach towards the establishment of medical services has provided benefits to the upper crusts of society, specially those residing in the urban areas." If the Government of India wants consequently to encourage the indigenous system of medicines as a part of the country-wide health system, the integration of the indigenous systems with the allopathic system should start at the highest level, in the medical colleges and in the hospitals in the cities. It should not be relegated to the poor Health Guides working in isolation in remote rural areas, who have to deal with patients asking for quick relief through allopathic medicines.

On the same subject, Talwar and Dosajh give useful data on health indicators for rural and urban areas, based mostly on the survey of infant and child mortality, 1979, conducted by the Registrar General, the family planning performance statistics of the Department of Family Planning and some data from the Sixth Five-Year Plan. They do not, however, spell out the health implications of rural urban disparities and come to a rather obvious conclusion that "emphasis on rural health services is greatly warranted if the target of Health for All by 2000 is to be achieved. The targets set by the Government of India for 2000 cannot be achieved unless rural health services receive more emphasis,— more than what it has been receiving so far."

Singhal's paper on the subject relates to Haryana. It gives useful data separately for rural and urban areas of the different districts of that state. It is not, however, clarified that the figures for urban areas include patients from rural areas who are free to go to any city or town hospital they wish. Therefore, data of bed population ratio, institution population ratio etc. cannot stand close scrutiny. It points to the present system of medical education as an important factor leading to neglect of the rural community. In support, it is noted that the infant mortality rate in urban areas is 54 per thousand compared to 122 in the rural areas.

The paper on 'Disparity in Consumer Expenditure and Mortality in India', compares the rural-urban disparity in regard to the crude death rate with the corresponding disparity in expenditure in the different states of India based on NSS data; it reveals that "at any level of expenditure, disparity in mortality is higher in high disparity states in consumer expenditure." It is not clear why this statistical exercise lists Goa, Daman, Diu and Pondicherry among states. It is also surprising that Kerala is bracketed with Uttar Pradesh in regard to some indicators. The attempt to spell out the implications of the results of this

regression analysis is neither firm nor adequate. It concludes by voicing a hope that "perhaps a more tangible relationship of the problem could be established if expenditure on food items only could be considered for the analysis".

Another paper discusses the availability of family welfare services to the rural population of Bengal on the basis of survey data. Though the paper is not of direct relevance to rural-urban disparities, it gives some valuable insights into the different levels of practice of family planning. It comes out with a negative correlation of sterilization acceptance with distance of the household from PHCs in case of upper caste Hindus. On the other hand sterilization acceptance among the backward groups was found to be independent of the distance from PHCs. Obviously, the poorest people are motivated to traverse long distances by financial incentives offered by the Family Planning Department, whereas the more well-to-do tend to consider sterilization only when such facilities are within their easy reach.

The case study of the 'Impact of Information, Education and Communication : Population Education and Health Education for removing Rural Urban Disparity in India' is again not relevant to the present discussion but it does present some interesting data which is relevant for understanding the higher incidence of infant mortality among females. On the basis of the survey conducted in three districts of Andhra Pradesh, the paper contends that "Breast feeding was of a longer duration in case of the male child than that of the female."

Finally, we have two other papers, one of them examines the problem of different types of disabilities in rural and urban areas on the basis of different surveys to reach to the conclusion that "the problem of disabled persons is greater in the rural area as compared to the urban area." The other paper is on the demographic characteristics of jaundice cases in Kolhapur city.

The papers taken together do not provide adequate basis for discussing at length the important issues concerning rural-urban disparities in health. The papers have reported only a few selected findings of individual scholars based on their ongoing work. Their discussion of rural-urban disparities in health is accordingly grossly inadequate. It must be said, however, that the subject is extremely difficult. It is rendered even more difficult by the lack of reliable and adequate data for rural and urban areas separately. I would like, however, to refer to one major aspect concerning rural-urban disparities in health. It is the much lower expectation of life at birth in rural areas compared to that of urban areas. According to the latest *Sample Registration Bulletin* (June 1982), the average expectation of life at birth in rural areas during 1970-75 was 48.0 years as against 58.9 years in urban areas, showing a difference of as much as 11 years in favour of urban areas. This is the quintessence of the rural and urban disparities in health. According to the abridged life table just quoted, only 49 percent of rural persons are expected to survive till the age of 60 years, while 63 per cent are expected to survive till this age in urban areas. This is a big disparity.

When we consider the separate life tables for males and females in rural and urban areas, we find that only in the *rural* areas, the expectation of life of females is lower than that of males at ages 0, 1 and 5; for urban females, the expectation of life is higher than that of males at ages 0, 1 and 5 and also at all the subsequent ages.

According to the SRS data on age-sex specific death rates for 1978 (excluding Bihar and West Bengal) in *rural* areas, the female death rate in age group 0 to 4 was 57.9 compared to 48.9 for males, while in the urban areas, the female death rate is 27.2 compared to 25.5 for males. In the next age group 5 to 9 years, the female death rate in rural areas was 5.5 compared to 4.2 for males, while in the urban areas, both for males and females, the death rate was 1.5. To what extent the higher mortality level of females in the rural areas is due to lack of medical facilities and to what extent it is due to the greater neglect of girls in rural areas should be a subject of detailed investigation on the part of the health workers and social scientists.