



“The Study Of The Rural Health System in India And Its Strategies Regarding the Populations Of India: A Brief Review “

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Abstract

Rural Health is one of vital elements of rural life. India being a nation of villages requires an intensive approach towards rural health. Nearly 75 per cent of health infrastructure and other health resources are concentrated in urban areas. Even if several government programmes for growth of rural healthcare have been initiated, the procedural delay in implementation leads to its ineffectiveness. Rural areas have been infected with various contagious diseases like diarrhea, amoebiasis, typhoid, infectious hepatitis, worm infestations, measles, malaria, tuberculosis, whooping cough, respiratory infections, pneumonia and reproductive tract infections. The insanitary conditions of households aggravate expansion of these diseases which is further promoted by apathy of people and government. Although unit level institution under rural healthcare takes care of sanitation through its outreach services yet, there is a long milestone to upgrade our health scenario. Rural Health Care services in India are mainly based on Primary health care, which envisages attainment of healthy status for all. The Primary Health Centre (PHC) has been stated to be prime location for diagnosis and first referral of these patients. The coordination between primary and tertiary level institutions needs to be strengthened for overcoming present challenges. Methodology: This article is a review paper based on analysis of data collected through secondary sources like books, journal articles, government records, NGO reports. The current paper seeks to pinpoint key challenges of rural health system and possible strategies taken by the state for overcoming them.

Keywords

Rural Health system, Primary Health Care, Infrastructure, Outreach, Sanitation



Introduction

India is having limelight at global front not only in terms of its exploding population but its health scenario also. Even after India's Independence, its population is still brewing under the scourge of degraded health system. There are nearly 716 million rural people who are constantly battling for basic healthcare services in their habitat (http://shodhganga.inflibnet.ac.in/bitstream/10603/7213/10/10_chapter%204.pdf). This condition has been aggravated by worsening living conditions of rural habitats. The unsafe and unhygienic conditions of households, drinking water, living areas promotes expansion of several diseases in rural areas. The majority of rural deaths are caused by communicable, parasitic and respiratory diseases which are somewhere linked with insanitary environment. About 2.3 million episodes and over 1000 malarial deaths occur every year in India. An estimated 45 million population are carriers of microfilaria, 19 million of which are active case and 500 million people are at risk of developing filaria (Patil, Ashok Vikhe, K.V Somasundaram and R.C Goyal, 2002). In addition, even agriculture related injuries like mechanical accidents, pesticides poisoning, snake and insects bites are adding to the existing rural health problems. This scenario is worsened through existing malpractices going on in rural health care. The archaic beliefs of tribals that any disease may be cured by magic, have dominated over the minds of rural tribal population of India. Due to this kind of notion, the rural areas are under the influence of various superstitions which ultimately leads to blockade in the advancement of modern pathology there. The magic based therapy is nothing but use of tantra and chants by saints upon ailing person. Even if there is availability of modern pathology-based health institutions like PHC in their locality, yet the tribal people adopt this indigenous magic based medication. However, the socioeconomic, cultural and political onslaughts, arising partly from the erratic exploitation of human and material resources, have endangered the naturally healthy environment (Patil, Ashok Vikhe, K.V Somasundaram and R.C Goyal, 2002). One of significant agents for downfall of rural health care is inadequate human resources in health system. The primary level health institutions like Primary Health Centres (PHC), Sub-Centre (SC) and Community Health Centres (CHC) are facing a huge problem of absenteeism of health professionals. Most health workers especially the 'doctors' do not want to serve in the rural areas due to overall infrastructural inadequacy and lack of incentives. In a study conducted by Banerjee et. al (2004) on health care delivery in rural Rajasthan, around 45 per cent of the doctors were found absent from PHC and 56 per cent from sub-centres.

