Chapter I

Introduction

"Health care policy can be seen as the networks of interrelated decisions, which together form an approach or strategy in relation to practical issues concerning health care delivery. A particular health care action at any one point in time results from the combination of many current and past decisions. Some of these may be technical in the medical or nursing sense; others may be decisions which are about how things will be done in the health sector as a whole, and still other may be decisions which have been made way beyond the health sector"[1]. On the other hand, according to Gill Walt health policy is about process and power. "Multinational companies, the World Bank and donor agencies have had considerable effects on health policies all over the world"[2]. However, the motive of formulation of health care policies is to improve the health status of the people. "A National policy is an expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them"[3]. Thus, importance of policy cannot be simply undermined. The seriousness with which a government deals with the problems of its people's health is evinced from the attention it pays to the formulation of the health policies. Hitherto, India has witnessed two National Health Policies (NHPs). The first NHP was formulated in 1983 and the second one in 2002. Before the formulation of the first NHP, many steps were taken to meet people's basic health needs in India, which is evident from the following discussion.

The health sector development in India was guided by two over-riding principles: first, the provision of health care services was the responsibility of the state and second, comprehensive health care should be available to the entire population irrespective of their ability to pay [4].

Before Independence, the Health Survey and Development Committee (Bhore Committee) was appointed by the Government of India to survey the existing position in regard to health condition and health organizations in the country, and to make recommendations for the future development. The Bhore Committee submitted its report

in 1946 and recommended a short term and a long term programme for the attainment of reasonable health services based on concept of modern health practice. After Independence, the Planning Commission gave considerable importance to health programmes in the Five Year Plans.

The first five year plan (1951-1956) initiated a process of all round balanced development to ensure a steady improvement in the living standard over a period of time. New programmes for the control of communicable diseases such as malaria, filaria, tuberculosis, leprosy etc. were instituted. Health and medical cadre, infrastructural facilities and water supply and sanitation were expanded with a view to improve the accessibility and availability of services. Education and training facilities for medical and paramedical personnel and other health functionaries were also instituted and expanded [5]. But along with this, emphasis was also given to the inculcation of the need and techniques of family planning.

By the close of the second five year plan (1956-61) in 1959, the government of India appointed another Committee known as "Health Survey and Planning Committee", popularly known as the Mudaliar Committee (after the name of its Chairman, Dr. A. L. Mudaliar) to survey the progress made in the field of health since submission of the Block Committee's report and to make recommendation for future development and expansion of health services. It also recommended that 'if the family planning movement is to produce early and successful results, it has to be in the nature of a mass movement' and outlined steps towards strengthening the programme [6]. From the Third Five Year Plan nomenclatures have changed and underlying emphasis of the health programme remained family planning and population control.

During the fourth five year plan (1969-74) two more committees, viz. the committee on 'Multipurpose workers under Health and Family Planning Programme' also known as Kartar Singh Committee (1972-73) and Srivastava Committee (1974) were constituted. Health and Medical infrastructure and facilities were expanded with a view to improve the accessibility of services. The recommendations of the Kartar Singh Committee were

accepted by the Government of India to be implemented in a phased manner during fifth five year plan.

1.1 National Health Policy 1983

The Government of India started the Health Guide Scheme in October 1977, to educate the people, especially in the rural areas, in matters of preventive and promotive health care system. After the Alma Ata Declaration of Health for All by 2000 AD through Primary Health Care in 1978, the Government of India formulated national strategies and plans of action to launch and sustain primary health care as part of a national health system. Keeping this in mind first NHP was formulated.

In the sixth five year plan (1980-85), the Ministry of Health and Family Welfare evolved the first National Health Policy in 1983 keeping in view the national commitment to attain the goal of Health for All by the year 2000. The policy lays stress on the preventive, promotive, public health and rehabilitation aspects of health care services to reach the population in the remotest areas of the country. The need to view health and human development as a vital component of overall, integrated socio-economic development, decentralized system of health care delivery with maximum community and individual self-reliance and participation [7].

