Chapter VII

Summary and Conclusion

7.1 Summary

The present study has been carried out to study the changing health care policies of the government of India and to find out why policies formulated to improve the health status of the people are not efficient enough to deal with problems in rural areas.

Health sector is an important part of economy. If the health status of the people of a nation is not satisfactory, then it cannot contribute to the economy of the nation. To improve the health status of the people, some strategies are necessary to be implemented. These strategies are based on policies. These policies keep on changing to improve the health status of the people and adopt to changing economic policies.

Two villages were selected for the purpose of the study. One village is located nearer to the sub-centre and other village is located five km away from the sub-centre (Kalkut). A sample study was carried out to represent the whole population. The data collected from the villages related to the different dimensions of the present health care policy. They include, morbidity rate, disease pattern, source of health care, utilization of health care services, expenditure on health, source of money for health care, utilization of maternal and child health services. The information was collected from different government institutions. Some key informants were also asked to verify the information, secondary sources were considered to collect the information. Data was collected through conventional anthropological field tools like –schedule, questionnaire, interview, and observation. The fieldwork was carried out in a period six months.

The theoretical dimension of the study is related to Applied Medical anthropology which "deals with intervention, prevention and policy issues and analyzes the socioeconomic forces and power differentials that influences access to care"[1]. The health policies formulated do not meet the requirement of the rural people who are economically backward. Due to inadequate health care facilities these marginal people do not have access to health care free of cost. Hence, in this study an attempt has been made to carry

out useful and ethical research which is the prime concern of applied medical anthropologist.

The majority of the households in both the villages are Hindu. The overall male and female in both the villages are 52.7 percent and 47.2 percent in Sisabari and 52,3 percent and 47.6 percent in Polash respectively. Literacy rate, turn out to be 59.8 percent and 60.7 percent in Sisabari and Polash respectively. There is one primary school, which is situated in the center of the two villages. So, the literacy rate in the primary school level is quite high i.e. 30.2 percent in Sisabari and 38.5 percent in Polash.

The findings of the study could be summarized as below.

The village economy is predominantly based on agriculture. Almost all the households partly depend upon collecting and selling of forest wood and firewood. Even those who claim to be cultivator, depend on wage earning and other livelihood sources like selling *hariya* (local beer). Monthly income of all the earning members in the family has been taken into consideration for computing the monthly income of the family. It is found that a high proportion of total population is relatively poor earning a monthly income of an average of Rs 2000.

To improve the health status of the people many strategies have been formulated since Independence. Bhore committee suggested three tier model and emphasized on primary health care, curative and preventive services and basic infrastructure as close as possible to the people which would also include the rural people.

The first two plans were concentrated on basic infrastructure, but this vision was diluted and minimum need programmes were initiated where multipurpose health worker scheme, feeding programmes, the community Health Guide Scheme, the integration of vertical programmes, and the Integrated Child Development Services were prioritized. From the third five year plan family welfare programme was in focus. Seventh five year plan has advocated the expansion of private sector and reducing the investment in preventive and curative care. On the other hand ninth plan had introduced cost recovery

from secondary and tertiary level care to improve the quality in public health from those who are above poverty line. Tenth plan envisaged referral linkages between three levels of care, decentralization of services, technology and integration of vertical programmes under one head that is, 'Health and Family Welfare Society' in state and district level.

After the Alma Ata declaration in 1978, 'Health for All by 2000 AD' was envisaged through primary health care. It emphasized on equity in basic health care through people's participation. But this comprehensive strategy was diluted and selective PHC was introduced where diseases were categorized as high, medium and low. These vertical national disease control programmes came to the forefront of health care programmes and immunization and child health were given priority.

The first National Health Policy was formulated in 1983 which adopted the primary health care (PHC) approach proposed by WHO in 1978 in order to bridge the very gaps in inequalities in the health care coverage between region and states and urban and rural areas. The priorities were to bring health to the door step, shift from curative to preventive and promotive aspects of health care.

India adopted the Structural Adjustment Programme (SAP) in 1990 and began to liberalise and restructure the economy in accordance with the IMF-World Bank agenda. A major part of this economic restructuring was the cutting back of government spending and the withdrawal of government responsibility for the fulfillment of the people's basic health needs.

