

Structurally Created Health Inequalities in Rural Punjab (Study Area Jampur)

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Abstract— This study was conducted a structurally created Health Inequalities Rural Punjab study area Jampur. The main focus was to study the socio-economic background of the respondents and the link of background with access to health care services. The main focus remained the socially created social structures that discriminate the lower classes into their access to health services. The study was conducted under quantitative research design with sample size of 150 respondents. The interview schedule was used as a tool of data collection. The data was collected from Tehsil Jampur locale. The data was analyze through SPSS and presented in tabular form with description and interpretation in chapter # 04. The study revealed that lack of education and economic capital disadvantage people in term of their health condition and availing health services. The study also reveals that people suffer from various diseases due to lack of facilities as well as their own ignorance.

Index Terms— Social,Structurally,Health,Inequalities,Rural,Discrimination

1. INTRODUCTION

NATIONAL PUBLIC HEALTH IS CURRENTLY INTRODUCED IN PAKISTAN. BEFORE THE PARTITION OF SUB-CONTINENT, THE BRITISH GOVERNMENT PROVIDED HEALTH CARE FACILITIES ONLY FOR THEIR GOVERNMENT EMPLOYEES, BUT RARELY ATTENDED TO THE HEALTH NEEDS OF THE POPULATION AT LARGE. THE BRITISH GOVERNMENT ESTABLISHED A FEW MAJOR HOSPITALS, SUCH AS MAYO HOSPITAL IN LAHORE NEAR KING EDWARD MEDICAL COLLEGE. IMPROVEMENTS IN HEALTH CARE REMAINED UNSUCCESSFUL BECAUSE OF THE LACK OF RESOURCES AND ALSO BECAUSE OF THE DIFFICULTY TO COORDINATE AT NATIONAL LEVEL PROVINCIAL GOVERNMENT. UNTIL THE EARLY 1970s, IT WAS THE RESPONSIBILITIES OF LOCAL GOVERNING AUTHORITIES. NATIONAL HEALTH PLANNING STARTED WITH THE SECOND FIVE YEAR PLAN (1960-65) AND CONTINUED THROUGH THE EIGHT FIVE YEAR (1993-98). PROVISIONS OF HEALTH CARE FACILITIES FOR RURAL POPULATION HAVE BEEN GIVEN PRIORITY BUT THE IMPLEMENTATION WAS HAMPERED BECAUSE OF

THE ADMINISTRATIVE PROBLEMS AND UNAVAILABILITY OF STAFF (HSPP, 2007).

In early 1970s, a decentralized system was developed in which basic health units worked successfully in providing basic care for local population of 6,000 to 10,000 people. Rural health centers offered their services to local units and both the basic units and the health centers referred patients to larger urban hospitals. In the 1990s, the orientation of Pakistan's medical system, including medical education favored the elite class. Then, in 1998 private clinics and hospital emerged, which reduced the services of nationalized hospitals (HSPP, 2007).

Health infrastructure in Pakistan

Pakistan's public health delivery system is working as an integrated health complex and it is managed by district administration. The federal government provides health care through three-level health care delivery system and a range of public health involvements. The previous includes Basic Health Units

(BHUs) and Rural Health Centers (RHCs) forming the core of the primary health care structure. Secondary care including first and second transfer facilities which are providing acute and inpatient care is provided through Tehsil Headquarters Hospitals (THQs), and District Headquarter Hospitals (DHQs), which are supported by tertiary care from teaching hospitals. Basic Health Units (BHUs) serve 10,000 to 15,000 populations and Rural Health Center (RHCs) server 25,000 to 50,000 populations. While the Tehsil and District Headquarter (DHQ) hospitals serve 1, 00,000 to 3, 00,000 and 1-2 million persons respectively (HSPP: 2007).

Why Does Health Matter?

