Rural Healthcare and Indebtedness in Punjab

NARINDER DEEP SINGH

Despite many policy measures taken by the central and state governments, the indebtedness of farmers, especially marginal and small cultivators, keeps increasing. Some recent studies on agrarian distress show the significant role of healthcare expenditure in increasing indebtedness. This article presents the result of a study conducted in selected villages of Amritsar and Gurdaspur districts of Punjab in 2008-09 to estimate the level of credit taken for healthcare purposes by marginal and small farmers. It also analyses the present scenario of public health services in rural Punjab.

Narinder Deep Singh *(ndsingh241074@yahoo.com)* is with the Faculty of Agriculture, Khalsa College, Amritsar.

The agriculture sector in India is presently facing a serious ecological and economic crisis. Agricultural productivity has nearly stagnated due to resource degradation (soil and water, especially) leading to a consistent rise in the cost of production or squeezing of profit margins/income levels of farmers (GOI 2007). The worst-affected are marginal farmers (having landholdings below one hectare) and small farmers (having landholdings below two hectares) resulting in a high incidence of indebtedness and suicides among them. The most disconcerting fact is that the largest number of farmer suicides was reported from states like Maharashtra, Andhra Pradesh, Karnataka, Kerala and Punjab, which are considered to be agriculturally prosperous states. The government of Punjab in a report to central government has confirmed 2,116 farmer suicides since 1988 due to indebtedness, but the actual figure according to unofficial sources was more than 40,000 between 1988 and 2005 (Jaijee 2005). Some of the reasons identified for indebtedness among marginal and small farmers are low income level of farmers due to low production/productivity levels, increased cost of production due to degradation and depletion of soil and water, rising cost of living, inadequate institutional credit, unproductive expenditure on social ceremonies and intoxicants, etc.

In recent studies on agrarian distress, it was found that health expenditure has been significant in causing or increasing the indebtedness of farmers, which has, in turn, been a proximate cause of farmer's suicides (Economic Research Foundation 2006). Credit taken for healthcare facilities was identified as one of the major components of total credit acquisition as nearly 41.6% of total credit acquired by marginal and small farmers was for healthcare purposes (NSSO 2005). Therefore, to have a better insight into healthcare credit availed by marginal and small farmers of Punjab, the present study was undertaken in 2008-09, with following objectives: (1) to estimate the level of credit acquisition for healthcare purposes by marginal and small farmers in Punjab; (2) to assess the present scenario of public healthcare services in rural areas of Punjab.

In the present study primary data was collected using personal interview method from 300 farmers (i e, 150 marginal and 150 small farmers) spread over two districts, namely, Amritsar and Gurdaspur for estimating the income and expenditure of marginal and small farmers, and purpose-wise credit acquisition by these farmers. Secondary data was collected from government reports/publications, journals, internet, etc, for evaluating the healthcare scenario in rural areas of Punjab.

Expenditure Exceeds Income

The annual/monthly income of marginal and small farmers from all sources was estimated to be less than their total expenditure. Table 1 (p 23) shows that total annual income was estimated to be Rs 56,428 (marginal farmer) and Rs 1,05,680 (small farmer), whereas their average annual expenditure were estimated to be Rs 79,769 per marginal farmer and Rs 1,46,378 per small farmer. The annual income of both categories of farmers fell short of their annual total expenditure by 41.4% in the case of marginal farmers and 38.5% in the case of small farmers (Table 1).

Consumption expenditure constituted a major part of the total annual expenditure of marginal and small farmers. It was estimated to be Rs 44,760 (56.1%) and Rs 65,892 (45%) of total annual expenditure per farm for marginal and small farms, respectively. The annual agricultural production expenditure per farm was only 28% and 35.2% of total annual expenditure of marginal and small farmers. The annual expenditure on payment of old debts constituted 15.9% and 19.8% of total expenditure of marginal and small farmers, respectively. The marginal farmers were incurring annual production expenditure of Rs 22,325 per farm or Rs 11,750 per acre (as the average farm size of sample marginal farmers is 1.9 acres), whereas the small farmers were

Table 1: Annual Expenditure and Income of Marginal and Small Farmers in Punjab (in Rs /farm)