The second NHP was formulated in 2002 which talks about vertical programmes, strengthening of infrastructure, promotion of public health, filling the gap of availability of doctors by introducing short-term training for basic services, decentralization of health care delivery through panchayati raj and autonomous monitoring institutions, setting up a national disease surveillance system as well as a national accounting system, strengthening ethical practices, and regulation of private practice.

Recently National Rural Health Mission has been formulated to improve the health status of the rural people. It emphasized on private-public partnership through intra and inter-sectoral development and community participation.

These changing policies have great impact on the rural areas. In this study the impact of changing policies is studied in Matigara bock, where the studied villages are situated is divided into two sectors, namely, Matigara sector and Kalkut sector. Matigara sector provides both preventive and curative services whereas Kalkut sector provides only preventive services. Each sector has six sub-centres. The studied villages are quite far away from the respective primary health center (PHC). Both PHC and SC are catering to more than number of people they are supposed to cater.

The PHC in Matigara is over-loaded by inpatient and outpatient services. Each doctor attends to at least 200 outpatients on an average per day. The sub-centres under the PHC are situated at a distance of 5 to 25kms from the studied villages. The PHC has 10 beds for indoor patients. One of the Medical Officers informed that on an average per year 3500 patients are admitted. Neither the Medical Officers nor the other staff of the PHC stays in Matigara, they commute from nearby town, Siliguri, because only four quarters are available in the PHC, which are occupied, and they are also not interested in the quarters as they are permanent residents of Siliguri. This creates a lot of problem for emergency patients. It is noticed that due to lack of facilities, doctors as well as other staff are not willing to work in the PHC. They neither have ambulance nor any other vehicle, so that the doctors and supervisory staff can visit the field and sub-centre conveniently. The supervisors visit the sub-centre by bus. Transport is the major problem for field supervisors. The laboratory facilities in the PHC are in poor condition. It has only one laboratory for DOTS (Directly Observed Treatment, Short Course Study) to test tuberculosis. The SC is manned by one male and one female health assistant, one trained birth attendant (TBA) and two Community Health Guides (CHGs). In SC the highest priority is given to Family Welfare and RCH, others are considered secondary activities.

To encourage the decentraliasation process Health Sthayi Samiti has been constituted to oversee the functioning of the health system in block level. Panchayat does not have the

political will to improve the water and sanitation situation and this is a major constraint of the health scene of the villages. According to the villagers, health workers are irregular and not easily accessible as they do not stay in the proximity of the SC to which they are attached. Panchayat does not have the political will to improve the water and sanitation situation and this is a major constraint of the health scene of the villages.

The sub-centre report was collected for 10 months to get information about health care delivery regarding communicable diseases, family welfare and stock position of medicine and other equipments. It is found that the average clinic days for 10 months is 11 and attendance of patients is 309.

In the studied villages the morbidity rate is 49.9 percent and 36.3 percent. The villagers suffer more from communicable diseases. The traditional healer plays an important role in the life of these villagers. According to them disease is caused by evil-spirits. No modern treatment is sought without getting rid of the evil spirits.

The study showed that quacks were utilized for nearly half of the illness episodes (45 percent in Sisabari and 40 percent in Polash); for 33.7 percent and 31.2 percent of the illness episodes private facilities were utilized. Villagers do not give a second thought when they go to the local quacks, because they (quacks) stock some medicines and give them to the patient on credit. This facility is not available with the government hospitals or qualified private practitioners. Accessibility to government hospital is not only difficult but also supplemented by inadequate facilities. If any person somehow manages to go to government hospital, he is denied medicines and proper check-up by government doctors.

The utilization of the government hospital also declined due to introduction of user charges. In both the villages, the average expenditure for treatment in secondary level medical care ranges between Rs5000 and Rs10125; the average expenditure for treatment in tertiary level medical care ranges between Rs4000 and Rs1250; the average expenditure for treatment in private clinic ranges between Rs1006 and Rs2325. Though

these are the expenditures, the duration of stay in the institution varies from 3 to 12 days only.

The expenditure pattern on health care reveals that seeking treatment, for outpatient and inpatient care in both government and private sources costs the patients dearly. The study reveals that to meet the hospitalization expenses the households have to borrow money and even liquidate their assets.

