Reasons for Non-Utilization of Institutional Healthcare Service in Rural West Bengal: A Perspective

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The present study is based on an astonishing data found in the Budget 2004 of the State of West Bengal. In spite of rising budgetary provision and actual expenditure on the rural health care services, 11% of the rural populace dies without any medical attention. Use of institutional medical services is still very low (just 14.75% of the reported death cases had used any sort of institutional health care before death). 74% of the populace of rural West Bengal dies after receiving non-institutional means of treatment. In this context, the paper assesses the basic causes of non-utilization of institutional health care services by the rural population of West Bengal.

Introduction

It is beyond any doubt that the wealth of a country is judged by the health of its people. Worldwide, nations are seeking viable answers to the question of how to offer a health care system which leads to increasing access to health care for their citizens. From the trends of recent practice in health care and its financing in developed and developing countries a huge diversity is noted.

Healthcare Systems in the Developed Nations

When the health care practices of the developed countries are analyzed, several common themes emerge. Most of the developed countries are successful in terms of universal access to health care for their populace. Nevertheless, some minor problems still persist in the systems. Some notable problems are:

a) the non-correlation of ambulatory care and inpatient care resulting in a weak role for primary care in Germany (Reinhard Busse et.al. 2004);

b) long waiting time for the patients in England (Moris et.al. 2003);

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c) problems in quality assurance and coordination between primary and secondary care; overuse of pharmaceuticals; excessive price control; equitable distribution of health care costs in cases involving elderly patients; rapid aging of the population and cost-containment and coordination among different social security systems in the Japanese healthcare system (Li,2002).

However, keeping the minor problems aside, an attempt could be made to observe the features of the global health care system from broader perspective .The U.S health care system has a highly decentralized structure like the Indian system, while Canada practices a centralized system in health care front. However, in the recent past, both the systems do appear to be converging towards models of governance that are, possibly a mixture of the two systems. To be more specific, while the U.S. system of governance is converging towards more centralized structure, the Canadian system is moving forward towards a more decentralized structure. In the UK, the health care system is the blend of centralized and decentralized structures (Globerman et .al. 2001). The secondary care in the National Health Services (NHS) in the UK is provided in about 200 general acute NHS trusts. Simultaneously, about 400 small-scale community hospitals also exist. Moreover, highly specialized tertiary level hospitals provide care to acute patients. The model is quite similar to the Indian system. However, the quality of care sharply differs. The UK model characterizes a perfect integrity in the public-private partnership. In this context, it can be stated that apart from 230 private hospitals, dominated by five for-profit chains, there exists independent hospitals or wings on NHS hospital sites as an integrated part of the NHS hospital.[1] On the other hand, the heart of Japan's success in universal coverage is the combination of uniform fee schedule with multi–tired insurance system i.e., varying degrees of subsidization according to perceived economic vulnerability of the part of the population insured(Oberlander,2004).

However, it needs to be mentioned that in Europe, U.S and Canada most of the populace work in organized sectors and hence it is quite easy to bring them under the umbrella of universal coverage of health insurance via employer-based schemes. On the contrary, in presence of huge populace engaged in agriculture or other unorganized sectors Japan's success in universal coverage of health care and health insurance is worth mentioning. In fact, Japan acted as a pathfinder in integrating small social security schemes. It was reported (Higuchi, 1974) that in 1928, a cooperative in Aomari in the rural Northeast of Japan went in a different way. After the initial teething trouble, this organization came up with a full-scale hospital with 60 beds and various specialty departments. This project was successful even in overcoming the

[1] See http://www.doh.gov.uk

financial difficulties of small-scale provision of care based on private practitioners. Perceiving this organization as a role model, by 1936, there were 738 cooperatives managing 2791 beds, employing 461 physicians and providing medical services to 502122 members (Higuchi, 1974). In the subsequent years, the Home Ministry of Japan has further improved this situation. These days the major part of the Japanese health care system is private with 81% of all hospitals and 94% of all physician offices (called clinics) under private ownership. Japan today boasts some of the best outcomes in the world in some of the health indicators (Oberlander, 2004).

Healthcare Systems in the Developing Nations

Studies from the developing countries have observed that except for some isolated examples like Thailand, most of them run with a deficit in health security. In Latin America and the Caribbean countries (Berman et al. 1999), the public sector provides a bigger share of funding for inpatient services and for hospitals. They provide a larger share of financing for outpatient treatment of illness and for private clinics and for private practitioners. Financing and provision of health care tend to be vertically organized for public sector payers through budget-financed services of government ministries and social security organizations.