A Annual Expenditure	Marginal Farmers	Small Farmers
1 Consumption expenditure (monthly/farm)		
(a) On food items	2,755	3,878
(b) On non-food items	183	298
(c) On education of children	376	535
(d) Miscellaneous	416	780
Sub total (monthly)	3,730	5,491
Sub total (annual)	44,760(56.1)	65,892(45)
2 Agricultural production expenditure (annual/farm) including labour charges	22,325 (28)	51,526(35.2)
Agriculture production expenditure/acre	11,750	12,268
3 Payments of old debts (annual/farm)		
(a) Short-term credit	5,088	13,170
(b) Medium/long-term	7,596	15,790
Sub total	12,684 (15.9)	28,960 (19.8)
Average annual total expenditure (1+2+3) (100)	79,769 (100)	1,46,378 (100)
B Total average annual income/farm	56,428	1,05,680
Difference of expenditure and income	23,341 (41.4)	40,698 (38.5)
C Agricultural production expenditure/acre (as per recommendation of PAU, Ludhiana)	15,500	
D Present annual agricultural production expenditure/acre	11,750	12,268
E Difference	3,750 (24.2)	3,232 (19.6)

* Figures in parenthesis are in percentage. PAU: Punjab Agriculture University.
Source: Field Survey.

incurring an annual production expenditure of Rs 51,526 or Rs 12,268 per acre (as average farm size of sample small farmers in 4.2 acres).

Credit Acquisition

Credit was acquired by marginal and small farmers for various purposes/uses from various sources. The maximum credit was acquired for production by both marginal and small farmers, i e, nearly 46.4% and 40.9%, respectively of the total credit taken (Table 2).

Short-term production credit which is 68.4% and 62.7% for marginal and small farmers was acquired for purchase of agricultural inputs such as seeds, fertilisers and agrochemicals, whereas medium-long-term credit was acquired for purchase of farm machinery, implements, farm buildings, livestocks, irrigation structures, etc, and it was estimated to be 38.9% and 31.3% for marginal and small farmers, respectively. The second important purpose for which credit was acquired by marginal and small farmers was for health reasons, i e, nearly 20% and 23.2%, respectively. The third important purpose for which credit was acquired by marginal and small farmers was social/religious ceremonies which include expenses incurred on birth, death, marriages and other social events, not only in their own family, but also in functions of relatives. Similarly, for payment of old debts, marginal and small farmers had taken fresh loans, i e, 10.9% and 13.1% of total credit acquired. Moreover, credit which was sought for agricultural production purpose was diverted to other purposes which were mostly unproductive like consumption of liquor, social/religious ceremonies, etc, resulting in accumulation of the debt burden on the farmers. The miscellaneous category includes credit taken for purchase of two-wheelers, televisions, mobile phones, etc. Under this category nearly 4.9% and 3.5% of total credit was acquired by marginal and small farmers (Table 2).

Healthcare Credit

Healthcare credit had a major share in the total borrowing by marginal and small farmers as cheap medical facilities through government health services were inadequate, and not available at times. There are fewer subcentres (SCs), primary health centres (PHCs) and community health centres (CHCs) than their actual requirement in the rural areas of Punjab. According to the Indian public health norms, there should be one SC for 5,000 people (3,000 in hilly areas), one PHC for 30,000 people (20,000 for hilly areas) and one CHC for 1,20,000 people (80,000 for hilly areas). But in rural areas of Punjab, there are only 2,858 SCs against the requirement of 3,219 (according to population estimates of 2001 Census, i e, 1,60,96,488 persons), 484 PHCs against the requirement of 537 and 126 CHCs, whereas 134 are required. Moreover, the number of health institutions in rural areas of the state has not increased and has remained more or less stagnant over the years, which highlights the poor commitment of state governments, whereas the population in rural Punjab which constitutes 63.3% of the total population, has increased significantly over the years. The actual requirement of medical institutions, on the basis of projected population estimates of rural Punjab for the year 2008, i e, 1,84,62,672 persons (calculated on the basis of state's average annual population growth rate of previous decade, i e, 2.1% per annum) is much higher – nearly 3,693 SCs, 615 PHCs, and 154 CHCs are required which outstrips the actual availability of these institutions (Table 3, p 24).

Due to the existence of a smaller number of public health institutions than their actual requirement, these institutions in rural areas are overburdened in terms of both area and the number of persons dependent on them. On an average, one PHC covers nearly 100 sq km, whereas one CHC caters to 383 sq km of area. One doctor is, therefore, available for 26 villages (on an average basis), as one PHC is available for 26 villages. And one CHC is available for every 101 villages, which sounds unbelievable. Some of the basic facilities in these government health institutions are not

Table 2: Credit Acquisition by Marginal and Small Farmers for Different Purposes (in Rs /farm)