Utilization of contraceptive methods among women in the age group 15-45 is not encouraging though it is higher in Sisabari (53.2 percent) whereas in Polash it is 38.7 percent which may be due to less contact with health workers in Polash.

The data from immunization came from a sample of 42 children in Sisabari and 43 children in Polash under 5 years of age. In both the villages it was found that coverage of OPV (Oral Polio Vaccine) is highest among all the vaccines that is, in Sisabari it is 37 percent and in Polash it is 33 percent. The highest coverage of OPV is due to the pulse polio programmes held in the village primary school every year.

The figures represent an encouraging figure of women going for antenatal check-up (in both the villages 66.6 percent of the sample women have had antenatal check-up). It is important to mention that even those who have had antenatal check-up, could not avail the TT injection and folic tablets from government sources, rather they had to manage it from private sources. The preference of deliveries is at home that is, 75 percent (in both the villages). It is found that, generally women are reluctant to go to hospital for a number of reasons.

7.2 Impact of SAP

After India embarked on SAP, public spending was reduced in health sector, curative care was shifted to private sector and recovery mechanism was introduced. The impact of these strategies in the studied villages are delineated in the following points.

1) The study shows that the functioning of the health center is characterized by preventive programmes like national disease control programme and family planning programmes which are also inadequate. Curative care in the health center is therefore, the weakest component in spite of a very high demand for such services as evident by the number of inpatient and outpatients who come for treatment. People need basic curative and preventive services but the existing system is obsessed with a fragmented health care delivery.

2) The services are reduced to limited services like acute diseases, normal deliveries and activities related to national programmes.

3) The overlooking of people's need on health and its gradual replacement by the drugs-disease-doctor orientation has affected most of the community health programmes, as a result, the new economic adjustment policies have imposed a heavy burden on low-income groups.

4) The idea of "market culture" has emerged in rural society where health care has become a commodity to be purchased.

5) The existing strategies enhanced the social pressure of debt and dependency, rather than a progressive health status.

6) The NHP 2002 ignores the 1983 policy's objectives of protecting and providing primary health care for all, specially the under-privileged. It encourages commercialization of secondary and tertiary level medical care, without first ensuring secondary and tertiary level care to the underprivileged, hence, the policy denies the rights of the poor to basic health care which is conspicuous in the surveyed village. The PHC does not provide comprehensive

primary health care but only family planning and selected immunization services. The location of PHC dismisses the importance of maintaining referral links between different levels of care.

7) As the underlying emphasis of the health programmes remain family planning or population control and because of a complete lack of regulation and control, the poor have to seek primary health care from private health providers, often from the large chunk of practitioners, who practice modern medicine without proper qualification in any system of medicine.

8) The villagers continue to use private health care with a tremendous load of out-of-pocket expenditure and whenever they use public facilities for primary care it is the urban hospital they prefer. User fee has marginalized the poor further and reduce their access to services and increased their burden. As user charges do not contribute to the quality of services the utilization level of health care is low especially for antenatal care and hospital birth, as it is unaffordable for them. This is also well reflected in studies from different African countries that due to introduction of user fees, utilization level of health care has declined. In Zimbabwe user charges were introduced in 1997. As user charges did not contribute to the quality of services but involved expenditure in the utilization level of health care from the public sector declined by about 50 percent. It mainly affected poor people in rural areas and other vulnerable sections of the society. In Ghana the SAP was introduced in the early 1980s and user fee policy was included in the mid-1980s. Introduction of fees led to a 50 percent drop in outpatient attendances. In Kenya, too the number of outpatient visits declined by about 40 percent despite the fact that user charges were small[2]. Inability to earn

income on a regular basis forces the poor to opt for alternatives like, going to traditional healers and informal and ineffective sources of care. In due course, they had to go for more expensive medical care, which led to further impoverishment of the poor households. Due to user charges the resurgence of communicable diseases particularly malaria, TB and jaundice all contributed to increased morbidity.

9) The NHP 2002 also talks about decentralization of health care delivery. But in such situation where people cannot avail the facilities of PHC due to locational problems, what steps should be taken is indiscernible.

10) Due to non-availability of rural health care services, the urban facilities are being over-crowded. The urban health care facilities are not supposed to care about the rural requirement.

11) The villagers are using private sources with a tremendous load of out-of-pocket expenditure and whenever they use public facilities for primary care, it is the urban hospital they prefer, overcrowding the urban facilities.