According to the World Development Report 1993, pp.17) benefits of improved health are manifold. Health plays the key role in determining the human capital. Better health improves the efficiency and efficacy of the labor, which ultimately contributes to the economic growth and leading towards the welfare of human beings. A positive relationship exists between public sector expenditures and the economic growth. To attain skillful efficient and productive human capital resources government subsidized the health care facilities for its people. A public sector pays whole or some part of cost of utilizing health care facilities. Healthy people are better able to learn. In developing countries like Pakistan one of the major causes of low enrollment rate is child morbidity. As better health can result in high enrollment rate at school level. Better health and nutrition can increase labor productivity. For the economy as a whole improved health can produce saving in treatment costs by reducing in the disease incidence. In developing countries like Pakistan many illness can be controlled

through enhancing the primary health care system and resources can be saved that otherwise have to be spent on treatment costs. Poverty is thus a cause and effect of poor health. Illness pushes people into poverty through lost wages high spending for disastrous illness and repeated treatment for other illness. Due to adequate nutrition and lower immunity, poor are more susceptible to diseases pushing them deeper into poverty. (WDR, 1993).

Health

In social science, health is a human condition measured by four components; physical, mental, social and spiritual. Health is defined in the WHO constitution of 1948 as 'a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.

Two Biases: Urban and Rural Class

A cursory glance at the distribution of health facilities in Pakistan gives a startling picture: despite the fact that half of Pakistan's population lives in rural areas, most of the medical personnel and health facilities are found in the cities. For example, 85 per cent of all practicing doctors work in the cities, which come to a (theoretically) favorable doctor- population ratio of 1:1801 for the urban areas of Pakistan. The rural doctor-population ratio, on the other hand, is 1 doctor to 25,829 inhabitants (PES, 1988).

In comparison with the urban communities, the rural communities are stay behind in matters connected with health. Lack of medical facilities, non-availability of essential energizing food, insanitation and ill health are normally found in the villages especially in the developing countries. Hospitals, nursing homes, maternity homes, drug shops, clinics, clinical laboratories and

such other modern medical facilities are rarely found in the villages. In many places like in especially in rural area people still follow the traditional methods of curing diseases. Two reasons may be cited here for the lack of enough facilities in the rural communities. The rural environment is naturally healthier than the urban. The stronger primary groups in rural environment have been able to take care of their own people in time of need, and especially, in times of disease. Hence the rural health programmed has suffered (Shankar, 1990)

An important factor in the rural health programme is the problem of the lower income of the rural people. Economic distress, the burden of children, superstitious beliefs and practices, the difficulty of attracting the medical staff to the rural areas have further added to the rural health (Shankar, 1990).

Health Inequality

As defined by World Health Organization (WHO), health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups. For example, differences in morbidity between elderly people and younger populations or differences in mortality rates between people from different social classes. It is important to distinguish between inequalities in health. Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case, it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution

may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health (WHO, 2011).

Social Structure

Health seeking behavior and beliefs are shaped by the social structure of the society. Variation in health facilities for people in different societies of the world is structurally created due to social class difference. Working environment of people, unequal distribution of resources, and lack of attention towards the sensitive issues of the people of specific area is artificially created in the favor of upper class and influential people of the society regardless of density and severity of health problems of the people. The influential social class does not consider as health hazardous social and physical environment for the people the living in backward area or far distant areas as influential people consider for themselves. The social and physical structure of the particular area is intentionally made to form the mentality of the people for adoption of available health facilities and ways for treatment. Urban and rural areas shows very clear picture of inequalities in health facilities (Germov, 2002).

Rural Punjab

Punjab is the most populous province of Pakistan, with approximately 56% of the country's total population. The Punjab is home to the Punjabis and various other groups. The main languages are Punjabi and Saraiki and the dialects of Mewati and Potowari. The name Punjab derives from the Persian words Panj (Five), and Ab (Water), i.e. (the) Five Wa-

ters - referring to the Indus River and its four primary tributaries of Jhelum, Chenab, Ravi, and Sutlej, that flow through Punjab. Punjab is the most developed, most populous, and most prosperous province of Pakistan. Lahore has been the capital of Punjab for a thousand years. The population of the province is estimated to be 81,330,531 in 2010 and is home to over half the population of Pakistan (WF, 2011).

Hypothesis

- a) Illiterate people have less awareness of health services as their right and therefore, do no or little effort to get it.
- b) The discrimination in health services is politically created.

Objective

- a) To study the socio-economic background of the respondents.
- b) To know the socio-cultural factors responsible for health inequality.
- c) To know the role of political leadership in the health inequality.
- d) To highlight community awareness of health creating and health services.
- e) To suggest policy measures for better and egalitarian health facilities to all.

METHODOLOGY

This chapter highlights the methodical strategy under which present research had been carried out. Methodology upon the nature of the research.

