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Review Article

Health Care Facilities in Rural Areas

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Abstract

The main objective of this research paper to acquire an understanding of health care facilities in rural areas. In rural communities, the health care facilities are not in a well-developed state. In some cases, the rural individuals do not have access to these facilities and are required to travel to distance places or urban areas. With the advent of globalization and industrialization, there have been initiation of technical, scientific and innovative methods in the health care centres. The rural individuals, earlier used to implement traditional methods in treating their illnesses, but in the present, they have also acquired appropriate information in terms of modern and innovative health care facilities, used to promote their well-being. The main areas that have been taken into account in this research paper include, health practices in rural India, origin and evolution of primary health care in India, primary health care resources in India, health insurance in rural India, and remedies in rural health system.

Keywords: Health Care Centres; Health Care Facilities; Health Care Resources; Health Insurance; Primary Health Care

Introduction

Health care facilities are regarded to be of utmost significance and individuals, belonging to all age groups and backgrounds need these facilities. Rural health care services in India are mainly based upon primary health care, which envisages healthy status and well-being for all. Also being holistic in nature, it aims to provide preventive, and promote curative and rehabilitative care services. The different health policies and programs within the country aim at achieving an acceptable standard for health for the general population of the country. With the main purpose of achieving this comprehensive objective, a widespread approach was advocated, which included improvements in health care, public health, sanitation, clean drinking water, proper diet and nutrition and knowledge of hygiene and feeding practices. Significance was accorded to cause a decline in the health care facilities across the regions. There should not be any disparities between regions and these facilities should be provided to individuals, belonging to rural and remote areas as well [1].

An assessment of the performance of the country's health related indicators depicts that significant gains have been made in them, e.g. life expectancy at birth, child and maternal mortality and morbidity. Primary health care is regarded as a strategy, which is a backbone of health service delivery for the country. India was one of the first few countries to recognize the significance of primary health care approach. Primary health care was conceptualized in 1946, three decades before the Alma Ata Declaration. Sir Joseph Bhore made recommendations, which laid the basis for the organization of basic health care services in India. Over the past decade, there have been appointment of several committees and commissions have been appointed by the Government, which examine the issues and the challenges that the health care sectors are experiencing [1].

Health practices in rural India

Rural individuals in India in general and tribal individuals in particular have their own beliefs and viewpoints in terms of health. The tribal communities are found throughout the country in hilly and mountainous regions. They are primarily dependent upon the natural environmental conditions, in order to fulfil their daily needs and requirements. When they experience various forms of health problems and illnesses, then too, they are dependent upon the forests and natural environments to obtain herbs and medicinal plants. The various health practices that are adopted by rural

individuals include, Ayurveda, unani, siddha and naturopathy to maintain positive health care and to prevent illnesses and diseases. The occurrence of socio-economic, cultural and political assaults, arising moderately from the exploitation of human and material resources have endangered the naturally healthy environment [2].

The primary cause for the occurrence of rural health problems are also attributed to lack of awareness, health consciousness, poor maternal and child health services and occupational hazards. In rural communities, the increase in the death rate is primarily due to the prevalence of infectious, communicable, parasitic and respiratory diseases, which are preventable. The rate of morbidity within rural communities is high due to infectious diseases. It is 40 percent in rural and 23.5 percent in urban. Waterborne infections, account for about 80 percent of the diseases in India. In rural areas, individuals are dependent upon water bodies to a large extent, as they experience shortage of water within their homes. Therefore, when the water bodies are polluted, then they experience waterborne infections. On an annual basis, 1.5 million deaths and loss of 73 million workdays are attributed to waterborne diseases [2].

The groups of infections that are widespread in rural communities have been classified as follows: [2].

1. Diseases that are carried in the gastrointestinal tract, such as, diarrhoea, amoebiasis, typhoid fever, infectious hepatitis worm infestations and poliomyelitis. There are 100 million rural individuals, who suffer from cholera and diarrhoea ever year.

2. Diseases that are carried in the air, through coughing, breathing and sneezing, such as, measles, tuberculosis (TB), whooping cough and pneumonia. In the present existence, there are 12 million TB cases, i.e. an average of 70 percent. More than 1.2 million cases are added every year and cases of measles that are reported every year account for 37000.