12) Private sector health care in rural areas are catering to public health demand and offering preventive and promotive services.

13) The villages are characterized by high cost and low attainment in the health sector. It points out a higher disease burden in the villages. The relatively higher expenditure on health in rural areas is mainly due to a higher proportion of private sector expenditure.

14) Private sector health care in rural areas are catering to public health demand and offering preventive and promotive services.

15) The government, after having launched the Schemes to improve the health situation in rural areas, seems to have failed in supporting it over time. Inputs like unbiased selection, regular training, monitoring and supervision, interaction with higher level of (health) bureaucracy, provision of medicines and other equipment, have eluded the basic health services. The existing system of medical care has failed to recognize their services. These steps do not match with the strategies taken to improve the health care delivery system in the National Health Policy 2002.

16) At the time when the resources are reduced in the public sector, the private sector is protected at the cost of the poor people as evident from the study. The bias of investments in the government sector provided an opportunity for the private sector to make profit in backward areas. The distortions in the supply of government services have adversely affected hospitalization services to the rural poor. The rural poor are prevented from accessing hospitalization services due to inability to pay. The adverse impact is on the household finances of even those who manage to pay is high.

17) Due to lack of adequate resources, the quality of care at public hospitals has deteriorated. With the initiation of SAP in 1990s, there is further decline in public expenditure on health services. However, it may be noted that the high proportion of outpatient and inpatient treatment in the private sector in the study does not in anyway indicate the underutilization of public hospitals. In fact, there is overcrowding and more than full capacity utilization of public institutions.

18) The overcrowding at the public hospitals has created conditions for the rapid growth of private sources in the rural areas. Further, absence of any control on the quality as well as pricing has made the medical care a very attractive source of investment for private capital even in the remote areas like the studied villages.

19) Since the reforms in the health sector are a part of drastic reforms in other major sectors, the overall impact on the health conditions of people and their access to medical care depend on the changes proposed by the health sector.

20) Since World Bank advocated contracting out of certain services, particularly supportive services like laundry, dietary services, sanitation, etc, to private agencies, investment in public sector even for these services have been eluded as it is found in the studied PHC. Contracting out of services create nexus between private contractors and hospital authorities and leads to absorbing of public resources.

21) The health sector reforms, guided by the World Bank, are aimed at limiting the role of the state mainly to the provision of primary care and to encourage the private sector in the provision of tertiary care.

22) The government institutions have their limitations in terms of overcrowding, lack of cleanliness, etc. which are basically due to lack of adequate resources and absence of professional management and accountability.

23) The govt. is first starved of funds; and then this very shortage is used as an argument to cut down on the range of services it provides to the people.

7.3 Conclusion

This study has been carried out to study on the impact of changing health care policies on the rural society. It has highlighted the changes on strategies formulated from first NHP (1983) to second NHP (2002) emphasising more on impact of new economic policies like SAP in the rural areas. In rural areas primary health centre is the main health service delivery institution to provide comprehensive health care as it was mentioned in NHP 1983. But this policy was changed to selective health care where vertical programmes became the fundamentals of PHC as it is quite evident from the study of the organizational structural of the PHC Matigara and the SC Kalkut that these institutions are providing preventive services and curative services playing a secondary role in providing basic health care.

The study shows inadequacy of PHC and SC in providing services to the villagers as these institutions lack basic infrastructure and are in a dilapidated condition. Lack of medicines and equipments and shortage of staff have made the situation worse whereas added problems like a large number of people they are catering to has made the problem acute. According to NHP 1983 a PHC is supposed to cater to 30,000 population but this PHC is catering to more than I,26,000 population. Similarly, SC is supposed to cater 5,000 population but it is catering 15000 (unofficially) population which clearly shows that it does not meet the norm of NHP 1983. Moreover, even if the institutions are providing the preventive services, the situation in the villages shows that the vertical programmes are not efficiently dealing with the diseases because we can see the resurgence of diseases like TB and malaria. Though this is the phenomena of primary level care provided by the primary health centres in villages, the NHP 2002 has totally ignored the primary health care at all. It has undermined the strategy of Health for all by 2000 (which was a forerunner of making the NHP 1983).