Topic

Structurally Created Health Inequalities in Rural Punjab study area Jampur.

Universe:- It is defined as total population from which a sample is selected, the aggregate of all possible cases of the group under consideration (Denscomb, 1999).

Rajanpur District is located in the extreme southwest part of Punjab, Pakistan (29:06 N, 70:19E) with a geographical area of 12,319 km. it is one of the only two districts of Punjab located west of the river Indus. The land is sandwiched by river Indus on one side, while the Sulaiman Mountains range on the other side. According to an NGO, Tipu Foundation Pakistan, Jampur city has the population of more than 200,000 inhabitants. Rajanpur district is divided into three Tehsils, Jampur (19 Union Councils), Rajanpur 14 (Union Counsels), Rojhan Mazari (08 Union Counsels) and a vast belt of provincially administer tribal area (PATA) and in all 44 Union Councils (UCs).

Population of Study

In research, the target group to be studied is called population of study (Henslin, 1997). A population also can be defined as individuals that meet the sample criteria for inclusion in a study. The populations for this study are all adults residing in Tehsil Jampur.

Sampling Procedure

Sampling is a smaller case of researcher selects from lager pool and generalizes the findings to entire population (Henslin, 1997).

There are various kinds of sampling used in a social

research such as random sampling, stratified random sampling, accidental sampling, quota sampling purposive sampling, snowball sampling, etc. As per the requirement of the present study, random sampling will be used to select the respondents.

Random Sampling

A random sample element is one that is chosen in such a way that every element in the population has an equal chance of being included in the sample (R. Shankar, 1990).

For this study population were divided into male and female. 150 respondents were selected randomly from male population.

Sample Size

A sample of 150 respondents will be selected from the study universe.

Tools of data collection

Detailed interviews are essential to get deep information and data. The interviews will be conducted with the help of interview schedule. The research will have questionnaire for literate and interview schedule for those who are illiterate respondents.

Interview schedule

Interview schedule refers to a formal meeting between the respondent and interviewer. Interviewing schedule refers to the questions formulated according to the requirement of research objectives. It is a technical procedure to collect the accurate data. The interview schedule consisted of structured and unstructured questions, prepared in English but at the time of interview the local language was also be used to ask the questions from the respondents. The

data was collected in face-to-face situation.

Pre-testing

Pre testing is a final trial use of a questionnaire or interview schedule prior to the large scale administration. Before the collection of the actual data in the field, it is required to test the accuracy and workability of the information that are designed by interview schedule. To achieve this end, the questionnaire was over tested on 5 respondents. At the earlier stage, some of the questions in the questionnaire were open ended. By collecting the responses of the people during the pre-testing the researcher developed a close ended questionnaire.

Data Analysis

After the data was collected a systematic analysis was used for data analysis. The researcher used the widely statistical package for social sciences (SPSS). The analyzed data has been presented in tabular forms. For the analysis of quantitative data, computer was used which facilitated me more than one ways such as time saving, reduction of large amount of data to basic pattern etc.

The analysis of univariate data

Univariate data analysis is the analysis of a single variable. Descriptive statistics organize and summaries the data to render it move comprehensible. Descriptive statistics enable the researcher to describe trends in the data and also to determine whether relationships exist between variables.

The analysis of bivariate data

Bivariate analysis is the analysis between two variables. It is utilized to determine whether relationship

exists between two interacting variables.

Percentage

The purpose of using percentage is to simplify quantitative characteristics into numerical form.

Second percentage reduces to frequency distribution to a common base.

Percentage was calculated with a following formula.

$$P = \frac{F}{N} \times 100$$

Where

P = Percentage

N = Total frequency

F = Frequency of class

Chi-Square

Chi-square was applied to ascertain the relationship between certain independent and dependent variables. The Chi-Square was calculated with the following formula.

$$\chi^2 = \sum \frac{(O - e)^2}{e}$$

Where:

O= Stands for observed value

e = Stands for expected value

Σ = Stands for observed expected total

FINDING, CONCLUSION AND SUGGESTION:

In this chapter, the researcher is going to wrap up

this research study and share the findings with social scientists as well as policy makers. This study is conducted with reference to Pakistani society under the title "Structurally Created Health Inequalities in Rural Punjab"

After extensive review, relevant data was collected through appropriate research methods (discussed in detailed in chapter #3). The data was analyzed with the help of statistical package for social sciences (SPSS) and presented in Chapter # 4 in tabular form with description. The main findings of the study are summarized in the succeeding text.