Even in private sector, rural health care service delivery system is not free from lacunae. Most of the practitioners are not even qualified to undertake the profession but still there are quacks. This situation is intensified through minimal public expenditure on health. The public health expenditure in India has been quite minimal in comparison to that of various developing countries. India's public health expenditure is only 17.9 percent out of total expenditure on health as per census of 2001 (Bhat, Ramesh and Nishant Jain, 2004). The public health expenditure of other developing countries has been pegged at 90.6 percent for Bhutan, 83.5 percent for Maldives, 73.4 percent for Democratic People's Republic of Korea, 59.5 percent for Timor-Leste, 57.1 percent for Thailand, 48.9 percent for Srilanka, 44.2 percent

for Bangladesh, 29.7 percent for Nepal, 25.1 percent for Indonesia during the same period (Bhat, Ramesh and Nishant Jain, 2004). This scenario is intensified by this fact that Out of Pocket (OOP) expenditure as percentage of total health expenditure in India is higher than that of several Asian, North and South American countries (Basu, Sambit and Saurabh Ghosh, n.d). While this Out of Pocket expenditure in India is 61.7 percent, it is pegged at 30.6 percent for Brazil, 14.2 percent for Canada, 36.5 percent for Chile, 35.3 percent for china, 17.2 percent for Columbia, 27.9 percent for Ghana, 47 percent for Mexico, 14 percent for Thailand and 11.8 percent for the U.S (Basu, Sambit and Saurabh Ghosh, n.d). In comparison with public funding, private funding of healthcare is quite high in India. This private funding consists of household health expenditure, private funds, funds from NGOs which is contributing a major chunk in Indian health care funding as compared to public funding. For detailed analysis, the data of public funding has been compared with private funding within a span of 4 years which is highlighted through below-mentioned table-1. In addition, a significant share of the spending is directed toward curative and tertiary health care services as opposed to preventive, primary, and secondary care. According to the latest National Health Accounts data for 2004-05, about 28 percent of total public expenditure was allocated for tertiary health care services, significantly higher than the target of 10 percent recommended by the National Health Policy of India (Rao, M. Govinda and Mita Choudhury, 2012). Therefore, inadequate public funding on primary health care institutions leads to degradation of preventive care services. Due to ineffective functioning of these primary level institutions, most of deliveries nearly 3 out of 5 happen at home only (International Institute for Population Sciences (IIPS) and Macro International, 2007). According to NFHS-III, deliveries at home are more common among women who received no ante-natal check-ups. Only 15 per cent of home deliveries were followed by a post-natal check-up. Therefore, it may be inferred from this status that these service delivery mechanisms are leading to various inter-related risks. The problem is not limited till delivery but persists up to infant health care also. The Infant Mortality Rate (IMR) in rural areas is higher than urban areas. In 2009, it was 55 per 1000 live births. Neo-natal mortality in India varies between 60-75 per cent in various states. The death of infants in rural areas is caused by a number of factors ranging from water-borne infections, infectious diseases, malnutrition, insanitary environment which get intensified if furthered by poor rural healthcare. Infections, which are more difficult to deal with, include malaria, filaria and kala-azar. More than 85 per cent of rural children are undernourished in India. According to NFHS -III, the IMR in India has been 57 per thousand live births (Iyengar, Shreekant, Ravindra H. Dholakia, 2011). The underutilization of human and material resources at all these levels leads to ineffective functioning of rural health system. Therefore, it is imperative that there may be provision for up gradation of existing rural health system based on analysis of respective shortcomings.

[Table 1.](#)

Sources	2004 - 05	2005 – 06	2006 – 07	2007 – 08	2008 - 09
Public Funds	19.67	22.72	23.82	25.09	26.70
Private funds	78.06	75.86	74.87	73.54	71.61
External flows	2.27	1.41	1.31	1.37	1.68
Grand total	100	100	100	100	100

Source: table 15, National Health Accounts (2004-05) of MOHFW / GOI and

Sources of Health Expenditure in India (2004-05 to 2008-09):

Challenges for Rural Health System - An Overview

The poor state of the health system in rural areas is not the outcome of a particular occurrence but a consolidated outgrowth of degraded system. It signifies not only lacunae in existing policy and infrastructure but blockage in potential development also. The expenditure on public health has not only been ignored by the state but by common man also. The Common man terms expenditure on public health as useless. In their view, the quality of treatment and medicines in government-run hospitals has degraded. Their diverted investment in private practitioner and private hospitals has worsened public health system in India. The disillusionment and frustration with the growing ineffectiveness of the government sector is gradually driving poor people to seek help of the private sector, thus forcing them to spend huge sums of money on credit, or they are left to the mercy of 'quacks'. Therefore, it is very essential for us to review primary elements for degradation of Public health system in India.