Given this situation NHP 2002 has emphasized on privatization in secondary and tertiary level institutions. This is quite evident in the study that due to lack of primary level health care, the villagers are moving to secondary and tertiary level institutions in urban areas crowding the urban facilities which is not supposed to provide services to the rural requirements. Due to lack of proper referral systems, they are not getting proper treatment in the secondary and tertiary level institutions. Other factor is the locational problem of the PHC as the PHC Matigara is located at a distance of 22 kms from the villages, so the villagers prefer to go to the urban secondary institutions which is available at a distance of 10 kms. These ground realities are overlooked in formulating the NHP 2002. On the contrary, ill behaviour of the health personnel and malpractice in the public institutions have forced the villagers to seek treatment from private sources.

These private sectors are mostly unregulated and informal because the main source of health care given to villagers in this unregulated system are the quacks. These are the untrained healers who are running their business with sophistication due to lack of proper public health systems. These quacks are available in the villages and can provide medicines anytime whereas the qualified practitioners are not always accessible and the expenditure is too high in accessing them. So, both the inadequacy of public and private sector has paved the way for the quacks. Instead of solving these problems the NHP 2002 has further undermined public health sector in delivering health services free of cost through primary health care in rural areas. To improve the health status in the rural areas NHP 2002 talked about decentralization, which is also not effectively working. The Panchayat Health Samity formulated in the block level is not at all interested in taking care of health problems of the rural people. The panchayat members are not coordinating with the health staffs of the SC in upgrading the betterment of the health care facilities. Secondly the strategy of integration of vertical programmes mentioned in the NHP 2002 is not well understood, because the major programmes like AIDS awareness programme being are not running properly by both the PHC and SC.

Though India has adopted the new economic policy, SAP in the 1990's the NHP 2002 has been visualized in the vicinity of this macro-economic policy. It clearly talked about levying user charges, cost-effective measures, cuts in government expenditure in health

sector which is quite evident in the secondary and tertiary level institutions like Civil Hospital, Siliguri and NBMC respectively. Rural people seeking treatment in these institutions have to face the problem of all these new formed strategies, nevertheless, they are not getting adequate treatment. So, no other way to go, they opted for private sources both regulated and unregulated, spending a huge out of pocket expenditure by selling their assets and are left impoverished in the process of development.

As the new economic policy is in the peak in implementing its strategies, the government has formulated National Rural Health Mission (NRHM) in order to improve the health status of the rural people. This initiative was formulated again on the line of second NHP emphasizing more on public–private partnership. Though the only service provided by PHC and SC family welfare services, it lacks basic services like sterilization, proper immunization , IUD insertion and IEC activities. In accordance with the NHP 2002 Department of Health and Family welfare, Government of West Bengal has introduced a new draft policy on private –public partnership. It has mentioned the health outcome goals by 2013 of eradicating of many major diseases, inducing reducing of mortality rate and morbidity rate without addressing the key issues like, whether involvement of private sources can ensure basic health services to the less privileged. Given the situation in the villages where we can see poor service delivery by inadequate public health institutions and spending huge out of pocket expenditure in seeking treatment from the private sources both from formal and informal network, these policies are formulated and implemented without evaluating the existing ground reality. At this juncture the rural people found themselves in a quagmire of jeopardized health care system making them paupers in the process of development.

Following are the points categorically mentioned to highlight the above understanding.

1) There are huge gaps between the policy commitments and their implementation.

2) The study reveals that the government health care set-up is unable to provide quality care to the villagers. As the PHC is not located at close

proximity of the village, access to basic health care remains unavailable. For treatment the villagers get admission to either secondary and tertiary level institutions or private clinics. The sub-centre has poor accessibility, often do not have requisite supplies of drugs and range of services available is limited to immunization. It seems that only health care providers from government are the health workers of the sub-centre where doctors refuse to go.

3) The public sector is confined to preventive health and is in a deplorable condition. Even under such circumstances, as mentioned in the earlier chapters that all illness episodes in poor households with 6 km radius are attended by govt. doctors. The number of beds did not increase. Given the increase in population, this has become inadequate to meet the growing demand for services.

4) In principle, the system is intended to provide more or less free and accessible health care to anyone who chooses to use the public health care system, with the sub-centre, staffed by a trained nurse (ANM) providing the first point of care. The sub-centre is ill-equipped and is in a poor condition because of poor maintenance.