3. Infections, which are more difficult to deal with include, malaria, filariasis and kala-azar. These are regarded as the result of development. The methods of irrigation causes malaria and filariasis, the use of pesticides have produced a resistant strain of malaria, the water that is collected on the roads, especially during rainy seasons and during the construction of roads are considered as breeding places for snails and mosquitoes. About 2.3 million episodes and 1000 malarial deaths takes place every year within the country. An estimation of 45 million are regarded as the carriers of micro-filaria. The active cases account for 19 million and 500 million are at the risk of developing filaria.

Every third person, who is suffering from leprosy is an Indian. Malnutrition is regarded as one of the dominant health problems within the country, especially in rural areas. There is widespread prevalence of protein energy malnutrition (PEM), anaemia, Vitamin A deficiency and iodine deficiency. The children, who account for 100 million are unable to obtain two square meals in a day. This states that more than 85 percent of the children, belonging to rural communities are undernourished [2]. The major cause of the prevalence of malnutrition is poverty. When individuals are residing in the conditions of poverty, they are unable to meet their daily needs and requirements. Due to these conditions, it becomes difficult for them to satisfy their nutritional requirements as well. Among children, the prevalence of malnutrition leads to spread of illnesses and diseases. Furthermore, problems also take place within their growth and development.

In addition, agricultural and environmental injuries and diseases are common in rural areas. These include, mechanical accidents, individuals may get prone to accidents, while making use of tools and machines, pesticide poisoning, snake, dog and insect bites, zoonotic diseases, skin and respiratory diseases, oral health problems, socio-psychological problems of the female, geriatric and adolescent population, and diseases due to addictions. The increasing rate of population growth in rural areas nullifies all the developmental efforts. In 1951, rural population was 299 million, and in May 2001, it was 750 million. Since 1951, the government has been making an attempt through vertical and imported programs to combat the problems, but to no avail. However, the new National Population Policy 2000 gave emphasis to a holistic approach. The main areas, which are needed to be improved include, enrichment of the overall quality of life of the individuals, no gender bias in education, employment opportunities, child survival rates, sound social security, and promotion of culturally and socially acceptable family welfare methods [2].

Though the system of primary health care services are appropriate in rural areas. It was put into operation in a proper manner, due to the efforts made by health professionals. The present system has not left any scope for the community members, nor for the grassroots level, health workers to take ownership for the programs and integrate them within the overall development. The concept of replacing a community-selected person from the village and providing them with essential training, so the community will be able to cope up with health related problems in an operative manner. As a result, the basic requirements of decentralized people-based, integrated, curative, preventive and promotive services have been completely undermined by vertical programs [2]. In

other words, in rural areas, there have been recognition of problems and challenges that the health care sector is facing. Another important aspect is, there have been formulation of measures that are dedicated towards overcoming these problems and promoting well-being of the community.

Origin and evolution of primary health care in India

The origin and evolution of primary health care in India has taken place with the establishment of committees and commissions by the Government of India. The main objective of the committees and commissions was to look into the problems and challenges within the health care sector. The purpose of these committees formed from time to time is to review the current situation, regarding health status within the country. In addition, suggestions are given to make improvements within the health care sector. The improvements are focused upon making provision of proper health care facilities to all individuals. The major committees have been stated as follows: [1].

Bhore committee on health planning and development

The most comprehensive health policy and plan document ever prepared in India was the "Health Survey and Development Committee Report", referred to as the Bhore Committee. The committee was appointed in 1943, with Sir Joseph Bhore, as its chairman. The main objective of this committee was to make recommendations for the modification of health services within the country [3]. The Bhore Committee report is the first health report, which was initiated in 1946. It was a plan, which was equivalent to Britain's National Health Service. The report was based on a countrywide survey in British India. It is the first organized set for health care data for the country. It considered that the health program in India should be developed on the foundation of preventive health work and proceeds in association with the administration of medical relief. The committee strongly recommended the health services system, based upon the needs and requirements of the individuals. The majority of individuals, belonged to deprived, marginalized and economically weaker sections of the society.

Sokhey committee report on national health

The National Planning Committee (NPC) established by the Indian National Congress in 1948, under the chairmanship of Colonel S. Sokhey. It stated that the maintenance of the health of the individuals was the responsibility of the state. It focused upon the fact that preventive and curative measures should be taken into account within the health care sectors. The Sokhey Committee report was not much detailed.