Inefficient Physical Infrastructure

The sub-centre (SC) is the most peripheral institution or first contact point between Primary Health Centre (PHC) and community. Each sub-centre is manned by one Auxiliary Nursing Mid-wife (ANM) and one Multi-Purpose Worker (MPW). The sub-centres are needed for taking care of basic health needs of men, women and children. Apart from it, PHC also keeps an important position in health services. It provides integrated curative and preventive healthcare to the rural population with an emphasis on preventive and promotive aspects. At upper level, remains CHC. The major function of CHC is to provide comprehensive coverage of health care to patients referred from PHC. In this affair, poor infrastructure of the hospitals is a matter of serious concern. As per government records, 49.7 per cent of sub-centres, 78 per cent of PHCs and 91.5 per cent of CHCs are located in dilapidated government buildings. There

are 12,760 hospitals having 576,793 beds in the country. Out of these, 6795 hospitals are in rural areas with 149,690 beds and 3,748 hospitals are in urban areas with 399,195 beds. Average Population served per Government Hospital is 90,972 and average population served per government hospital bed is 2,012 (Kumar, Avaneesh and Saurav Gupta, 2012). Even in terms of availability of vaccines in these hospitals, the situation is very dismal. The availability of life saving vaccines is also not up to the mark, e.g. the gap between demand and supply of DPT in 2009-10 was above 26 per cent while that of vaccines of Tetanus Toxoid (TT) was about 16 per cent (Kumar, Avaneesh and Saurav Gupta, 2012). Penetration of basic infrastructure availability is very low in all the BIMAROU states (India Development Report, 2012/13). 4 percent of PHCs were functioning without electricity, and 7 percent were without regular water supply as of March' 2013 (NRHM, Budget Briefs, 2014-15). This situation has been quite abysmal in case of sub-centres whose figure is around 25 per cent lacking regular water and electric supply in India as of March'2012(India Development Report, 2012/13).

Underutilization of existing rural hospitals On one hand, there is lackness of efficient health infrastructure in rural areas, on the other hand, these infrastructure are not being utilized by people. Many a time, rural patients bypass local rural hospitals despite the availability of comparable medical services. The general conditional analysis of data on patients and hospitals suggests that hospital characteristics (size, ownership, and distance) and patient characteristics (payment source, medical condition, age, and race) influence rural patients' decisions to bypass local rural hospitals (Chilimuntha, Anil K., Kumudini R. Thakor and Jeremiah S. Mulpuri, 2013). The rural population deems urban hospitals fit for any kind of hospitalization. Therefore, the rural hospitals remain closed or wide open but without any patient. In many areas, accessibility is diminished by the lack of all-weather roads, making access subject to weather conditions (Chilimuntha, Anil K., Kumudini R. Thakor and Jeremiah S. Mulpuri, 2013). This leads to widespread absenteeism from service and closure of facility. The public doctors quite often provide private services instead of going to their designated centres (Bhandari, Laveesh and Siddhartha Dutta, 2007).

Inadequate human resources

The rural public health facilities are battling with the problems of inadequate manpower. There exists shortfall across all cadres in rural health system. The deficiency of trained doctors and medical professionals has paralysed the rural health facilities. As of March' 2013, the vacancy rates of doctors at PHCs has been 12 percent while the same at CHCs has been 47 percent at India level (NRHM, Budget Briefs, 2014-15). Apart from inadequacy, absenteeism is also adding to the problem. The data of survey done by Nazmul Chaudhury, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan and F. Halsey Rogers, reveals that absenteeism among the primary health providers in India, is the highest nearly 40 per cent (Chaudhury, N, et.al, 2006). During this survey, 143 public facilities in India were visited weekly during regular hours for an entire year. Around 45 per cent of the doctors were found absent from primary health centres (Chaudhury, N, et.al, 2006). Absence rates among nurses range from 27 per cent in Madhya Pradesh to over 50 per cent in Bihar, Karnataka, Uttarakhand and Uttar Pradesh. This



frequency of absenteeism may be attributed to the fact that there is certainly a serious lack of zealous administrative action towards effective service provisioning (Chaudhury, N, et.al, 2006).