In accordance with the NHP 1983 in the seventh five year plan, active community participation and involvement in health and health related programmes were initiated. In particular, the emphasis was given to active community participation and involvement of non-governmental organization in a massive health education [8].

In the eighth five year plan (1992-1997), the objective of the State and National Health Plan was to continue the reorganization of the health services infrastructure, already begun in the seventh five year plan (1985-1990) and strive towards the goal of Health for All by 2000 through provision of universal primary health care to all sections of society [9]. By the end of the eighth five year plan, it was envisaged (as laid down in the National Health Policy 1983) that the infrastructure for primary health care as required on present population norms would be fully operational with regard to village health guides, primary

health centers and sub-centres and multipurpose health workers. Programmes for the control of communicable diseases, of health services, research of health education were supposed to be strengthened. The plan envisaged universal immunization of expectant mothers and all eligible children by the year 1997 [10].

In the ninth five year plan (1997-2001) role of people's planning under Panchayati Raj was vigorously pursued. This plan also includes horizontal integration of vertical programmes, hospital infection control and waste management, and disease surveillance and response [11].

1.2. Structural Adjustment Programme (SAP)

Since, the 1990s, India has also embarked upon the Structural Adjustment Programme (SAP). The structural adjustment is a long run process aimed at a fundamental restructuring of the Indian economy. The package consists of policies to increase the outward orientation of the economy, reduce the role of the public sector and liberalise various sectors, including health to make them more responsive to markets, especially international market signals [12]. It is in this context that the World Bank's World Development Report of 1993 (WDR) devoted to health, entitled 'Investing in Health', is of extraordinary salience as it outlines the Bank's perspective for health sector development in developing countries [13].

The Government has introduced budget cuts, a new drug policy with decontrol and privatization of medical care, and is also exploring cost recovery schemes such as introduction of user fee and health insurance [14].

On realizing that the goal of "Health for All' (HFA) by 2000 AD laid down in the National Health Policy (1983) was unlikely to be achieved within the time specified, after adoption of structural adjustment policies. So, the eighth plan restated the goal as 'Health for Underprivileged (HFU) by 2000'. But this nominal target had not been achieved within the plan period.

The strategies of SAP are reflected in both second NHP (formulated in 2002) as well as in tenth five year plan.

1.3. National Health Policy 2002

The second NHP emphasized on increasing health sector expenditure; equity in both inter-regional and rural-urban divide; integration of national health programmes; strengthening of decentralization; extending public health services from allopathic to Indian Systems of Medicine and Homeopathy. The NHP 2002 also envisaged on IEC policy; participation of the private sector in all areas of health activities- primary, secondary and tertiary.

The areas of attention in the tenth plan (2002-2007) includes the reorganization and restructuring of existing health care infrastructure, for delivering Indian System of Medicine and Homeopathy (ISMH) services, at primary, secondary and tertiary care levels, so that they have appropriate referral linkages with each other, recruitment of adequate health personnel in medical institutions and strengthening of Panchayati Raj Instirutions (PRIs) so that there is local accountability of the public health care providers, and problems relating to poor performances can be sorted out locally.

The eighth, ninth and tenth plan has proclaimed many strategies to develop the status of health in the country. But in India, higher expenditure in health is due to a higher proportion of private sector expenditure. Estimate regarding the share of the public sector varies from 22 percent to 37 percent, which implies that the private sector accounts for two-thirds to three-fourths of total health expenditure incurred [15]. The share of central grants for public health declined from 27.92 percent in 1984-85 to 17.17 percent in 1992-93[16]. The public sector in India has been estimated to account 25 percent of overall health expenditure in 1990s [17]. This may be due to the policies of IMF and World Bank funding under SAP in which India has embarked upon in 1990.

The Country Statement for the International Conference on Population and Development, the Draft Population Policy and the annual budgets for the Eighth Five Year Plan of India have already accepted the major recommendation of the World Bank [18]. World Bank has

replaced the term Primary Health by and 'essential' Public Health and Clinical Services, which creates the illusion that the old notion of minimum basic health care is, still the central concern. But PHC is experiencing important distortions like altered priorities, delinked clinical and public health services, and conscious denial of those welfare inputs which were earlier considered necessary for basic health.