Community development program

With the beginning of the First Five Year Plan (1951-1955) and health planning in India, the community development program was initiated in 1952. The main purpose of this program is to promote development of rural areas in all dimensions. This program is considered as an important landmark in the history of rural development. It was defined as the process, which was designed to create the conditions of economic and social progress of the entire community. The members of the community were encouraged to render an active participation and generate awareness in terms of necessary areas. The other areas that have been covered under the program include, health and sanitation. Through the establishment of primary health care centres and sub-centres and other related sectors, including agriculture, education, transport, social welfare and industries. Each community development block consists of 100 villages with an approximate population of about 100000. One primary health care centre was created for one community development block.

Mudaliar committee on health survey and planning

By the end of the second five year plan (1956-1961), Health Survey and Planning Committee was initiated, which was headed by Dr. D.L. Mudaliar. It was appointed by the Government of India to review the progress made in the health care sector, after the submission of the report of the Bhore Committee. This committee found the conditions in the primary health care centre to be unsatisfactory and suggested that the primary health care centre, already established should be reinforced, along with the strengthening of the sub-divisional and district hospital. The major recommendation of this committee report was to limit the population served by the primary health centres to 40,000. There were improvements made in the health care services provided by these centres. Another area that was recommended was provision of one basic health worker per population of 10,000 individuals.

Mukherjee committee reports on basic health services

The Mukherjee committee was formed under the headship of Shri Mukherjee. The main purpose of this committee report was to review the factor of family planning. The committee observed that the multiple activities of mass programs of family planning, small pox, leprosy, trachoma, National Malaria Eradication Program, were imposing problems for the states to undertake them in an efficient manner. Financial problems were the major hindrances within the course of implementation of activities and programs.

The committee does visualize that at a later stage, there can and should be a much greater integration between family planning and maternity and child health programs and basic health services.

Jungalwalla committee on integration of health services

The Jungalwalla Committee on the integration of health services was established in 1964 under the chairmanship of N. Jungalwalla, the Director of the National Institute of Health Administration and Education. The main objective of the committee was to look into various problems, related to the integration of health services, abolition of private practice by the doctors in government services and the service conditions of doctors. Integrated health services were defined as services with the unified approach for all problems. The committee recommended integration from the highest to the lowest level in the services, organization and personal. Well-qualified, skilled and capable individuals should carry out the administrative functions in medical care and public health programs.

Kartar Singh committee on multipurpose workers

The Kartar Singh Committee was initiated in 1973. This committee laid down the standards and principles regarding the health workers, with the main purpose of forming a framework for the integration of medical and health services at peripheral and supervisory levels. For ensuring proper coverage, the committee recommends the amalgamation of peripheral workers into a single cadre of multipurpose workers. An organizational change was recommended, which was one primary health care centre was recommended to the population of 50,000 individuals. The job duties, carried out by three to four health workers need to be supervised by one health assistant.

Shrivastav committee on medical education and support manpower

The Srivastav Committee was established in 1974, as a group on medical education and support manpower. The primary objective of this committee is to determine the steps that are needed to reorient medical education in accordance to the national needs and priorities. Another important area that needs to be taken into consideration is, to establish a curriculum for health assistants, who rendered a significant contribution in the promotion of health care services. The major recommendations of the committee are, creation of bands of paraprofessional and semi-professional health workers from within the community, like school teachers, post masters and so forth; the development of the three cadres of health workers between the community level workers and doctors at the primary health centres; the development of “Referral Service Complex” by establishing connections between primary health centres and higher level referral and service centres, i.e. taluka, regional, district and medical college hospitals. Furthermore, there would be establishment of medical and health education commission for planning and implementing the reforms needed in bringing about developments in the health and medical education on the lines of University Grants Commission (UGC).

Rural health scheme: Community health volunteer scheme-village health guides

Acceptance of the recommendations of the Srivastav Committee Report led to the initiation of Rural Health Scheme in 1977. Under this scheme, the main areas that were taken into consideration are, providing training to the community health workers, reorientation training of multipurpose workers and establishing connections between medical colleges to rural health. The initiation of community participation, the community health volunteer, village health guide (VHG) scheme was launched on 2nd October, 1977. In accordance to the VHG scheme, the village community makes the selection of the volunteer, to be a person from the village. In most cases, women were appointed, they were imparted short-term training, and small incentive for the work performed. It is their job duty to provide health education and generate awareness in terms of maternal and child health and family welfare services. One needs to possess adequate knowledge in terms of communicable diseases, various health problems and illnesses and provide medical treatment to the patients.

