Regional human development indicators health and social care essay

Introduction:

It is a well-established fact that most of the underdeveloped countries in the 1950s and 1960s opted for a growth policy which is often referred as the 'policy of modernization'. These theories of modernization originated in the developed countries, which were appreciating the fruits of industrialization in the form of high growth rates. Contrary to that a large number of underdeveloped countries were agrarian or rural-based in terms of population, with agriculture as the highest contributor towards GDP and employment. When the UDCs (underdeveloped countries) followed the growth policy of modernization, the development and modernization that ensued, in most cases, was urban-based in the form of import substituting industries. This does not imply that the agriculture sector has not undergone any modernization. Indeed there has been growth but the blueprints from the developed world, accepted and adapted by the indigenous ruling classes. This form of development with its varying manifestations has resulted in a phenomenon which one writer has called the 'urban bias'. This urban bias " involves an allocation to persons or organizations in towns, of shares of resources so large as to be inefficient and inequitable, or a disposition among the powerful to allocate resources in such a way."[1]Lipton was amongst the leading economists to have claimed the existence of urban bias in world development. He argued that urban areas are endowed with resources in terms of economic and social services which far exceed the percentage of population living there. Since the government and the elites have their seating in the urban areas, therefore the urban areas are developed at the expense of rural areas. The situation in Pakistan is no

different than other developing countries. After independence, the ruling elite chose a capitalist path of growth, where the industrial sector was allowed to grow at the expense of agriculture. No doubt, such a capitalist industrialization policy secured promising growth rates for the country as a whole, but also led to the concentration of economic and political resources in the urban areas and the emergence of 22 families controlling a large part of mercantile and industrial capital. Since, little attention was paid to the rural populations; they suffered on all grounds including politics, economics and social services. The current study aims to highlight the phenomenon of ' urban bias' in healthcare facilities in Punjab, Pakistan. Punjab is ranked as the second largest province in terms of area as well as the most enriched, developed and populous province of Pakistan with a population of 91, 379, 615 people which constitutes approximately 55% of the country's total population. The economy of Punjab is mostly agrarian based, although industry also makes a substantial contribution. As per constitution, after the abolition of the concurrent legislative list it is the responsibility of the Provincial Government to provide health facilities to the people of Punjab. The Health Department is the key department responsible for providing healthcare facilities to the masses. The Health Department provides an extensive range of primitive, preventive as well as curative health care services expanding from Primary Health Care level to the Tertiary Health Care level. These services are provided through a well-designed infrastructure. The Health Department across the province provides its services through:[2]Basic Health Units (BHUs)Rural Health Centers (RHCs)Tehsil Headquarters Hospitals (THQs)District Headquarter Hospitals (DHQs)Teaching/ tertiary Care HospitalsThe health sector of Punjab despite

its utmost efforts is riddled with numerous issues, obstacles and contradictions. One of the most pressing issues is the imbalance between urban and rural areas in terms of availability as well as the utilization of health care facilities. Despite the fact that more than half of the population of the province resides in rural areas, most of the health facilities and trained medical personnel are found in the cities. This lack of facilities and discrimination against rural inhabitants has somewhat lead to the prevailing urban bias in health facilities. It is a known fact that in most underdeveloped capitalist countries very few medical facilities exist in rural areas. In some cases, even basic health facilities are not available outside the national or provincial capital[3][Lipton (1977), pp. 265–269]. Lipton argued that an ' urban bias' exists in UDCs (underdeveloped countries) where cities live off rural areas and most of the investment, whether of a social or economic kind, takes place in the cities, very often at the expense of the rural areas themselves. Although the existence of an urban bias is highly recognized by economists and policy makers around the world, yet to prove whether such a bias exists or not is it is quite difficult. ' It requires demonstrating the widespread existence, inefficiency and inequity of substantially worse rural than urban outcomes and such material is extremely difficult to find'[4]. In Pakistan, investments in the Health sector are viewed as an integral part of the government's poverty alleviation endeavor. An improvement in the overall health sector indicators has important ramifications not just for the quality of life of its citizens, but for economic development generally, through the channels of productivity enhancement and poverty alleviation. While there has been noticeable improvement in some health indicators over the years, on the whole, Pakistan ranks poorly on this count. Overall, life

expectancy in Pakistan remains lower than many in its peer group, while infant as well as maternal mortality rates are amongst the highest.