	Short-Term Credit		Medium/Long-Term Credit		Total Credit	
Use of credit	Marginal	Small	Marginal	Small	Marginal	Small
Production purpose	7,794 (68.4)	13,547 (62.7)	12,930 (38.9)	1,75,304 (31.3)	20,724 (46.4)	28,851 (40.9)
Consumption purpose	536 (4.7)	691 (3.2)	2,859 (3.6)	3569 (7.3)	3,395 (7.6)	4,260 (6.0)
Health purpose	1,379 (12.10)	2,938 (9.6)	7,546 (22.7)	13,398 (27.4)	8,925 (20)	16,336 (23.2)
Social/religious	592 (5.2)	1,621 (7.5)	4,467 (13.5)	8,801 (18.0)	5,079 (11.4)	10,422 (14.8)
Payments of old debts	832 (7.3)	1,923 (8.9)	3,490 (10.5)	6,259 (12.8)	4,322 (9.7)	8,182 (11.6)
Miscellaneous	262 (2.3)	886 (4.1)	1,928 (5.8)	1,565 (3.2)	2,190 (4.9)	2,451 (3.5)
Total	11,395 (100)	21,606 (100)	33,240 (100)	48,896 (100)	44,635 (100)	70,502 (100)

Figures in parentheses are percentages.

Table 3: The Availability and Requirement of Medical Institutions in Punjab (in numbers)

Particulars	SCs	PHCs	CHCs
1 Availability			
(a) Sixth Plan (1981-85)	2,602	130	10
(b) Seventh Plan (1985-90)	2,852	460	70
(c) Eighth Plan (1992-97)	2,852	484	105
(d) Ninth Plan (1997-2002)	2,852	484	105
(e) Tenth Plan (2002-2007)	2,858	484	126
(f) Eleventh Plan (up to March 2008)	2,858	484	126
2 Requirement			
(a) As per 2001 population	3,219	537	134
(b) As per 2008 population estimates	3,693	615	154

Source: *Rural Health Statistics*, 2009.

Table 4: Facilities in Public Health Institutions in Rural Punjab (as on March 2008)

Particulars	SCs	PHCs	CHCs
(1) Total no of institutions	2,858	484	126
(2) Population covered by one	6,460	38,146	1,46,529
(3) Population to be covered as per IPHN	5,000	20,000	120,000
(4) Average rural area covered (sq km) by one	16.89	99.76	383.20
(5) Average no of villages covered by one	4	26	101
(6) Institutions without buildings or to be constructed	1,025	82	10
(7) Institutions without electricity	404	5	_
(8) Institutions without regular water supply	389	24	_
(9) Without all-weather motorable road	134	10	_

Source: *Rural Health Statistics*, 2009.

available, such as electricity (404 SCs and five PHCs), water (389 SCs and 24 PHCs) and all-weather motorable roads (134 SCs and 10 PHCs) do not exist (Table 4).

Similarly, acute manpower shortages also exist in these institutions. For example, a shortage of 283 and 294 doctors in PHCs and CHCs (i e, nearly 60% shortage), 1,380 health workers, 650 health assistants/auxiliary nurse midwives (67.2% shortage), 340 laboratory technicians and 342 nurses/staff nurses exists in these institutions (Table 5).

Furthermore, the absenteeism of medical staff, poor/outdated/non-working medical equipment and lack of basic infrastructure are some of the other problems which rural inhabitants face. One of the major reasons for this pathetic state of rural healthcare in Punjab, is the ever-decreasing state government expenditure on health. The share of health sector in the overall budget as the state expenditure on health sector which was 7.19% of the total budget in 1985-86 subsequently decreased over the years to 3.45% in 2007-08 (GOP 2008). Low public sector spending on health services results in an overdependence on private sector for getting health services. In other words, out-of-pocket expenditure comprises a major share of expenditure on healthcare in Punjab, especially in rural areas.

In Punjab, households have undertaken nearly 76.1% of the total healthcare spending from their own sources, whereas public spending is only 18%, and all other sources like non-governmental organisations, charitable trusts, etc, contribute only 5.9% of total health expenditure. The ratio of 1:4 for public to private health expenditure reflects the inadequate quantity and quality of public health services in rural areas of Punjab *(Rural Health Statistics* 2009). The rural people, who are more prone to diseases like tuberculosis, cancer, liver dysfunction, etc, due to nutritional imbalance, lack of proper sanitation facilities and residual effect of agro-chemicals, are forced to avail of the services of private medical treatment, which are quite costly. The poor rural people pay from their own sources which are many times inadequate, forcing them to acquire credit sometimes at an exorbitant rate of interest, thereby increasing the debt burden on them. Therefore, it was found during the study that although nearly 11% marginal and 9.4% small farmers were suffering from serious ailments requiring immediate medical assistance, due to lack of funds they were unable to avail of these services.