Similarly, in majority of the African Countries like Kenya, Senegal, and South Africa, there is a deficit in the social health protection, which is a matter of concern particularly for the vulnerable groups (people living close to or in poverty, persons living in rural regions, women, and the elderly). The level of coverage of any form of health insurance all the three is very low (Filmer, 2001). In rural Senegal, the existing health insurance schemes have failed to enroll the poorest of the poor in the communities (Jutting, 2001)

In the Chinese rural healthcare system, the concerns are with regard to financial incentives which weaken proper clinical quality, distort consumption patterns, and contribute to spread of infections by unsafe clinical practice (Chu, 2005). Government financed care with public provision of medical services is at the centre of national policy in the case of our neighbours, Bangladesh, Nepal, and Sri Lanka. In these countries, government services are generally tax-financed, with no significant involvement from community-based insurance, and with a very limited role for public sector user fees. At the same time, in all three countries, private sector financing and provision of medical services is permitted, and the general government attitude is one of laissez-faire towards its operations. In general, Sri Lanka is characterized by a greater degree of state involvement in both financing and provision than Bangladesh and Nepal. In addition to this in all these three countries, the socio-economic disparity in terms of perceived illness is a major contributor to the differences level of health

care services utilization. The poor in all the three countries have a tendency to suppress sickness. Therefore, in these countries, the actual requirements of health care cannot be gauged by the extent of utilization of health care facilities. In Sri Lanka, although the rates of utilization of all modern providers are relatively equal across income levels, the poor are more likely to choose public provision than the rich. The incidence of government subsidies favours the poor in Sri Lanka. However, in Bangladesh, this is the reverse. The inequality in government expenditures between the capital region and other regions is considerably higher in Nepal than the other two countries. It is notable from the study that while in Bangladesh and Sri Lanka all the peripheral regions receive at least 80 percent funding of the national average; in Nepal, some districts are receiving only one-tenth the per capita subsidies of developed districts. However, in all the three countries, the health care system is financed through two mechanisms only: general revenue taxation, which is used to fund mostly-free, government health care services, and out-of-pocket payments by households, which are mostly used to purchase medical care from the private sector (Begum et al. 2001).

An Overview of the Indian Healthcare System

The Indian health care system is more or less similar to those found in other nations in the Indian subcontinent. The country's policy towards health has traditionally identified the provision of primary health care as the states' responsibility and encouraged the establishment of a countrywide, state-run, primary care infrastructure. The role of the central government has been limited to family welfare programmes and design of disease control programmes. The policy has remained silent on the role of the private sector in provision of medical care. Notwithstanding this, the private medical care sector has developed to meet the increasing demand for medical care services. Some isolated evidences of community-based health care-cum-financing options have been reported, like Self Employed Women's Association in Gujarat, Yeswashini Trust in Karnataka, and ACCORD in Nilgiri district in Maharashtra. However, in the absence of a nationwide consensus, high literacy or an extensive high quality health care network like Japan, their success is limited to the boundaries of the pioneering districts. Even the highly subsidized Universal Health Insurance Scheme announced by Government of India and administered by the Government Insurance Companies have resulted in a serious market failures.

From an analysis of the institutional setup of Indian rural health care, it is evident that it mostly depends on primary health centres, sub-centres and community health centres. The private sector is largely fragmented and is dominated by the nursing home segment. However, despite a highly extensive medical care investment in the public sector its utilization had declined over time and accounts for 43.8 percent of all hospitalization

cases in rural India and 43.1 percent in urban India. Even in the outpatient medical care segment, the private sector dominates. The inadequacy of resources in government-run medical care infrastructure had led to severe under utilization of its facilities (as much as 50 per cent in rural areas) and shifted the demand towards private providers[2]. This situation is similar to Bangladesh. While considerable progress has been made in improving the health status of Indian population, it still compares poorly with that of many other developing countries. Like in Nepal, people in the rural areas of India, have a poor access to health care services. A substantial portion of expenditure on health by rural population is incurred on expenditure related to accidents, transportation, and bribes, which do not directly contribute to any healthy gains.