1.4 Statement of the Problem

From the preceding section it is evident that development of the Public Health and Medical Services in India has made radical changes for health care development. Many health related programmes have been launched at the national and state levels.

1) Rural Health Scenario in India

There were no uniform health programmes implemented, as reflected in the quality of health care in rural areas. The primary health centres and sub-centres are the focal points for delivery of health and medical care in rural areas. But most of the rural areas do not possess primary health centers and sub-centres. Even if these centers are present, they are not in convenient location. Both PHC and SC network function with staff shortage for both medical and paramedical staff. It is marked by stringent recruitment procedures like introduction of contractual short-term appointment of doctors and complete abolition of certain cadres/groups of paramedical workers. The system is not efficient enough to provide more or less free and accessible health care to anyone who chooses to use the public health care system. Moreover, both PHC and SC are catering to more than the number of population they are supposed to cater. These public facilities open infrequently and unpredictably, leaving people to guess whether it is worth while walking for such a long distance to reach PHCs and SCs. In practice, these public facilities do not always provide free medicines. These problems encouraged the entry of private sector which is often untrained and largely unregulated. Hence, access to basic health care in the rural areas remains unavailable to a large majority.

In case of West Bengal, a study in Birbhum district Soman referred, " unlike government health services, the non-governmental sector is quite un-evenly distributed in the villages. The providers not only practice different systems of medicine (such as allopathy,

homeopathy, ayurveda and other traditional system), but also vary in their ownership styles (e.g. not-for-profit and for-profit) and types of organization (hospitals, dispensaries, clinics, visiting, etc). It includes both, non-profit and for profit institution"[19]. This phenomena is also evident in the area under study.

2) Emergence of private sector

As early as 1960 private practice not only flourished but also got entrenched into the public sector, making free medical care illusory[20]. Primary health centers, which had generated into agencies for meeting family planning targets, also served the doctors as a source of private income. As a consequence, poor have to seek primary care from private health providers, often from those not qualified in any system of medicine. The Multipurpose Workers Scheme (health workers in the subsidiary center) fell prey to the voraciously expanding and essentially vertical Family Planning Programme because from the third five year plan latter has steadily acquired immense control over the general health services through its integration at the district level, where it took full advantage of the infrastructure expansion under the Minimum Need Programme[21].

The sixth plan proclaimed the coming of age of the private sector to which medical care was opened up. Moreover, the programme of immunization and later the child survival strategies were promoted, and Selective Primary Health Care (SPHC) silently became a part of health sector planning. Hence, access to basic health care, especially in the rural areas remains unavailable to a large majority.

The public health services by contrast are bureaucratic, with poor access, especially in rural areas, have inconvenient timings are generally impersonal, often do not have requisite supplies like drugs, and are plagued by nepotism and corruption[22]. Despite a large expansion of rural health infrastructure, it does not meet the health care needs of the people.

Since WHO has adopted a strategy of selective vertical disease control, cost benefit has become the criteria upon which decisions about health care are made. In the 1990s, India has also embarked upon the SAP. Due to these policies people are pushed into the logic

of the market. Secondly, with user costs introduced, the poor, and among them women especially may delay medical care so as to minimize health costs. Thirdly, it is likely to undermine the already declining role of the primary health centers as initiated in the NHP 1983 in the total health delivery system. Therefore, the poor would face a situation of decreasing real incomes, thereby limiting their demand for health services.

Investment in health care is an important factor for providing health services, without which the large masses will not be able to realize good health and contribute to the economy. India is spending about 3 percent of GNP on health and family welfare. Management techniques such as cost-effectiveness and cost-benefit analyses are now being used for allocation of resource in the field of community health[23]. The WHO in its Alma Ata Declaration had recommended that public health care expenditures should be at least 5 percent of GDP if equity and universal coverage are to be realized. In India 1.5 percent of GDP is spent on health and health welfare (excluding water supply and sanitation, nutrition etc), which includes health expenditure, by municipal bodies. At the state level, departments of health (excluding family welfare and water supply) are spending around five percent of the total government expenditure, plan and non-plan on revenue account on medical and public health programmes[24].