5) The performance of the MCH component in the field of immunization and antenatal care is also far from satisfactory. The study reveals that reproductive health care service is poor despite the fact that SC is emphasizing more on MCH. The quality of public service is abysmal and unregulated which correlates with low acceptance of family planning methods, although concentration is more on family planning services.

6) Public health services were poor in terms of access and quality. The minute feature of the health system like catering to a number of people, infrastructure, process of demand and supply, proper referral linkages, working hours of health personnel are never addressed which affects the

service delivery. The quality of health services may affect the health of the rural people but does not seem to influence governments perception of poor health care facility or the service they are delivering. It also reflects the unsatisfactory result of the decentralization of health services.

7) In the words of Duggal, "Let alone provision of primary medical care, the rural health care system has not been able to provide for even the epidemiological base that the NHP of 1983 had recommended. Hence, the various national health programmes contour in their earlier disparate form, as was observed in the NHP 1983"[3]. The hope that diseases like TB, AIDS and malaria can be controlled through the present vertical strategies seems to be not working efficiently by the available evidence in the studied villages. In fact, the surveyed villages have shown resurgence of communicable diseases.

8) The concept of reproductive health care has been imposed upon the rural people. As the underlying emphasis of the health programmes remain family planning or population control, the rural people are even denied this nominal service. In this process, these people found themselves in a quagmire of "commercial advantage" impinging upon them and are being increasingly drawn into the system of surgical intervention.

9) The study reveals that inaccessible and inadequacy in institutions are the main reasons of child birth at home.

10) The rural area is characterized by high cost and low attainment in the health sector. It points out a higher disease burden in the villages.

11) It is suggested that the target of the family planning cases should not be a compulsion because health workers can motivate the rural population but cannot force them to go in for sterilization.

12) A high proportion of child birth at home are, of course, worrisome. This assumes greater seriousness because of the non-use of disposable delivery kits during the home deliveries in several cases. There is a need to motivate both the communities to go for a safe delivery at some government health outlet or a private nursing home.

13) Dissatisfaction regarding working conditions acts as a deterrent for provision of health services to the rural population. The villagers are dependent upon PHCs for provision of basic health amenities.

14) The study reveals that the sample households do incur a substantial expense on the treatment of ailments (both outpatient and inpatient treatment) even if the treatment is sought from a government facility. It is learnt that in case of outpatient care even though the households do not have to pay any consultation fee, they have to spend on medicines and diagnostic tests. This is one of reasons why the villagers try to avoid or delay hospitalization till they are able to raise money. In spite of this poor situation government is encouraging private-public partnership to improve the health care delivery. But government must ensure that basic health facilities should be accessible to poor as Bhat has argued in his study.[4]

15) It was also found that respondents having higher literacy rate, the extent of the practice of family planning was higher among the mothers who had utilized antenatal care services. These findings show important program implications, and just by strengthening the MCH services, the possibility of increase in the practice of family planning would increase.

16) Villagers seem quite confused with what they are getting. Self-reported health and well-being measures, as well as the number of symptoms reported appear to be contradictory with the quality of public facilities.

17) In spite of being under the panchayat, the PHC and SC do not have much flexibility in operations to meet the specific needs of the local communities.

18) Despite panchayat control of PHCs, accountability in the system is limited.

19) The overall picture that emerges is that panchayats have not paid very much attention to health functions. The PHC and SC are no better under panchayats than they were under State control. A similar phenomenon is also evident in a study in Gujarat, which was one of the first states to implement Panchayati Raj, is plagued by shortcomings and inadequacies.[5]

20) Local level health workers tend to feel accountable not to the communities they serve but to state level authorities who cannot possibly monitor their actions.

21) Government health services do not reach this section of the population very easily. This obviously has a serious impact at the local level, as health, being integral part of overall development, is fundamentally related to the availability and distribution of socio-economic resources to the households and individuals.

22) Another aspect that has far reaching consequences for the functioning of the rural health services is the waiving of traditional healing and arrival of the quacks in the rural scene. The quack had a dominant role in the dispensing of health care.

23) Given the current focus of the medical system on curative rather than the preventive approach in the achievement of good health, the health assistants are no match for the quacks in the tasks that villagers expect

them to perform. The private medical practitioners, of all types, are clearly aware of the advantage.