Apathetic attitude of medical professionals

Primary health care has been a neglected stream for most of the medical practitioners. In 2010, according to the approach paper for the 12th Five Year Plan, 10 per cent of posts for doctors at the PHCs and 63 per cent of the specialist posts at the CHCs and 25 per cent of the nursing posts at PHCs and CHCs combined, remained unfilled (Govt. of India Approach Paper for 12th Five Year Plan, 2012-17). The situation for support staff is similar with 27 per cent of pharmacist and 50 per cent of laboratory technician posts also vacant (Rao, Mala and David Mant, n.d). A 2007 World Bank investigation of healthcare in Delhi reported that doctors in primary care centres had less competence and made less effort than staff in the private hospital sector (Rao, Mala and David Mant, n.d). The medical education does not prepare the graduate to function effectively in areas of need. Students who have paid high fees for private medical education, prefer to pursue career where they are able to recover their investment. Among developing countries, India is the biggest exporter of trained physicians with India-trained physicians accounting for about 4.9 percent of American physicians and 10.9 percent of British physicians in 2008(Kaushik, Manas, et. al, 2008).

Dominance of unregulated Private medical professionals

The apathy of public doctors leads to unregulated private practitioners in health sector. Some of them are quacks. In case of Bihar and Uttar Pradesh, less than 15 per cent of households depend on public facilities (Bhat, Ramesh and Nishant Jain, 2004). Nearly 63 per cent of rural households receive medical care from private practitioners. 42 per cent of those classified as allopathic doctors in rural areas, actually have no medical training. This proliferation of unregulated and unqualified private providers demands an effective regulatory system (India Development Report, 2012/13). 80 per cent of general practitioners practise allopathic medicine without proper training.

Non-Preparedness to fight with Epidemic in rural areas

The rural health system is lagging behind in its responses to pandemic eradication. Most of the epidemics in rural areas are not controlled through proper vaccination policies. Every year there are many epidemics which take hundreds and sometimes even thousands of lives like Dengue, Malaria, Cholera, Diarrhea, Pneumonia. The government hospitals inherently lack the adequate facilities to deal with the cases of different epidemics and deadly diseases; moreover at many places, the hospitals are understaffed and lack even the basic healthcare facilities like beds, X-ray machines (Kumar, Avneesh and Saurav Gupta, 2012). Encephalitis is just one of those instances which has crippled the government efforts to control its expansion in rural areas. In 2010, there were 3350 reported cases of encephalitis in



Uttar Pradesh. Indian policy makers have failed to provide full vaccine coverage to population. It has been estimated that around 20 per cent of Indian population is not covered under the vaccination coverage.

High Neonatal Mortality

The death of infants till age group of 5 years, is alarming in rural areas. In 2007-08, 30 per cent of rural children died of diarrhoea, dysentery (India Development Report, 2012/13). This frequency of infant deaths among 1 year old is 51 per 1000 live births. The share of neo-natal deaths in infant mortality nationwide has increased from 66 per cent to 70 per cent between 1990 and 2009 (India Development Report, 2012/13). The in-depth analysis of causes for these deaths is supposed to be premature birth, low weight, birth asphyxia, trauma etc. This problem is substantiated by malnutrition of children and their mothers. In addition to medical factors, socio-cultural factors are also contributing towards neonatal deaths. The gender bias towards infants also leads to several female infant deaths. In terms of infant mortality, for instance, the worst faring districts are not only in the BIMAROU states but also in Andhra Pradesh, Karnataka and Maharashtra (India Development Report, 2012/13). Child mortality among Scheduled Tribes (STs) is much higher than other social groups (India Development Report, 2012/13). This condition of high infant mortality of India has been compared with some selected Asian countries also. It seems that it outnumbers several countries like Srilanka, Maldives, Nepal, and Bangladesh in this affair. Therefore, it is inferred from both inter-state and inter-country data for IMR that India is having high IMR and contribution to it comes from majority of states. It is highly concentrated among eastern and southern states. Therefore, IMR is not a problem of one or two Indian states but of majority which downgrades India's position in terms of global ranking of IMR. The condition of India in terms of Infant Mortality may be visualized through following table-2:

Table 2.