The average percentage distribution of health care expenditure is only 34 percent in the rural as compared to 66 percent in the urban sectors[25]. The plan investments on health and family welfare sector have increased considerably over the successive plan periods. In the first five year plan investment it was Rs98 crore, which increased to Rs6700 crore in the Seventh Five Year Plan and Rs14075 crore in the eighth five year plan respectively[26]. Besides these considerable increase, the investments in Medical and Public Health has declined from 3.3 percent of the total plan to 1.75 percent in the eighth five year plan, despite the fact that the eighth plan claimed human development to be its ultimate goal[27]. The decleration in real per capita revenue and capital expenditure on health since the mid-1980s and the decline in the share of the health sector in total revenue expenditure in several states has undermined the role of public sector in the curative services is sought to be provided by the private sector. The health expenditure in 2000-2001 was Rs5860 crores, which is 1.73 percent of the total budget expenditure[28].

Taking into account the gap in health care facilities, it is planned under the policy to increase health sector expenditure to 6 percent of GDP, with 2 percent of GDP being contributed as public health investment, by the year 2010.

The public health care programmes in the health system have been changed consistently over the years in order to improve the health status of the country. On the one hand, there has been an increasing recognition of the development and social dimensions of health and health care. Attempts had been made to develop measures for "well being" and to incorporate social choices within medical and public health decision-making, as reflected in the declared policies of the government. On the other hand, there has also been increasing medicalization. The programmes which have been formulated since the first five year plan to the tenth five year plan, claims to provide proper health care through primary health care. But since 1990 onward, when India adopted the SAP, World Bank proposes to reduce subsidies in public health services including tertiary level medical care and shifts to strengthen population control, shifting of curative care to the private sector, introducing of cost-recovery mechanisms in public hospitals and introduction of user charges. These proposals are likely to have an adverse effect on the poor people. Besides this, as mentioned earlier the investment in Medical and Public Health has declined from 3.3 percent of the total first year plan allocation to 1.75 percent in the eighth plan. "On the one hand there has been democratization within the medical system (patient's voice and choice given importance in deciding between management options, recognition of the worth of other "complementary healing system", etc). On the other hand there has been an increasing stronghold of specialists and super specialists, hi-tech clinical care, and expensive private sector expansion"[29]. Moreover, NHP 2002 has emphasized on commercialization of tertiary and secondary level medical cares, without first ensuring secondary and tertiary care to the underpriviledged, may deny the rights of the poor to basic care. The poor, who have limited access to welfare services, are likely to fall sick more often. Hence, user fee may tend to shift the burden of care on to the poor.

In developing countries health care costs fall more directly on the poor, women, children and elderly. Inability to earn income on a regular basis forces the poor to opt for

alternatives like, doing without health care, delayed or incomplete treatment, self-medication and, informal and ineffective sources of care.

In India where significant proportion of the population lives in the villages, the strengthening of private sector may result only in further impoverishment. The pressure for delimiting the state and privatizing welfare services has evidently more to do with finding newer markets than with the welfare of the poor. The implementation of such policies in rural areas is likely to become a burden for rural people. The study attempted here would try to identify the discrepancies in the healthcare policies, which has far reaching consequences in the rural areas. The impact of policies like cut in budgetary allocation and other aspects like privatization of health care are well reflected in the villages of India. North Bengal being a backward area where the rural facilities are limited, the implementation of health care policies and the discrepancies therein may cause added problem to the already existing poor health situation. Hence, to understand the problem involved in formulation and execution of the health policies in a real field situation, two villages in the plains area was studied. This has helped in getting first hand knowledge of the current phase through which government and private health care passing, and which has provided much scope for research in the health sector.