24) The overwhelming importance of the private sector in the provision of health services is not to be construed as an exercise of choice on the part of individuals.

25) The bulk of health expenditure was out-of-pocket, and a largely unregulated private sector in health was becoming increasingly dominant.

26) Place of delivery of child is varied with the socio-economic characteristics of the population.

27) One of the most important findings here is that health outcomes is positively related to the level of health infrastructure in terms of access to facilities and availability of skilled professionals such as doctors.

28) The increasing importance of inefficiency in the performance of health system in the villages arises from the resource crunch faced by these government institutions and the low utilization of services.

29) In spite of the increase in the number of private hospitals and nursing homes, for the poor people the government facilities would continue to be the main source of treatment. But it is uncertain how long public health care facilities can provide services, if this is the situation, as reflected in the study.

30) The years of neglect and the lack of a comprehensive system for addressing quality issues in the health sector are preventing the poor from availing the existing health care facilities.

31) In spite of several significant strategies taken, the health services provided by the government suffer from weaknesses and deficiencies. Health insurance is emerging as a solution in delivering better health services but it depends on quality of service provided under the scheme.[6]

32) It is obvious that current policies and processes are inadequate to ensure that health care delivery is of high quality and malpractice is prevented.

33) North Bengal being a backward area where the rural facilities are limited, the fragmented health care delivery has caused added problem to the already existing poor health situation. In rural areas, inadequacy in infrastructure, man power, ill-equipped Primary Health Centre (PHC) and Sub-Centre (SC) reinforced the poor delivery of reproductive health services.

7.4 Social Change

1) It is found that these villagers behave differently in different conditions and a confusion starts prevailing in their mind which gave rise to the idea of "medical pluralism". Many of them seem to be sure neither of their own tradition nor of the newly acquired one. The inclination towards modern treatment is gradually disapproving home health care system which was once the main source of care was, probably due to the attraction and power of the industry of "medical cure".

2) Changes in rural society, in terms of class structure and the resultant differences of interests, has led to the emergence of contrasting health seeking behaviour. While slight illness in the family makes the little well off to flock to the best facility in private or public sector, wherever available outside, the rest are left to search for some facility within or near the village.

3) The earlier practice of not seeking care until health problems are more advanced has changed on the basis of accepting preventive cure like immunization, antenatal check-up, family planning methods and institutional delivery. These are the indicators, which are perceived with the awareness of better health for women and children. They have accepted the innovation, which is contributing to the change in attitude and knowledge towards health care. This tradition bound society, embodied in a network of spiritual value is gradually moving to secular value, which includes interest, preference and choice. Technological intervention, which is associated with efficiency, has come into existence. It reflects that modern medicine is slowly and gradually making roads into their deep-rooted belief.

4) While individual behaviour responses may vary, rural people used to turn to their community's support groups for help in times of illness. This attitude of community help, support attention has now converted into individual responsibility. The family members not only take time off from work to take care of the sick person but also have to manage the modern medical care themselves including expenditure, which requires the purchase of modern treatment by any means like borrowings, mortgaging land and selling of their assets. This tradition bound society characterized by consumption oriented subsistence economy is slowly moving to a deprived society. Hence, the present study also reveals that health care services have only marginal role in determining the health status of the people. It indicates that role of socio-economic development is, equally essential to improve the health status of the people.

5) If we consider the contemporary rural situation in the national context, it is evident that rural people have undergone significant departure from their traditional cultural habits because change is inevitable in the way of progression of a society. So, the rural health care practices are compelled to change, in the process of accepting modern medical care. The present

study highlights the trajectory of change which is making the rural people more marginalized in the process of development.

7.5 Recommendations

1) To implement any health policy in rural areas social factors are to be considered, hence, anthropologists must be recruited in Panchayati Raj Institutions. In rural areas, health staff come from different cultural background, because all staff are not recruited from the community. Anthropologists can play an important role in linking the villagers with the staff of government health institution. A study by Salil Basu and Koumari Mitra has suggested an action plan to provide better health services in the tribal areas.[7]

2) The present health scenario is emphasizing more on privatization. This is a phenomena which has been accepted after the introduction of liberalization policies. As the government is following this policy, it is uncertain whether there will be improvement in the health status of the people in rural areas because the recently formed Rural Health Mission is solely dependent on public private partnership. Hence, if the government is serious about health problems of the masses a serious review of the entire is called for.