Regional Human Development Indicator

CountryLife Expectancy2011Mortality Rateunder 5 per 10002010Infant MortalityRate per 10002011Population GrowthRate (%)2011

Pakistan

63. 26

India47. 57China16. 06Indonesia27. 95Bangladesh50. 73Sri lanka9. 70Malaysia15. 02Nepal44. 54Thailand16. 39Philippines19. 34Source: World Development Report 2011

Literature Review:

Numerous health care disparities have been documented for rural healthcare consumers (Geyman, Hart, & Norris, 2001; Stamm, 2003). For example, rural populations face more challenges and barriers in assuring appropriate, timely, and cost-effective care (Jensen & Royseen, 2002; Mohatt, 2000; Strasser, 2003) and have less access to specialized health care (Geller & Muus, 2000; Merwin, Golsmith, & Manderscheid, 1995). Zaidi (1985) examined the bias in the distribution of healthcare facilities and services among the rural and urban areas in Pakistan. The study revealed that the problem of health facilities whether in terms of quality or quantity of the services provided, is not one of urban vs. rural--there is no urban conspiracy against the rural population. The difference in resources between the urban and rural areas is based on the class structure and collusions within the country. Two factors were held responsible for this bias namely the type of

medical education provided in Pakistan and the role played by government. Mwansa (1989) explained the imbalances in health services between rural and urban areas in Zambia. The study discussed the historical forces as well as the ideology, power and distribution of income as the core factors that have led to the distributional differences between the rural and urban areas. According to the study the imbalances are skewed towards the urban areas because of the pattern of investment being made in these areas and lack of government intervention towards a just and equitable distribution of resources. As a result, health services were provided only to the foreign sponsors or to those people who would yield economic, political and social benefits. Zhang, et al (2003), present some basic facts on the evolvement and patterns of spatial inequalities in education and health sector in China over the long run. The paper discusses the outcomes of the various reforms (initiated in 1978) upon educational and health inequalities. The inequalities in education were examined by the gini co-efficient and the generalized entropy (GE) technique where the results reveal that the illiteracy rate has declined steadily over the years, reflecting the success of nine-year compulsory education and the high primary-school enrollment rate, but there still exists large rural-urban and gender-gaps and the gender gap tends to increase. The analysis of health inequalities revealed that the regional variation in health outcome enlarged over the reform period in both rural and urban areas and the driving force behind this inequality was the skewed distribution of healthcare provision, not only in terms of services but also in terms of the health personnel in rural and urban areas. Levin, et al (2006), compared the health inequalities in rural and urban populations in Scotland for all-cause mortality by using multi-level Poisson modeling and discussed

the changes in these inequalities over time. For the purpose of analysis the postcode sectors in Scotland were ranked into four categories by level of deprivation and the Carstairs indicator and male unemployment were used for this purpose. Ratios of health status between the most destitute and the most opulent areas for the years 1979-2001 were investigated using all-cause mortality for the Scottish population, which revealed that health inequalities between those living in opulent and those in destitute areas in Scotland are increasing over time. Increases have been particularly great in remote rural areas and especially amongst the rural elderly, probably due to growing socioeconomic inequalities amongst this group. Liu, et al (2007), described patterns and differences in physician and hospital utilization among rural and urban populations in China by utilizing the data provided by the third National Health Survey. Descriptive statistics and multiple binomial regressions with a log link were used to test the statistical differences in socio-demographic characteristics, physician visits, and hospitalizations between rural and urban residents. The results highlighted the existence of disparities in rural and urban health utilization in china and reveal that rural residents used physicians more and hospitals less than urban residents, particularly among uninsured populations. Riva, et al (2009), analyzed the nature as well as the extent of inequalities in health status between urban and rural areas in connection to other health indicators, as well as inequalities in health across the rural areas of England. The focus was on indicators of self-rated health, common mental disorders and obesity. The data for the underlying study was obtained from the Health Survey for England (HSE) for the years 2000–2003 and was further categorized into the following: two groups of urban areas (Greater London area or ' other cities')