1.5 Objectives of the Study

Generally, the focus of the study will be on "Impact of Changing Health Care Policies on Rural Society" with special reference to people's perception about utilization of health care. The study will proceed with the hypothesis that the health care policies, which have been implemented in the rural areas, are not effectively dealing with the health problems faced by the rural people. Specifically, following are the specific objectives of this study:

1) To examine the changing health care policies.
   - to enquire how policies has changed from 1983.
   - to enquire whether proposals of NHP 2002 and tenth five year plan have been initiated.
2) To examine the nature and availability of health care facilities and their utilization by the villagers.
   - to find out the nature and availability of health care facilities.

- to find out the organization and structure of health centers.
- to enquire about the extent to which rural health care facilities are utilized by the villagers.
- to find the problems (if any) faced by rural people due to implementing of structural adjustment policies.
- to enquire about the extent to which rural health care system has been decentralized and adequate functioning of the decentralized health system.

3) To enquire about the extent to which health care has become a part of all round development of the rural people.
4) To find out the existing social values with relation to health system.
   - to find out why the rural people continue to depend upon traditional health care services.

1.6 Theoretical Framework

The theoretical dimension of my study is related to Applied Medical Anthropology. It deals with "clinics serving multicultural population, in maternal and child health programmes, on surveys of community responses to environmental hazards, on program planning and evaluation in psychiatric hospitals, on AIDS prevention projects, and on the reintegration of people on the margins of mainstream society- refugees, native peoples, rural elderly, drug addicts, people with disabilities and ethnic minorities. The difference between basic and applied research is that applied medical anthropologists deliberately advocates for the community and attempt to do research that is useful and ethical"[30]. My study concerns those marginal people who cannot afford treatment in the private sector and are severely affected by the non-functioning of the public sector. An added dimension in the public sector health care, which has increased the plight of the marginal people, is the continuous rise in cost involved in utilization of public health care services. "Health care is a commodity to be bought and sold, and its distribution determined by the market. Here the main priorities are the rights and responsibilities of individuals to make decisions for themselves and the efficiency of allocation of health services"[31].This political economy of health approach to the study can be placed within an overall functional framework. "The society is the system of usage and procedures, of authority and mutual aid, of many groupings and division of controls, of human behaviour and

liberties. It is the web of social relationship. Society must be organized and in a well-organized society various processes such as political, social, health system management, economic and cultural activities are structured and each organ performs its duties efficiently. In the more recent years, a more holistic multi-sectoral approach to the determinants of health has emerged which attempts to integrate medicine with health economies, political processes and socio-cultural factors. Hence, a variety of social, economic, political and cultural issues are seen as additional determinants of society's health"[32].

Health system is a sub-system of the society as a whole. The function of the various institutions and their inter-relationship maintains the uniformity so that the system can function effectively. The functionalist approach has been taken into consideration to discuss the changing health care policies and rural societies in India. Health is a primary prerequisite. A society must evolve ways and ensure a healthy life to its members if it is to maintain an effective balance among its constituent units. Like economy, polity, culture and education, health is a matter of utmost importance for a society to survive. This means that societies set up ways to achieve a condition where the health of the people would be a primary concern of the social system as reflected in the formulation and implementation of policies by the state power.

The health care policies, which have been formulated, are supposed to make the whole system function effectively for the welfare of the society. The proper implementation of such policies is likely to maintain uniformity in the system for the survival of the whole system. But the reorientation of the Indian economy through SAP, which includes cuts in public sector, cost-effectiveness and introduction of user charges is likely to disturb the uniformity of the system, which may have a negative impact in the society.

The study argues how the existing health care system has marginalized the rural people in the process of development. Policies make the situation poignant with the fact that; villagers are increasingly being drawn into the system of surgical intervention of drugs as part of the larger agenda of development in rural areas. The onslaught of modern medical facilities reflects the forces of commercialization as impinging upon rural areas.