3) The political will of the government is of utmost need to change the present health situation, otherwise the liberalization policies initiated by the multinational companies will contribute to privatization and cost-effective technology in health. The parties in power need to reflect their political will through the health programmes to be taken up.

4) A great share of ill-health is due to social conditions. Unless areas like employment opportunities, provision of better education, nutrition, supply of drinking water and sanitation are taken into consideration, there will be no improvement in the health of the poor.

5) Village panchayats will have to play a more active role via committees preferably composed of women motivated to use the villagers. Panchayats at the village level can take up the role of monitoring of the health workers work routines and village level provision of care. They will have to ensure that health services are accessible and reach the people.

6) The panchayat will have to serve as a link between the community and health care providers. It will have to make efforts to change the behaviour of the community and the provider so that the unmet need for curative and preventive services is reduced.

7) A strong and well designed system of orientation and training for panchayat members should be undertaken. The process of involving panchayats in planning, implementing and monitoring health and family welfare programme has to be steered well and in the right direction.

8) Regarding the services used for normal delivery and in emergencies, the presence of doctors and nurses must be ensured round the clock in PHC.

9) Role of the anganwadi workers and their helpers need to be enhanced. There is a need to sensitise them towards imparting of health and nutritional education.

10) It has become necessary to increase the efficiency of the health sector, that is, moving further to the frontier and to create more health infrastructure and thus provide better access to rural health facilities and making more physicians available in rural areas. Increase in efficiency as well as providing more facilities implies that both qualitative and quantitative measures need to be taken for the health system performance to produce results. In a study in rural Rajasthan showed how inadequate delivery of health services effect the health status of the poor people.[8]

11) States should not only increase their investment in health sector, but also manage it efficiently to achieve better health outcomes. In an era of liberalization of the health sector and diminishing role of government in health provision, the emphasis should be definitely on improving performance. However, the recently formed National Rural Health Mission suggested an increasing allocation in health with improving in accountability and management in health care system in the rural areas.[9]

12) To achieve a further decline morbidity rate, the PHC and SC staff should be motivated to perform their work and better amenities can help them in this respect.

13) There is a need to launch an intensive reaching out programme in order to improve the utilization of social services by strengthening specific IEC activities. Illiteracy, coupled with poverty and severe deprivation among the people has given rise to ill health and related problems. A solution to the population problem in general lies in improving the general socio-economic conditions of these under privileged groups. Government has to stress more on strategy to increase their capabilities and empowerment by facilitating their education and health care. A study in slum, pavement dwellers and squatter in Mumbai also support this view that health condition is the consequences of socio-economic and environmental factors.[10]

14) Apart from additional resources, there is need for professional management and accountability to improve the quality of care in the public hospitals. A major weakness in public health care system is poor performance of the primary health centers, mainly due to staff absenteeism. Apart from providing adequate incentives to motivate the staff to stay in the rural areas, community participation should be

encouraged to bring accountability of staff and to improve the maintenance.

15) As far as utilization of health facilities is concerned, a significant proportion of the sample population do not seek treatment for all their illnesses. These findings indicate the need for providing free healthcare services especially those belonging to the lower strata. This has a significant implication for financing of healthcare in the context of poor population. Promoting of privatization has jeopardized access to health care to a large number of populations those live under poverty.[11]

16) There is still widespread unmet demand for medical care among the poor and the government should expand facilities in the public sector to meet the demand. Because a great majority of the patients in the government hospitals are desperately poor and not in a position to bear even the minimal indirect expenditure on travel, medicines, etc.

17) The findings suggested there is a need to increase the number of PHCs and SCs according to population, the work performance of health assistants in SCs must be evaluated, TBAs and CHGs must be well-equipped.

18) The findings suggest that there is need to strengthen dai training programme, since traditional dai being a member of the same village or community would be easily accessible for conducting the delivery.

19) It is suggested that the target of the family planning cases should not be a compulsion because health workers can motivate the rural population but cannot force them to go in for sterilization.

20) PHC services need to be strengthened and PHC staff more accountable to the community under the panchayati raj system, so that the vertical programmes can run in an effective manner. Panchayats at all levels must

be oriented to community and women's needs. Availability and quality of services must be monitored.

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