Major Finding

The finding of the study illustrated the basic health facilities problems in Rural Punjab, Pakistan.

- 63 percent respondents were in the age group 15-30 years.
- 66 percent respondents were married.
- 88 percent of respondents were living in joint family system.
- 25 percent of respondents were educated up to middle.
- 27 percent of respondents were belonging to labor class.
- 58 percent of the respondents' monthly income was less than 10,000.
- 50 percent of the respondents' family income was less than 10,000.
- 54 percent of our respondents' families were comprised of 6-10 members.
- 90 percent of our respondents had their own houses.
- 80 percent of the respondents had concrete houses.

- 85 percent of the respondents had toilet facilities in their houses.
- 66 percent of the respondents had the facilities of hand pumps in their houses, with 34 percent using electric pumps.
- 77 percent of the respondents' mothers and 55 percent fathers were illiterate.
- 43 percent of the respondents' fathers had their own businesses whereas 99 percent of the respondents' mothers were house wives.
- 55 percent of the respondents did not have their own conveyance facility.
- 92 percent of the respondents did not have the resources to purchase medicine and therefore, 42 percent of the respondents borrowed said they money from others to purchase medicine.
- 63 percent of the respondents had not the purchasing capacity of the medicine.
- 39 percent of the respondents due to the lack of money they were unable to purchase medicine.
- 26 percent of the respondents' family members were suffered from Hepatitis.
- 29 percent of the respondents' mothers were suffered from illness.
- 71 percent of the respondents had access to THQs.
- 38 percent of the respondents were living at a distance of two kilometers from the THQs.
- 57 percent of the respondents visited doctors in case of severe fever.
- 99 percent of the respondents claimed that they did not have free medical camps arranged by district health departments.
- 69 percent of the respondents did not have the availability of medicine because they did not have the awareness about the treatment.
- 99 percent of the respondents did not have health facilities in their areas from NGOs after flood.
- 81 percent of the respondents had the routine of taking breakfast daily.
- 55 percent of the respondents did not have the proper intake of fruit daily.
- 67 percent of the respondents did not drink a glass of milk daily.
- 65 percent of the respondents reported that they were properly considered by the doctors.
- 93 percent of the respondents did not have the cooperation of public hospitals.
- 55 percent of the respondents claimed that the available doctor in the public hospitals were local person.
- 74 percent of the respondents claimed that the doctors were not available in the public hospitals.
- 95 percent of the respondents claimed the community was not strict in case of unavailability.
- 55 percent of the respondents claimed the availability of female doctors in the public hospitals in THQ.

Conclusion

The current study has unearthed the bare facts of poor healthcare system and the apathy of people in power towards the public health. The study revealed that the area, Suffers from lack of

health facilities. The study also depicted that majority of the poor people in the area cannot afford their treatment, even the purchase of very basic medicine. The local public hospitals do not have free treatment and medicine for common people. If it is available, only the elite class or vested interest group gets benefit of it. People in the area suffered from serious disease and a great number consult quacks which is very dismaying in contemporary healthcare system. People in the power position are least bothered about the dismaying condition of health in the area as they have access to better health both locally as well as in the big cities. The implementation of social model of healthcare is the need of the time to keep people safe from various fatal as well as ordinary diseases and health problems

Suggestions

After grasping of a complete picture and lightening the pros and cons of the topic "Structurally Created Health Inequalities in Rural Punjab", and in the light of the respondents' conditions and responses, following suggestions are put forward for the people concerned and policy maker to improve health services in the study locale.

- Health related awareness; especially about water should be created in the area through schools, local television and wall chalking as most people suffered from malaria and Hepatitis.
- People should also be educated that health is the basic human need and they should know whether the funds al-

located for their area are spent for their health. Moreover, they should take an active part in ensuring the duty of the government doctors.

- The local authority should be informed about the short coming and gapes in the health infrastructure and modern equipment's.
- Since the people in the area are poor, therefore, NGOs and other organization needed to contacted for improving the health status of the people.
- Government should be informed, and if informed, should be forced to stop quack from practice so that people lives can be saved from their fatal way of treatment.

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