Alma Ata declaration - Health for all by 2000

The Alma Ata Declaration of 1978, initiated the concept of health for all by 2000. It was signed by 134 governments, including India and 67 other agencies. The Alma Ata Declaration in 1978 gave an insight into an understanding of primary health care. It viewed health has an integral part for leading to socio-economic development of the country. It provided effectual understanding to the individuals in terms of health. In addition, the framework is provided that is required by the states to achieve the goals of development. The Declaration recommended that primary health care should include, education concerning prevailing health problems and methods, diet and nutrition, safe water and sanitation, maternal and child care, immunization against major infectious diseases, prevention and control of locally endemic diseases, promotion of mental health and provision of essential drugs. The participation of the committee is regarded important in every stage of development in the spirit of self-reliance and self-confidence.

Primary Health Care Resources in India

The primary health care resources in India have been stated as follows: [1].

Infrastructure

Health infrastructure is regarded as an important mechanism for the health care delivery provisions and mechanisms within the country. Health infrastructure indicators are sub-divided into two categories, these are, educational infrastructure and service infrastructure. Educational infrastructure provides details of medical colleges, number of students that have been enrolled in medical colleges to pursue M.B.B.S, post-graduate diploma programs in dental colleges, AYUSH institutes, nursing courses and para-medical courses. Medical education infrastructures within the country have shown rapid growth during the last 20 years. There are 314 medical colleges within the country. The total admission of 29,263 (in 256 medical colleges), 289 colleges for BDS courses and 140 colleges conduct MDS courses, are 21547 and 2783 respectively, during 2010-2011. There are 2028 institutions for general nurse mid-wives, with the admission capacity of 80332 and 608 colleges for pharmacy and diploma, with the intake capacity of 36115 on 31st March, 2010.ds

Service infrastructure in the health care sector include, details of allopathic hospitals, hospital beds and other amenities and facilities required to make provision of proper medical and health care facilities to the individuals. In addition to these, the other areas that are taken into account include, Indian System of Medicine and Homeopathy hospitals, sub-centres, primary health care centres, community health centres and blood banks. In the country, there are 12,760 hospitals having 5,76,793 beds. Within rural communities, there are, 6795 hospitals, with 1,49,690 beds and within urban communities, there are, 3748 hospitals with 3,99,195 beds. In the states of Bihar and Jharkhand, rural and urban bifurcation is not available. The availability of health care and medical facilities under AYUSH by management status i.e. dispensaries and hospitals are 24,465 and 3,408 respectively as on 1.4.2010. In March 2010, there are 1,47,069 sub-centres, 23,673 primary health centres and 4,535 community health centres in India. Total number of licensed Blood Banks within the country as on January 2011 are 2445.

The information available on health infrastructure within the country, the number of health medical and paramedical health personal, the adequacy of their training, the types of organizations involved in providing medical relief, the nature of services provided by them and the conditions of service of various health personnel, availability of various therapeutic substances, instruments and appliances and facilities for their production and the control of trade in these substances and equipment are some of the important aspects that need to be taken into consideration [4].

Sub-Centres

The sub-centre is the most bordering and first contact point between the primary health care system and the community. Each sub-centre is required to be manned by at least one Auxiliary Nurse Midwife (ANM) or female health worker and one male health worker. Under NRHM, there is a provision for one additional second ANM on contract basis. One Lady Health Visitor (LHV) is assigned with the task of supervision of six sub-centres. Sub-centres are allocated the tasks relating to interactive communication with the purpose of bringing about behavioural change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. The sub-centres are provided with basic drugs for the treatment of minor ailments, the other areas are needed for taking care of essential health care requirements of men, women and children.

The Ministry of Health and Family Welfare is providing 100% central assistance to all the sub-centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. The salary of the male worker is borne by the State Governments. Under the Swap Scheme, the Government of India has taken over an additional 39,554 sub-centres from State Governments and Union Territories since April, 2002 in lieu of 5,434. Rural Family Welfare Centres transferred to the State Governments and Union Territories. There are 1, 47,069 sub-centres functioning within the country as on March 2010.

Primary Health Centres (PHCs)

Primary Health Centre is the first contact point between village community and the medical officer. In other words, through this, connection is established between village communities and medical officers. The primary health centres were envisioned to provide an integrated curative and preventive health care to the rural population with emphasis put upon preventive and promotive aspects of health care. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP) and Basic Minimum Services (BMS) Programme. As per minimum requirement, the functioning of the PHC is carried out by medical officers, supported by 14 paramedical and other staff.