An Overview of the Healthcare System in West Bengal

If the state of West Bengal is considered as a proxy measure for an overview of the Indian healthcare system it can be concluded that the state uses a collaborative approach, which involves financial support, strategic planning, and health prioritizing legislation that involves the government, community leaders, and private and public health care professionals. It must be mentioned that the West Bengal Government largely complies with the Indian structure of rural health care system consisting of primary health centres, sub-centres, community health centres. NGOs working in the health care front are hardly found in West Bengal. In fact, the deficienceis of the West Bengal rural medical system has become apparent within the last decade as economics forced hospitals to run with inadequate infrastructure facilities and reducing staff, thereby reducing clients' access to timely services. This situation is analogous with our neighbours, Sri Lanka, Bangladesh and Nepal, where underutilization of health care services is the resultant phenomenon emerging from large socio-economic disparity.

As per the West Bengal Human Development Report, 2004, the public health system is subject to high demographic pressure in the State and the bulk of curative services are in civic hands. The wide coverage of the public health system in the state is apparent from the fact that 76% of health care establishments in the state are run by the government, in contrast to less than 40% elsewhere in India and as little as 25% in the States like Kerala and Tamilnadu. Moreover, in West Bengal, there is a wide discrepancy between urban and rural areas in the provision of physical infrastructure and human capital. As per one study, 84 % percent of hospitals in India are sited in urban areas, which only account for roughly 35% of the population. (Duggal 1995).

[2] Report from Prime Minister's Council on Trade and Industry,2001

Of the state's rural population 36.68% are in the Below Poverty Line (BPL) cluster[3] and therefore, have no options other than the free health care institutions run by the government, which are also quite inadequate. It is true that over the past twenty years, the number of trained doctors and nurses have gradually been increasing. Nevertheless, the growth is so insufficient that as of now, there exists a large disparity in their availability between the urban and the rural areas. Nearly, 75 % of allopathic doctors are positioned in urban areas. In the State of West Bengal, the availability of recognized medical practitioners in rural areas is only 27 per one lakh population whereas in urban areas it is 155 per one lakh population (Duggal 1995). The lopsided distribution of medical professionals in West Bengal, with only a trifling proportion of medical practitioners ready to work in rural areas, is at the heart of the poor health care access of rural areas. In this context, the study of the availability and accessibility of the requisite health care by the rural populace of West Bengal deserves special attention.

Performance indicators of the rural hospitals in rural West Bengal show that in January 2005-December 2005 only 1.6% of the total in-patients and out-patients received electro medical test facilities. In Block Primary Health Centre level, electro medical test facilities are not available. Only 8% of the total in-patients and out-patients in the rural hospitals in the state acknowledged any sort of laboratory tests. In Block Primary Health Centre level, 5% of the total in-patients and out-patients attributed any sort of laboratory investigation[4]. From West Bengal Human Development Report, 2004 it was found that the incidence of Asthma (2654 among 100,000 population), Jaundice (3544 among 100,000 population), Tuberculosis (537 among 100,000 population) and Malaria (1669 among 100,000 population) is quite high in rural West Bengal. Nearly 17 lakh people in the state have been diagnosed with arsenic-related skin symptoms. Moreover, the burdens of Viral Hepatitis, Enteric Fever, and Diphtheria are also worth mentioning in some districts. For healing of all diseases appropriate laboratory diagnostics is indispensable. In the absence of proper laboratory diagnostics amenities in rural West Bengal, the condition of the patients is precarious.

In rural West Bengal, only 14.7% death cases obtain any institutional medical attention. 74% of the death cases receive non- institutional medical attention and 11% do not receive any sort of medical attention before death. Therefore, it can be estimated that almost 85% of the total death cases did not make use of the state run rural health care infrastructure.[5] In rural West Bengal only 19.7% of expectant mothers receive all types of antenatal checkups. This portrays that 80.3% of the expectant mothers do not receive complete medical care[6]. It is noteworthy, that the neo-natal mortality

[3] http://indiaimage.nic.in/pmcouncils/reports/education/edu-chp4.html
[4] http://www.wbhealth.gov.in

rate in rural West Bengal has reached an alarming level of 34 %[7].