Countries	1990	2008
Sri Lanka	23	13
Maldives	79	24
Nepal	99	41
Bangladesh	103	43
<i>India</i>	83	52
Bhutan	91	54
Pakistan	101	72

Note: Infant mortality rate refers to the number of deaths of infants under one year old per 1,000 live births

Source: UNDP Human Development Report 2010.

Infant Mortality Rate in selected South Asian countries (1990 & 2008)

Inequitable Immunization

The government-run immunization programmes are also not equity-based. An analysis of district level data through DLHS data of 2007-08 shows a strong negative correlation between immunization and child mortality rate (India Development Report, 2012/13). What is worrisome is, share of children fully immunised decreased in 59 districts in these BIMAROU (Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha, Rajasthan, Uttar Pradesh and Uttarakhand) states between 2002-04 and 2007-08 (India Development Report, 2012/13). Households in districts with civil disturbances and inaccessible terrain have particularly poor access. For instance, in Bijapur, a Left Wing Extremist affected district in Chhattisgarh which is among the most backward in the country, only 0.4 per cent of rural households have access to all three facilities (India Development Report, 2012/13). Poorer access to health services among the STs is partly because they live in remote rural and forest areas with an inhospitable terrain where medical facilities are often unavailable, or even if available, absenteeism of healthcare providers is high and monitoring difficult (India Development Report, 2012/13).

Inclination towards Home-based deliveries

The maternal mortality is still a major roadblock in the advancement of rural health. The prevalence of home-based delivery is leading to frequent deaths of pregnant women. Most rural women choose home deliveries due to poor access to and low quality of healthcare in the maternity centres (India Development Report, 2012/13). As per DLHS data in 2007-08, less than 40 per cent of rural births were



at institutions (compared to 70 per cent in urban areas) and only about 6 per cent of home deliveries were conducted by skilled professionals (India Development Report, 2012/13).

Lack of coordination between Medical Research Institution and Health Service delivery Institution

Indian medical care lags behind even in terms of research and innovation. In some of cases, even the researchers from reputed medical centres are not capable of diagnosing the problems. For ex-In June 2011, more than 50 children died in Bihar because of a mysterious disease which included the symptoms of high fever and unconsciousness, the doctors from the National Institute of Virology visited the hospital full of infected children after several days but even they could not identify the disease (India Development Report, 2012/13). Apart from diagnosis of disease, the efficient medical research institution is required for formulating epidemic response plan also. They can help in indigenizing global technologies and ensure its availability at economical rate. The collaboration between various research institutions across globe will assist in terms of sharing of resources. Downstream research requires the identification of well-tested knowledge in relevant areas of health and the processes to facilitate the application of that knowledge for adoption in health sector and policy development. Applied research may address adequately the issues related to sectoral convergence by partnership development between the community, health service providers and the Government. The medical research institution may have potential for updating the technical knowledge of existing medical professionals. Therefore, it is prerogative that there must be coordination and cooperation between different research centres and health service delivery institutions in India.

Lack of Community Participation ..

The Public health system especially in rural areas has been quite disconnected from rural masses' needs. The demands of community in terms of treatment, diagnosis, prevention of various disease, have been ignored which result into pandemic. The absence of consultation with residents of areas leads to ineffective monitoring of disease and maintenance of hygiene and sanitation. The outbreak of epidemic is driven by the fact that there is zero communication between health professionals and residing masses of the concerned locality. Therefore, Communities should be involved in designing, staffing, and functioning of local primary healthcare centres and in other forms of support.

Remedies in Rural Health System

There have been several strategies and missions initiated for improvement in rural health scenario. The Government has taken various steps for institutionalizing the existing rural health framework.