1.7 Conceptual Framework

A conceptual framework is a representation either graphically or in narrative form of the main concepts or variable and their presumed relationship with each other[33]. Changing health care policies during the five year plans have a great impact on rural health care. Changing health care policies have also increased emphasis on privatization of health care, which may have an adverse effect on rural health care facilities. The rural health care is also associated with a person's level of education, income (economic deprivation), health perception of individual, attitudes of health personnel, facilities in health centers, functioning of health centers. The tenth plan proposes to introduce user charges, which may be a burden for villagers. This has an ultimate impact on their economic condition. The socio-economic factors and the perception of the villagers influenced the utilization of health care facilities in rural areas, the independent variable. The variables like age, sex, education, income determined the variation in morbidity rate, disease pattern, inpatient and outpatient care, awareness and using of family planning methods and immunization. Based on the above variables, a conceptual framework is evolved. The diagrammatic illustration (Figure 1.1) of the conceptual framework presents the specific variables and their relationship.

Figure 1.1
Conceptual Model of the Study Showing the Relationship between Independent and Dependent Variables

Independent Variable	Dependent Variables
Age	Level of upliftment of the health care services
Sex	Functioning of health centers: - Programmes associated with health centers. - Diagnostic and curative measures. - Health delivery system - Relationship between health personnel and villagers
Education	Social factors: - Belief and attitude towards health care utilization - First choice of treatment
Income Occupation Ethnic background	New policies: - Introduction of user charges - Emergence of privatization - Decentralization of health services - Consequences

Situation of rural health care with the changing health care policies

1.8 Definition of Key Concepts

Age : Refers to the age of respondent at the time of interview.

Sex : Refers to whether the respondent is male or female.

Civil Status : Refers to the married or single status of the respondents.

Religion : It is personal set of institutionalized system or religious attitudes, beliefs and practices adhered to by the respondent.

Caste : It is the type of social stratification that is totally based on "inherited inequality". Individual or group status is ascribed from birth and remains unchanged through several generations.

Ethnic group : The properties of an individual/group who share a similar culture, particularly language, custom, religion and history i.e., distant from that of other groups in society.

Education : Refers to the level of schooling attended by the respondent. It will be categorized either literate or illiterate.

Class	:	Class refers to the economic status, level of education, way of life, attitudes and expectations and exposure to different types of degree of stress of the respondent.
Size of farming Land	:	Refers to the total area of farm land in acre, which is cultivated land either as owner, owner-cultivator or tenant/sharecropper.
Tenurial status:		Refers to the status possessed by the respondents. It will be labourers categorized as owner-cultivator of tenant/sharecropper, tenant sharecropper and landless labourers.
Household Monthly Income	:	Refers to the monthly income of the household in terms of the household members.
Occupation	:	Refers to the employment status whether the respondent is employed or unemployed in an organization or fully dependent on farming.
Village	:	For the research purpose village refers to the people inhabited within the territory of Matigara Block.
Health Behaviour	:	It refers to the way of determining the condition of one's health and utilization of health care facilities.
Community	:	Refers to the people living in the villages who have common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norm, values, and social institutions. The individual belongs to the broader society through his family and community.
Social Institutions	:	Refers to the family, health center and panchayat, which are organized complex pattern of behaviour in which a number of persons participate in order to further group interest. Within each institution, the rights and duties of the members are defined.

Socialization	:	It refers to the villagers who have accepted the health care facilities.
Culture	:	It refers to culture of the villagers, where traditional values, norms play an important role to accept the modern health care facilities.
Acculturation	:	It refers to the culture contact between health personnel's and the villagers who come from different cultural background.
Health	:	A human condition generally measured by four components viz., physical, mental, social and spiritual.
Health Service Delivery	:	It refers to the health services provided by the health personnel (all kinds) and health volunteers.
Primary Health Centres	:	It refers to the primary health care provided to the rural people through primary health centers.
Sub-centre	:	Refers to the function of sub-centre, which involves mother and child health care, family planning and immunization.
Health Personnel	:	Refers to doctors, nurses and other staffs who are working in health center.
Health Programmes	:	The selective health care approaches undertaken by health centers.
Social Values	:	For the purpose of this study the common element will be the recognition of values as an expression of the respondents towards their ultimate ends, goals, or purposes of their action towards utilization of health care services; and their first choice for treatment against sickness.
Perception	:	Attitudes and Beliefs. These will be used together in the process of understanding the respondents about the utilization of health care facilities provided by the health center within the universe (Sisabari and Polash).
Society	:	Public health is an integral part of the social system. It is influenced by society and society by public health. For the purpose

of the study social organization of the health centers could be studied.