Mission Failed

Although the government of India has launched a new massive health policy known as the National Rural Health Mission (NRHM), with the objective to improve the availability of and access of quality healthcare to people, especially for those residing in rural areas – the poor, women and children (NRHM 2005), the pace of implementation of this scheme is very slow. The Accredited Social Health Activists (ASHAs), who are the key players, to work as an interface between the community and the public health system are few in number and the state has not made any arrangement for their training. In India, as a whole, out of the total 2,28,327 ASHAs proposed to be selected only 1,45,546 ASHAs were selected, and in most of the states, the progress of NRHM has been very tardy (Garg and Nath 2007). A government-funded review of the NRHM reveals its slow progress due to problems in the implementation of the NRHM such as administrative constraints, governance issues, inadequacies in human resources as well as the poor investment in public health services in the recent past (Shrivastava 2008).

Similarly, the Punjab government had introduced two reforms in health policy. First was the opening of healthcare services to the private corporate sector. Private sector hospitals were given land and facilities at concessional rates, and were expected in return to provide free treatment to yellow card holders (people below the poverty line) up to 10% of outpatients and 5% of inpatients. The second policy decision was the setting up of the Punjab Health Systems Corporation (PHSC) in October 1995 by the state government, under the World Bank-sponsored State Health Systems Development Project II, in which more than 150 healthcare institutions run by the government were transferred to PHSC. In these hospitals doctors were contractually appointed on an honorarium of Rs 30,000 per month and with this money they were supposed to keep temporary staff of one nurse, one health worker and one *safai karamchari*. Nearly 1,200 doctors were appointed out of which 800 doctors left their jobs within one year for permanent jobs in neighbouring states like Haryana and Himachal Pradesh. Therefore, both these measures failed miserably. Hospitals no longer provide free services, and instead, charge all patients a user fee, including people below

Table 5: Manpower Availability in Rural Health Institutions of Punjab (as on March 2008)

Particulars	Required	Available	Shortage
Health workers (SCs) (male + female)	5,716	4,336	1,380 (24.1)
Health asst/ANMs (PHCs) (male + female)	968	318	650 (67.2)
Nurse/staff nurse (PHCs+ CHCs)	1,366	1,024	342 (25)
Lab technicians (PHCs+ CHCs)	610	270	340 (55.7)
Radiographers (CHCs)	126	61	65 (51.6)
Doctors (PHCs)	484	201	283 (58.5)
Doctors (CHCs)	504	210	294 (58.3)
(a) Physicians	126	56	70 (55.6)
(b) Obst and gynaecologists	126	46	80 (63.5)
(c) Paediatricians	126	39	87 (69.5)
(d) Surgeons	126	69	57 (45.2)

Figures in parentheses are percentages.
Source: *Rural Health Statistics*, 2009.

the poverty line. Moreover, the complex and cumbersome procedures in these institutions were constraining the access of the poor to healthcare services.

Conclusions

Commercialisation and privatisation of health services have excluded a sizeable proportion of the population, particularly those belonging to socially disadvantaged groups like landless labourers, marginal and small farmers, and poor from the coverage of health services provided by organised sector in rural areas. The subsequent financial burden of private healthcare services is responsible for a large proportion of total borrowing by these underprivileged sections of society. Therefore, policy measures like increasing the share of state's expenditure on healthcare, especially in rural areas, improving the existing healthcare facilities, filling up of vacant posts in these institutions, frequent surprise visits by higher officials to check absenteeism, compulsory rural postings of staff and fixing accountability of employees are necessary to improve the rural health scenario in the state.

REFERENCES

Economic Research Foundation (2006): "Government Health Expenditure in India: A Benchmark Study", undertaken for the MacArthur Foundation, India: 8-11.

Garg, S and A Nath (2007): "Current Status of National Rural Health Mission", *Indian Journal of Community Medicine,* 32(3): 171-12.

GoI (2007): "Towards Faster and More Inclusive Growth: An Approach to the 11th Five-Year Plan (2007-2012)", Government of India, Planning Commission, New Delhi, 9.

GoP (2008): "Economic Indicators of Various Sectors", *A Report of Economic Advisor, Statistical Abstract of Punjab*, Government of Punjab, Chandigarh.

Jaijee, I J (2005): "Farmers Suicides Being Under Played: Report", *The Pioneer*, 10 August.

NRHM (2005): National Rural Health Mission, Ministry of Health and Family Welfare, Government of India, New Delhi. retrieved, 5 December 2008, from NRHM web site: http://mohfw.nic.in/nrhm.htm.

NSSO (2005): National Sample Survey Organisation, Income, Expenditure and Productive Assets of Farmers, 59th Round, Report No 497 (59/33/5).

Rural Health Statistics (2009): Final Tables, *Bulletin*, from NRHM web site: http://mohfw.nic.in/nrhm.htm.

Shrivastava, B (2008): "Rural Health Mission: Slow to Take Off, Hit by Manpower Crunch", retrieved 5 December from livemint.com web site: http://www.livemint.com/2008/05/15233313/Rural-health-Mission-slow-to.html.