National Rural Health Mission (NRHM)

One of key achievements in the area of rural health is National Rural Health Mission (NRHM). It was started in 2005 with an aim to address infirmities and problems across primary health care and bring about improvement in the health system and the health status of those who live in the rural areas. It



provides accessible, affordable, effective, accountable, and reliable healthcare to all citizens and in particular to the poorer and vulnerable sections of the population, consistent with the outcomes envisioned in the Millennium Development Goals and general principles laid down in the national and state health policies. NRHM is a flagship scheme of central government to improve the provision of basic healthcare facilities in rural India by undertaking an architectural correction in the existing healthcare delivery system and by promoting good health through improvements in nutrition, sanitation, hygiene and safe drinking water. Under the NHRM, some steps have been taken for the transformation of rural health infrastructure so that degraded conditions of infrastructure may be improved. Through NRHM, the unit level health care centres like PHC, SC have been strengthened. Various PHCs have been transformed into 24X7 PHCs with proper medical facilities. In addition, the patients have been linked with mainstream health system through a wide network of ASHA workers across the country. In most of the Indian states, hospital deliveries in rural areas have increased during 2005 to 2008. At the national level, relative increase in hospital deliveries was 57 per cent (Singh, Sharad Kumar, Ravinder Kaur, Madhu Gupta and Rajesh Kumar, 2011). The performance of NRHM has brought drastic changes among various aspects of rural health care. In terms of reduced mortality rates, it has achieved a significant goal like reduction in IMR from 57 per cent in 2007 to 55 per cent in 2008 as per DLHS-3 of 2007-09 (IFMR Research Brief, 2009-10). During the same period, full immunisation increased from 20.7 per cent to 41.4 per cent in Bihar, 25.7 per cent to 54.1 per cent in Jharkhand, from 30.1 per cent to 36.1 per cent in Madhya Pradesh, from 53.5 per cent to 62.4 per cent in Orissa, and from 23.9 per cent to 48.8 per cent in Rajasthan (IFMR Research Brief, 2009-10). In eight of the fifteen states surveyed in Phase 1 of DLHS-3, more than 90 per cent of women who had given birth in the preceding three years, reported receiving antenatal care (IFMR Research Brief, 2009-10). Between DLHS-2 and DLHS-3, institutionalised delivery has increased by 66.4 per cent in Madhya Pradesh, 47.3 per cent in Bihar, 43.8 per cent in Orissa, 20.9 per cent in Andhra Pradesh and 12.4 per cent in Uttar Pradesh (IFMR Research Brief, 2009-10).

Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana is a flagship programme of Government of India under NRHM which is intended to promote institutional delivery to reduce maternal and neo-natal mortality. It provides cash incentives for women to deliver in a government or accredited private medical facility (India Rural Development Report, 2012/13). Under JSY, the ASHA workers increase cases of institutional deliveries through escorting pregnant women, proper medical facilities for ante-natal care. They work as interface between rural health system and community. The study findings of Development Research Services (DRS) of UNFPA indicate that 73 per cent of the births during the year 2008 in Madhya Pradesh and Orissa were conducted in a health facility. Among these institutional deliveries, those conducted in government centres and in accredited private hospitals were found to be 68 per cent in MP and 67 per cent in Orissa (UNFPA Report, 2009). The combined estimates of five states like Rajasthan, Bihar, Uttar Pradesh, Orissa and Madhya Pradesh indicated 55 per cent of institutional deliveries in 2008 (UNFPA Report, 2009). Majority of the deliveries were conducted in PHCs in the state of Bihar (70 per cent), Orissa (58 per cent)

and Madhya Pradesh (42 per cent). While in the state of Uttar Pradesh and Rajasthan around 44-47 per cent of the deliveries were reported in CHCs (UNFPA Report, 2009). In Orissa around 91 per cent of the mothers were given advice by the ASHAs for institutional deliveries, followed by Uttar Pradesh (84 per cent), Bihar (74 per cent) and Rajasthan (64 per cent). More than 90 per cent of the mothers reported having their pregnancy registered during the ANC period except in Bihar where it was relatively low at 85 per cent. Overall, it was found that more than two-thirds of the women in Bihar and Madhya Pradesh and four out of five mothers in Orissa, Rajasthan and Uttar Pradesh received PNC after childbirth at the institution under the JSY scheme. Bihar come out to be the only state in which only 16 per cent of the mothers stayed for two days or more at the institution after their delivery. More than 90 per cent of the beneficiaries who delivered in an institution in these five states, reported having received Rs. 1,400 as incentive. In the states of Bihar, Madhya Pradesh and Orissa, 79-86 per cent of the mothers received the incentive money from the institution in which they had delivered, while in Rajasthan and Uttar Pradesh, 40-44 per cent of the mothers received the money from the institution and got similar proportions from other sources (UNFPA Report, 2009).