Social Structure : Refers to the repetitive, regular and recurrent relation and some of these social actions and relations form a part of the health behaviour of the people.

Infant Mortality : It refers to the infant mortality within last three years.

Female Maternal Mortality : It refers to the maternal mortality within last three years.

Family Planning : It refers to the family planning methods, which are using by the males and females of the villages.

Health Care Practices : It refers to the health care facilities which are being utilizing by the villagers.

User charges : It refers to the charges, which are being paid by the villagers to avail the health care facilities.

Health Care Policies : It refers policies, which are being formulated to provide rural health care.

Primary Health Care : It refers to primary health care provided by the primary health center and sub-centre.

Health Care : It refers to the services rendered to individual, family and community to improve the health status of the people.

Decentralization: It refers to the devolution of power to lower levels i.e. health services rendered through Panchayati Raj institution.

Structural Adjustment Programme : It refers to the liberalization policies India adopted during 1990's

which reduces the cut in social service sectors like health and education in the way of commercializing these sectors.

1.9 Methodology

1) The Universe of the Study

In accordance with the objectives two villages have been taken as the universe of study viz., Sisabari and Polash. Selection of these villages has been done on the basis of purposive sampling in view of their geographical location, which is quite far away from the respective health care (Primary Health Centre, Matigara). The villages have a heterogeneous mix of population inhabited by Oraon, Mech, Rajbanshi and Nepali. The purpose of this study is to document the phenomena of health care facilities provided by the government in rural areas, which amplify the rationale for undertaking these villages as the universe of the study. Administrative information of two villages according to 2001 Census is given in table 1.1.

Table 1.1
Administrative Information of the Two Villages according to 2001 Census

Name of the Villages	Sisabari	Polash
Total Area (in acre)	314.10	547.81
Irrigated land (in acre)	299.45	352.35
Non-irrigated land (in acre)	14.65	195.46
Total Population	694	1526
Male	362	769
Female	322	757
Total Number of Households	250	300

a) Rural Infrastructure

i) Water Supply

Almost all households in the villages rely on well and tube well for all purpose from drinking and bathing to kitchen and laundry. Contamination of water is also a problem. They responded that boil water is sometimes preferred.

ii) Transport

The villagers of Sisabari have to rely entirely on walking for five kms to reach the sub-centre. Connectivity with the PHC is very poor. The nearest post office is 10 kms and the bank is 15 kms away from the villages. The villagers have to walk five kms to reach the

nearest bus stand. Then, they have to catch buses to reach those places. Apart from this, there are some grocery shops and one medicine shop, which is run by a quack.

iii) Sewage, Drainage and Toilet Facilities

Toilet is one of the most serious and common problems among all the villagers. Private toilets attached to dwelling are virtually non-existent. Hence, a large portion of population practice open defecation in nearby open spaces and fields. Solid waste disposal in villages came across both technical (lack of refuse bin in the vicinity) and socio-economic (lack of adequate awareness) problem. The households throw garbage into the adjacent areas. In the present study it is seen that, houses have no drainage, which is a perpetual source of poor environmental hygiene. This is chiefly responsible for mosquito breeding and is also a potential source for the spread of fungal and bacterial infection among the members of the community. Cows, bull/ox, goat, sheep, fouls, are the main domesticated animals. For irrigation they totally depend upon rainwater.

2) The Sample Frame and Sampling Procedure

The data for this study has been collected from a sample rather than the whole population. In selecting the sample a simple random sampling technique has been is employed to select the sampled households. The sample size is large enough from the statistical perspective to give the meaningful representation of the populace. Considering the total number (550 households) a total of 110 households is interviewed. The fieldwork has been done for a period of 5 months (July 2003 to November 2003). The sample frame presents population under-served by the existing health care system.