Under NRHM, there is a provision for two additional staff nurses at PHCs on contract basis. It acts as a referral unit for six sub-centres. It has four to six beds for patients. The activities of PHC involves remedial, precautionary, promotive and family welfare services. There are 23,673 PHCs functioning as on March 2010 throughout the country.

Community Health Centres (CHCs)

The Community Health Centre, third tier of the network of rural health care units, was required to act as a referral centre for the neighbouring PHCs, primarily four in number. This is for the patients requiring specialized treatment in the areas of medicine, surgery, paediatrics and gynaecology. The objective is two-fold, one is to make modern health care services available to the rural individuals and to ease the overcrowding of the district hospitals (Functioning of Community Health Centres, 1999). CHCs are being established and maintained by the State Government under MNP and BMS programme. As per the minimum norms, the functioning of CHC is carried out by four medical specialists i.e. surgeon, physician, gynaecologist and paediatrician, and supported by 21 paramedical and other staff members. It has 30 in-door beds with one OT, X-ray, labour room and laboratory facilities. It serves as a referral centre for four PHCs and also provides facilities for obstetric care and specialist consultations. As on March 2009, there are 4,535 CHCs, operating within the country.

First Referral Units (FRUs)

An existing facility, which may include a district hospital, sub-divisional hospital, community health centre and so forth can be declared, completely operational first referral unit (FRU), only if it is equipped to make provision of round-the-clock services for emergency obstetric and new born care. These are in addition to all the emergencies that the hospital is required to provide. It should be noted that there are three critical determinants of the facility being declared as a FRU. The emergency obstetric care include, surgical interventions like the caesarean sections, new-born care and blood storage facility on a 24 hour basis. FRUs provides comprehensive obstetric care services, including emergence care of sick children, complete range of family planning services, safe abortion services treatment of STI/RTI and referral transport services. There has been a significant increase in the number of FRUs from 940 in 2005 to 3104 in 2018 [5].

Human resources

The formulation of policies in terms of human resources must create a balance on a continuous basis, the need for the financial health teams in primary, secondary and tertiary sectors. The major challenge encountered in achieving health care goals are, non-availability and uneven distribution of health care providers. One of the aspects that is regarded as unfortunate in the health care facilities within rural India is, there is lack of qualified and skilled personal. Hence, it is necessary to formulate measures that would enable the recruitment of qualified and skilled health care providers and medical practitioners to meet the needs and requirements of rural individuals.

World Health Organization (WHO) estimates that worldwide, this factor may lead to failure in attaining the Millennium Development Goals within the timelines. One international norm a minimum of about 25 skilled health workers, i.e. doctors, nurses and midwives as per 10,000 population, with the main purpose of achieving a minimum of 80% coverage rate for deliveries by skilled birth attendants or for measles immunization as seen in cross country analysis. According to 2001 census, the density of health workers falls approximately eight per 10000 population, of which Allopathic physicians around 48%, followed by nurses and mid-wives of 30%, pharmacists of 11%, AYUSH practitioners of 9% and rest are others. Also 60% of the health workers reside in urban areas, which skew their distribution considerably. The density of health workers per 10000 population in urban areas is 42, which is nearly four times that of rural areas, which is only 11.8, and also the majority, 70% of health workers are employed in private sectors.

Health insurance in rural India

Due to non-accessibility of public health care and low quality health care services, a majority of individuals within the country turn to the local private health sector as their first choice of care [6]. If one looks at the health care facilities available, within the country, particularly in rural communities, it has been found that in rural communities, the health care centres and hospitals are not in a well-developed state. There are lack of infrastructure, facilities, qualified staff, health care and medical practitioners and other modern and innovative methods and techniques. As a result of these, the individuals are unable to obtain proper medical and health care facilities. In most cases, within rural communities, proper health care centres and hospitals are not available. Hence, the individuals are required to make visits to urban areas in order to obtain access to medical and health care facilities.

The individuals within rural communities are in most cases unaware of certain facts. For instance, when they obtain water from the wells, water bodies and rivers located nearby, then they

are mainly unaware of the fact of water pollution. Hence, they get prone to many health problems and illnesses, due to contaminated water. Besides the lack of overall health care infrastructure, the second most important influence upon the health care industry of the country is the shortage of medically insured population and high expenditure. There has been fluctuations in the India's insurance industry, between public and private ownership for most of the 20th century. The Insurance Amendment Act of 1950, ultimately led to the government of India in making decisions in terms of nationalization of the insurance business [7].