Health Insurance through Rashtriya Swasthya Bima Yojana (RSBY)

Rashtriya Swasthya Bima Yojana (RSBY) is one of landmark schemes in the area of Rural Health. The RSBY offers a micro-insurance product for households designated as “below the poverty line (BPL)” and aims to cover up to 60 million households throughout the country over the next five years (2008-2013) (Das, Jishnu and Jessica Leino, 2011). The objectives of the RSBY are to provide financial protection for households affected by major health shocks and improve health outcomes for poor households (Das, Jishnu and Jessica Leino, 2011). It was launched in 2008. RSBY insures BPL families for hospitalisation costs and allows them to choose between public and private hospitals. Beneficiaries must pay a nominal registration fee while the cost of premium payments is shared by the central and state governments (Sethi, Sonam, n.d). First, insurance companies are selected by competitive bidding in each district and receive a premium for every household enrolled by them in the scheme (Das, Jishnu and Jessica Leino, 2011). Secondly, insurance companies empanel in-patient care facilities (ICFs), they then reimburse ICFs for in-patient care provided to enrolled households. ICFs may be either public or private, public facilities may retain payments from the RSBY in self-governed societies known as Rogi Kalyan Samitis (Das, Jishnu and Jessica Leino, 2011). Thirdly, eligible households (those identified as BPL by their states) can enrol in the programme by paying Rs. 30, in return for which they receive a smart card. A maximum of five members may enrol from any family, including the head, spouse and up to three dependents of the head of the household (Das, Jishnu and Jessica Leino, 2011). As of March’ 2014, the RSBY has been rolled out in over 436 districts in 29 states and covered around 37 million BPL families (<http://www.rsby.gov.in/overview.aspx>). The beneficiaries under RSBY are entitled to an insurance cover of INR 30,000 for most of the diseases that require hospitalization. The Government has fixed package rates for medical and surgical interventions, or procedures, for a large number of interventions. Pre-existing conditions are covered from day one and there is no age limit for the insured. Coverage



extends to a maximum of five members of the family which includes the head of the household, the spouse and up to three dependents (Sethi, Sonam, n.d). The scheme places control over a significant amount of resources in the hands of the beneficiaries. This makes them visible as potential sources of revenue, worth pursuing by the health care providers (Sethi, Sonam, n.d). Every BPL household is now a potential client from whom the hospitals can earn significant revenues if they can get themselves empanelled and provide quality health care (Sethi, Sonam, n.d). The survey results of Indian Development Foundation show that RSBY patients were given prompt treatment. About 52 per cent of the patients were attended by the staff within 5 minutes, 32 per cent were attended between 5 to 15 minutes (Sethi, Sonam, n.d). Indeed, as is evident from Table 5, in 84 per cent cases, the patients considered the treatment received at the hospitals, to be good (Sethi, Sonam, n.d). In an analysis of another health insurance scheme targeted to the poor, Desai (2009) points out that 43 per cent of the gynaecological claims were for hysterectomies that were actively encouraged by participating hospitals (Sethi, Sonam, n.d). Within the RSBY, presently insurance companies are focused primarily on controlling outright fraud rather than examining medical necessity (Sethi, Sonam, n.d). In addition, Hospital empanelment and de-empanelment is sometimes not transparent and some of the good hospitals are either not empaneled. Hospitals often provide unauthorized/inappropriate treatment, either to charge more from the IC and/or beneficiary, or to discourage beneficiaries from availing services under RSBY. Beneficiary has no flexibility to opt out of the hospital once a procedure is blocked on his card, nor he can go to any other hospital for availing treatment. The share of private sector hospitals is 95 percent in Kanpur, 87 percent in Amritsar, 90 percent in the Dangs and 100 percent in Karnal which is a very worrisome factor (Basu, Rumki, n.d). The profit motive of private hospitals has potential to liaison with insurance companies and siphon off public money.