and two groups of rural settings (semi-rural areas or villages). Multilevel logistic analyses were conducted and the results showed that rural inhabitants significantly less likely report about their health status or common mental disorders, as compared to their urban ' counterparts'. The analysis of geographic inequalities revealed significant variations in health indicators within categories of urban and of rural settlements, thus accounting for the presence of inequalities in health within small rural areas and urban settings alike. Weiner, et al (2011), by using cross-sectional data of 10 provinces of Canada and by means of multilevel logistic regression models and unadjusted odds ratios, evaluated the access and utilization of health care services across the rural and urban communities in Canada. A comparison of five different measures of access and utilization was made across the continuum of rural-urban, where the determinants of utilization were taken in accordance with the Andersen's Health Behavior Model (HBM), and location of residence at the levels of province, health region, and community. The results reveal the existence of inequity in access to health care services across the rural-urban continuum. Moreover some of this inequity tends to persist, even when the other determinants are accounted for. Teckle, et al (2012), examined the association between rurality and health in Scotland, after adjusting for the demographic and socioeconomic characteristics of the individuals living in different areas, and the characteristics of the general practices serving them. The study analyzed four health outcomes namely Hypertension, all-cause premature mortality, total hospital stays and admissions due to coronary heart disease (CHD). The data from the Scottish health survey SHS linked with the Scottish hospital admission and mortality database (SMR) was employed for the study.

Hierarchical models were utilized to provide a nationally representative sample. The results of the study bring into light the fact that old age people and those belonging to the lower social class were strongly associated with an increased risk of each of the four health outcomes measured. After adjustment for individual and practice characteristics, no consistent pattern of better or poorer health in people living in rural areas was found, instead stronger relationships were found between compositional determinants (age, gender and socio-economic status) and health than contextual factors (including rurality).

Problem Specification:

Access to good health has positive repercussions for the economic and social development of a country. The international community adopted the Millennium Development Goals (MDGs) in 2000. There are a total of eight MDGs and out of those eight, three MDGs are targeted to achieve health outcomes. The MDGs targeting health outcomes cannot be achieved if masses of populations do not have access to skilled medical personnel and other basic facilities. In order to achieve the desired objectives the health system should be just and equitable so that the masses of people face no geographical, financial, organizational or social barriers to receiving adequate care. Evidence from literature suggests that urban-rural disparities in health facilities do not have favorable outcomes on the health indicators and socio-economic status of a country. Therefore, this study aims to examine if such disparities or biases exist in the healthcare facilities in rural and urban areas in Punjab, Pakistan and to suggest measures to alleviate them.

Objectives:

To examine the phenomenon of urban bias that exists in the healthcare delivery system in Punjab. To assess the health facilities in urban areas which are not in line with the expansion of cities. To identify the role of government in constraining the health facilities in rural areas. To analyze political interference in the health sector. To suggest recommendations for future policy options.

Hypothesis:

Following hypotheses will be tested in the course of study: H1: There is provision of better health facilities in urban areas vis-a-vis rural areas. H2: The healthcare facilities in urban areas far exceed the percentage of urban population. H3: Expansion of healthcare units in the rural areas is constrained by government policies. H4: Medical staffs are reluctant to work in rural areas because of the political interference prevailing in our system.

Data and methodology:

The data for the following study will be taken from various issues of the Punjab Development Statistics. Keeping in view the objectives of the study the data will be collected on the following variables:

Health manpower distributed among rural and urban areas

Variables include registered doctors, registered dentists, registered nurses, registered midwives, naib/dais and registered lady health visitors. Due to lack of sufficient data, the number of doctors, dentists and nurses will serve as proxy variables for the health manpower in urban areas while the number

of mid-wives, naib/dais and lady health workers will serve as proxy variables for the health manpower in rural areas.

Health facilities distributed among rural and urban areas

Variables include hospitals, dispensaries, Basic health units, rural health centers, and maternity & child health centers. As mentioned above, due to unavailability of appropriate data, the current study is bound to use proxy variables for the purpose of analysis. The number of hospitals and dispensaries will serve as proxy variables for health facilities in urban areas while the no of rural health centers, basic health units and maternity & child health centers will be used as proxy variables for the health facilities being provided in rural areas. There is no such methodology to measure or assess ' urban bias'. In fact it is extremely difficult to appraise the performance of health sector or health indicators. The current study will employ the techniques of gini coefficient and Lorenz curve to determine the existence of disparities prevailing in the health sector in the rural and urban areas.

Organization of the study:

The current study consists of six chapters. Chapter 1 provides a brief introduction about the concept of urban bias. Chapter 2 provides the theoretical background. Chapter 3 presents the review of literature on healthcare disparities among urban and rural areas. Chapter 4 gives the data sources and methodology Chapter 5 reports the results of the study. Chapter 6 presents summary of results, draw conclusion and gives suggestions regarding future policy making.