However, in August 2000, The Insurance Regulatory and Development Act (IRDA), opened up the market in order to accept the registration applications. In the present existence, the major insurance companies within the country are, New Delhi (17.9 percent of the market share), United India (15.1 percent), National (14.1 percent), ICICI Lombard (12.0 percent), and Oriental (11.9 percent). These public and private insurance companies, only cover a small minority of the population. The rest of the country is subjected to self-funding of the medical expenses. These are the ones that are not covered by the government's universal health care. While the insurance industry is limited in a number of individuals that it reaches. But it does put into practice, certain professional strategies and methods to carry out the tasks and activities [7].

While the insurance industry is limited in a number of individuals it reaches. There is a public reinsurer, general insurance company (GIC), is the sole reinsurance company within the country. There are also more than 12,000 registered actuaries, with the Institute of Actuaries within the country. In the health insurance companies, they are rendering a significant participation in the pricing, reserving, and other analytical roles. Through the Actuaries Act of 2006, these professionals are governed by myriad of rules and policies that are mandated by the collection of councils, committees and advisory groups [7]. In other words, in health insurance companies, when recruitment of staff takes place, they are required to undergo the training and development programs. After the acquisition of training, they obtain a license, and then they can implement insurance policies among the clients. Among the rural individuals, it is vital to generate awareness in terms of health insurance.

Remedies in rural health system

There have been formulation of programs and schemes, which aim at bringing about improvements in the rural health system. The Government has taken up various programs and measures, which aim at its development and have been stated as follows: [8].

National Rural Health Mission (NRHM)

The initiation of National Rural Health Mission took place in 2005. The main purpose of this program was to take into account the problems taking place in the health care sector in rural areas. It makes provision of reachable, inexpensive, effective, accountable and consistent health care services to rural individuals. The major focus of the program is upon the deprived, marginalized and underprivileged sections of the society. NRHM is regarded as the flagship scheme of the central government. It has the major objective of bringing about improvements in the provision of basic health care services within rural communities. The important areas that are needed to be taken into consideration are, diet and nutrition, safe drinking water, sanitation, hygiene and making provision of appropriate medical and health care facilities to the individuals, particularly belonging to deprived, underprivileged and economically weaker sections of the society.

Under NRHM, some of the steps have been undertaken to bring about transformation in the rural health infrastructure. In this manner, improvements can take place within the infrastructure. Infrastructure is regarded as one of the aspects that is of utmost significance, particularly in hospitals and health care centres, when individuals are coming to obtain medical treatment and health care facilities. Another vital aspect is, through this scheme, there have been strengthening of primary health care centres. There have been transformation of various primary health centres into the 24x7. Due to this, individuals are able to obtain access to medical and health care facilities in an appropriate manner. In addition, there has been establishment of the connection between patients and mainstream health system, through a wide network of ASHA network, throughout the country.

Janani Suraksha Yojana (JSY)

Under the Government of India, there has been introduction of the JSY program under NRHM. The primary objective of this program is to lead to a decline in institutional delivery to cause a reduction in maternal and neo-natal mortality. It makes provision of cash incentives for the poverty stricken individuals, particularly women to deliver in a government or accredited private medical facility. Under JSY, ASHA workers increase the cases of institutional deliveries through escorting women, who are expecting, proper medical facilities and anti-natal care. Their contribution is like an interface between the rural health system and the community. The study findings of the development research services (DRS) of UNFPA indicate that 73 percent of the births, during 2008 in Madhya Pradesh and Orissa were conducted in a health facility.

Another aspect, which was found was more than two-thirds of women in Bihar and Madhya Pradesh and four out of five mothers in the states of Orissa, Rajasthan and Uttar Pradesh, received proper facilities after child birth. Bihar was regarded as the only state, in which only 16 percent of the mothers stayed at the institution for two days or more after their delivery. More than 90 percent of the beneficiaries, who delivered in the institutions in these five states, reported as having received 1400 rupees as an incentive. In the states of Bihar, Madhya Pradesh and Orissa, 79 to 86 percent of the mothers, received the incentive money from the institution, in which the delivery has taken place. Whereas, in the states of Rajasthan and Uttar Pradesh, 40 to 44 percent of the mothers, received the money from the institution and received similar proportions from other sources.