Mobile-based Primary Health Care System

The Mobile-based Primary Health Care System is having crucial role in the area of rural health. Primary health care services based on mobile devices ensures improved access to primary healthcare (Murthy, M.V Ramana, n.d). This system of mobile healthcare which was initiated in 2005, uses a mobile phone to transmit a person's vital signs. The health professionals may be able to remotely monitor patients suffering from chronic diseases across the country. This implies offering a wide range of services such as health education, promotion of nutrition, basic sanitation, the provision of mother and child family welfare services, immunisation, disease control and appropriate treatment for illness and injury (Murthy, M.V Ramana, n.d). In this affair, the initiative has been taken by a Bangalore-based firm called Centre for Development of Advanced Computing (CDAC). The Software components under development are Patient Database management, Interaction between doctor and a patient, capture of Medical data acquisition- such as ECG, images of heart, lung, eye etc. and Scheduling management (Murthy, M.V Ramana, n.d). A Central repository of Primary Health Center management System with a Web interface is proposed to be developed in an Open source database (Murthy, M.V Ramana, n.d). It also provides



development of Localization Support in national and other Indian languages in mobiles by providing interface for translation.

Indira Gandhi Matritva Sahyog Yojana

Indira Gandhi Matritva Sahyog Yojana (IGMSY) was started in 2010 with a purpose of encouraging women to follow Infant and Young Child Feeding (IYCF) practices including early and exclusive breast feeding for first six months. IGMSY is a centrally sponsored scheme which would be implemented through the State ICDS Cells with 100 per cent financial assistance from the Ministry of Women and Child Development. It has been piloted in 52 districts across the country. It has been implemented through existing district ICDS cell. Under this scheme, there is a provision for cash transfers to all pregnant women and lactating mother in selected districts. It promotes the demand for mother and child care services through providing incentives based on fulfilment of specific conditions. Under IGMSY, registration within four months of pregnancy would be the first milestone for receiving cash benefits of Rs.1500/- at the end of second trimester. Every registered mother under the IGMSY would have a Mother and Child Protection Card (IGMSY Report, Govt. of India, 2010). IGMSY would strive to ensure the optimal immunization of every pregnant woman in close collaboration with the health workers. The scheme would also ensure accessing provisions for counselling, iron and folic-acid supplements that are vital for the health of both the mother and the child (IGMSY Report, Govt. of India, 2010). Research studies around the world highlight that globally, the universal practice of exclusive breastfeeding for the first six months of life reduces young child mortality by 13 per cent (IGMSY Report, Govt. of India, 2010). In this way, this scheme is very vital for the purpose of encouraging mother and child health development. Apart from this, cash incentives to the Anganwadi Workers (Rs. 200/-) and Anganwadi Helpers (Rs. 100/-) would be provided which would together be Rs.300/- per beneficiary. Under the overall supervision of the ANM, the ASHA would support all health related interventions under the IGMSY in coordination with the AWWs (IGMSY Report, Govt. of India, 2010).

Conclusion..

The Rural Health in India has been one of the important issues for development. But it has been one of the neglected sectors in Indian economy. The existing state of public health in the country is so dissatisfactory that any attempt to improve the present position must necessarily involve administrative measures. These administrative measures consist of regulation and enforcement in public health, human resource development & capacity building, population stabilization, strengthening of disease surveillance machinery so that direct or indirect association of these factors with health may be robust. The existence of strong surveillance mechanism will assist in monitoring and further policy making. The strong Human Resource in public health sector will assist in imparting management skills and leadership qualities among health professionals. There has been shortfall not only in terms of physical infrastructure but also human resource in rural healthcare. Even though, the posts are sanctioned by the government, many of them are lying vacant. The apathy of various medical professionals also leads to

degradation of rural health scenario. Many rural residents are not able to obtain treatment for basic ailments either due to the non-presence of health care services in the vicinity, or due to lack of funds to access the same (Bhandari, Laveesh and Siddhartha Dutta, 2007). The system of Health planning and decision making has been highly centralized and top-down with minimal accountability, little decentralized planning or scope for genuine community initiatives; the failure of most State supported community health worker schemes being one of the most striking consequences of this top-down approach. Therefore, it is imperative for us to revitalize the existing rural health system from both structural and functional points of view.

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