3) Tools of Data Collection

The data on health care indicator were collected on the basis of utilization of health care facilities during the last three years. The health care indicator data as well as data on socio-economic variables were collected using a semi-structured interview schedule. The data collected in the household survey includes information on economic condition, education, perception of reproduction health and experience with health system (both public and private sources). The information collected is from married couples of the households. Regarding education, though the husband's education is preferred to draw a

conclusion, but in some cases wife's education is also considered, where wife is more educated than the husband. Using cluster sampling methods, 117 women from both the villages were selected. For the family welfare services, the unit of study was all married women in the reproductive age group of 15 to 45 years. Monthly reports of 10 months from SC (April 2004 to January 2005) are also considered for analysis of records the service they are providing.

The study is based on both primary and secondary sources of data. For the collection of empirical data fieldwork was done with the help of conventional anthropological field tools viz., schedule, interview, observation, etc. Simple and direct questions have been included in the interview to gather the information. The noted affecting variables are age, sex, caste, ethnic group, education, family size, technical status, and income and health care utilization. Other than this, the researcher has talked formally with the health providers and the key informants of the area to solicit the information. The required visits were also made to the health posts of the area to gather the relevant information. As a secondary source, published books, papers, government reports etc. were also used to have a better understanding of the changing scenario.

4) Data Collection

The respondents were contacted at their house and health centers. After establishing rapport with the respondent, the purpose of the study and the intent of interviewing were explained. For the purpose of the study the queries at the field level mainly concerned the adults (male and female), women and children.

a) For Adults

1. Prevention and control of local endemic diseases by primary health centers.
2. Appropriate treatment of common diseases by primary health center.
3. Provision of essential drugs.
4. Introduction of user charges and how they have been affected.

b) For Women

1. Proper treatment of problems related to reproduction.

2. Obtaining of family planning methods.
3. Proper reception of antenatal and postnatal care at due course of time.

c) For Children

1. Provision of proper immunization.
2. Steps taken to eradicate malnutrition.
3. Proper treatment of diseases like dental ailments, skin diseases, worm infections etc.

d) For personnel involved in the administration of health

1. Problems relating to infrastructure.
2. Manpower.
3. Financial constraint.
4. Gap in people's expectation and ability to fulfill them.

The health service delivery provided by other institutions like NBMC (North Bengal Medical College), Civil Hospital, Siliguri, BPHC (Block Primary Health Centre)/Rural Hospital, Naxalbari were considered to determine the service delivery and utilization level. The sub-centre (SC) was selected on the basis of, the nearest government institute to provide health care services.

5) Method of Analysis

Data obtained from the field were edited, compiled, categorized and analyzed in accordance with the objective of the study. Descriptive and statistical measures were used as and when necessary.

1.10 Significance of the Study

The findings of this study have been envisaged to provide some valuable information that will help policy-makers, planners, implementers, teachers and the researchers. The study intends to provide first hand information about the functioning of health centers and the extent of utilization of health care facilities, provided to the rural people. So, the finding will be helpful in understanding the problem and prospects of health system and the way

it operates, which give some insights into the failure of policies and programmes. It is also expected that the data of this study will serve as basis for follow-up studies in this field by further researchers. The findings may be helpful to know how the implementation may be oriented from rhetoric to action.

1.11 Limitation of the Study

This study was undertaken to have an understanding of "Impact of Changing Health Care Policies on Rural Society" in general with special reference to people's participation in utilizing health care facilities provided by government in the two villages viz., Sisabari and Polash under Matigara Block of Darjeeling district of West Bengal. So far, primary data is concerned, the study is limited to Primary Health Centre, sub-centre and the two villages. Thus, only selected variables were examined. Hence, the findings may not be generally conclusive. The study includes behavioural aspect of the community as a whole, the attitudes of the health personnel of the health center and the functioning of health center. Therefore, illiteracy, ignorance, inefficient functioning of health centers may affect the quality of data received from the informants.

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