Health Insurance through Rashtriya Swasthya Bima Yojana (RSBY)

In the area of rural health, Rashtriya Swasthya Bima Yojana is regarded as one of the essential aspects. It offers a micro-insurance product for the households that are designated as below poverty line. One of the primary objectives of this scheme was to cover the households that account for around 60 million, throughout the country. The RSBY primarily aims to make provision of financial protection for all the households that are affected by major health problems and illnesses. The individuals and families, who are residing in the conditions of poverty and those who cannot afford health services are the ones, who are addressed. RSBY was launched in 2008. It ensures the families, particularly the ones, who are residing below the poverty line to meet the hospitalization costs and make a selection between public and private hospitals.

Beneficiaries are required to pay the nominal registration fees. Whereas, the costs of the premium payments are shared by the central and state governments. First, insurance companies are selected by the competitive bidding in each district and receive the premium of every household, enrolled by them within the scheme. Insurance companies empanel in-patient care facilities (ICFs), they then reimburse ICFs for in-patient care, provided to the enrolled households. These may be either public or private, public facilities may retain payments from the RSBY in the self-governed societies, known as the Rogi Kalyan Samities. The beneficiaries under RSBY are entitled to an insurance cover of 30,000 rupees, for most of the health problems and illnesses that require hospitalization.

Mobile-Based primary health care system

The mobile-based primary health care system renders a significant contribution in the area of health care services, particularly within rural communities. In simple terms, it means the primary health care services that are based on mobile devices. Its main purpose is to ensure improved access to primary health care. It was launched in 2005 and a mobile is made use of to transmit the vital signatures of the individuals. Through this system, the health professionals will be able to remotely monitor the patients, suffering from chronic illnesses and diseases, throughout the country. The major areas, in terms of which services are provided include, diet and nutrition, health education, basic sanitation, mother and child family welfare services, immunization disease control and appropriate treatment for illnesses and health problems.

Indira Gandhi Matritva Sahyog Yojana (IGMSY)

Indira Gandhi Matritva Sahyog Yojana (IGMSY) was initiated in 2010. The major objective of this program is to encourage women to follow infant and young child feeding (IYCE) practices, including early and exclusive breast feeding for the first six months. IGMSY is a centrally sponsored scheme, which would be put into operation through the state ICDS cells. Financial assistance is available to 100 percent from the Ministry of Women and Child Development. Throughout the country, it has been piloted in 52 districts. Under this scheme, there is a provision of cash transfers to all expecting and lactating women within the selected districts. It leads to encouragement in the demand of mother and child care services, through making provision of incentives, based on specific criteria.

Conclusion

Health care is regarded as one of the important aspect that is a major requirement of the individuals, belonging to various castes, creeds, races, ethnicities gender, age groups and socio-economic background. In rural communities, the health care and medical facilities are not in a much developed state. In some cases, when rural individuals experience severe health problems and illnesses, they are required to migrate to urban communities. When the origin and evolution of primary health care in India takes place, the main programs and schemes are, Bhore Committee on Health Planning and Development, Sokhey Committee Report on National Health, Community Development Program, Mudaliar Committee on Health Survey and Planning, Mukherjee Committee Reports on Basic Health Services, Jungalwalla Committee on Integration of Health Services, Kartar Singh Committee on Multipurpose Workers, Shrivastav Committee on Medical Education and Support Manpower, Rural Health Scheme: Community Health Volunteer Scheme-Village Health Guides and Alma Ata Declaration - Health for All by 2000.

The primary health care resources in India are, infrastructure, sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), First Referral Units (FRUs) and human resources. In rural areas, it is vital to generate awareness among the individuals in terms of health insurance. In order to provide solutions to the problems of rural health, there have been introduction of remedies in the form of programs and schemes. These are, National Rural Health Mission (NRHM), Janani Suraksha Yojana (JSY), Health Insurance through Rashtriya Swasthya Bima Yojana (RSBY), Mobile-Based Primary Health Care System and Indira Gandhi Matritva Sahyog Yojana (IGMSY). In the effective implementation of these programs, the individuals are required to possess the necessary skills and abilities. They need to make efficient use of their skills and abilities to generate awareness among the rural individuals in terms of not only improving their health conditions, but overall quality of life as well.

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