As per the statistics of 2005 provided by the official website of Department of Health and Family Welfare, Government of West Bengal[8], the total number of beds of rural BPHC in West Bengal in an aggregate is 4699. Therefore, in a year the existing number of beds has to be 17,15,135. From the performance indicators we find that the bed occupancy rate is 56.3%. Bed turnover rate is 102%. Hence, the percentage of discharged patients is 43.7%. Subsequently, the total number of discharged patients is 7,49,776. It is observed from the performance indicators that 14.4% of the total discharged patients have been referred out. This suggests total number of discharged patients has been referred out is 1,07,968. However, it has been reported by the same source that in 2005 all the rural hospitals, which are considered as the next hierarchical level in the State health care system, received only 20,629 referred patients.[9] This implies that remaining 87,339 referred patients either could not reach the rural hospital or had forgone further necessary treatment. Some examples can be cited in this regard.

(i) From West Bengal Human Development Report, 2004, it is evident that in Hooghly, Howrah and South 24 Paraganas, Maldah etc all together about 17 lakh pepole are suffering from Arsenocosis. The researcher visited at least 15 primary health centres of Hooghly, South 24 paraganas districts for the purpose of this study. These primary health centres do not have the provision or medicines for the treatment of Arsenocosis. As per the hospital records, the number of patients visiting the hosptial for the treatment of Arsenocosis is considerably low in these health centres. Moreover, the number of patients with Arcenocosis visiting the nearest available rural hospital is negligible. Arsenocosis is not a mere exeption. Diseases like, neonatal Tetanus (21% of the reported cases of India), Diptheria (17% of the reported cases of India), Measles (40% of the reported cases of India) have a considerably large incidence in rural West Bengal. Malaria (nearly 35% of the reported cases of the country), accute respiratorry tract infection (24.48% of the total population of the state) are some other diseases that are prevalent.[10]. In spite of such high incidence of several diseases

[5] Government of West Bengal, *Health on March, 2004-2005.*
[6] UNDP, *West Bengal Human Development Report, 2004,* pp.131-152
[7] Government of West Bengal, *Health on March, 2004-2005.*
[8] http://www.wbgov.com
[9] http://www.wbhealth.com

in the state, it is worth mentioning that in the rural hospitals of the concerned area like Amtala, Jaynagar, L.B.Dutta, Mathurapur, Padmerhat, Raidighi, Sagaretc (South 24paraganas), Dhaniakhali, Khanakul, Pandua,Singur, and Tarakeswar (Hooghly) the number of referered patients received for any diseases was nil in 2003-04. In fact, execpt in some isolated cases, the number of refered patients in rural hospitals are insignificant. Moreover,in many rural hospitals like Minakhan, Sandeshkhali, Taki (North 24 Paraganas), Sagar, Jaynagar, L.B. Dutta(South 24 Paraganas) Jangipara, Khanakul, (Hooghly) Bagnan (Howrah) the bed occupancy rate is less than 50%[11].

(ii) As per the statistics of 2005 provided by the official website of Department of Health and Family Welfare, Government of West Bengal[12], we find that the total number of patients referred out from all rural hospitals in West Bengal is 67,991. However, it has been reported from the same source that in 2005, all the Sub-Divisional and State General Hospitals, which are considered as the next hierarchical level in the State Health Care System, Government of West Bengal received only 34,863 referred patients.[13] This implies that remaining 33,128 referred patients could not reach the Sub-Divisional and State General Hospitals, had forgone the further necessary treatment, or else obtained treatment from any private source.

In the above-mentioned scenario, it is worth analyzing the dynamics of consumer behaviour in this regard. The rural poor populace can best give us the reasons for non-utilization of institutional health care. Therefore, the major objective of this paper is to find out the reasons behind non-utilization of institutional health care services by the rural population. The authors have selected the state of West Bengal as the proxy measure to find out the obstacles on non-utilization of institutional health care services by the rural population in India.

Methodology

The authors have chosen three different segments of the rural market to find out the

[10] UNDP, *West Bengal Human Development Report, 2004*, pp. 131-152
[11] Budget Publication, 2005, Government of West Bengal and www.wbhealth.com
[12] http://www.wbhealth.com
[13] http://www.wbhealth.com

physical and psychological inertia for non-utilization of institutional health care services in rural West Bengal. The three segments are solely demographic, based on the parameters of family income, literacy level, occupation, average health care expenses per month, average number of dependents and age. In the present study, we have conducted in–depth interviews of 60 respondents in each category to find out the basic reasons of non-utilization of rural institutional health care services. Therefore, the total sample size was 180. We have used stratified random sampling method. The data was collected from different villages of Hooghly, Howrah, Darjeeling, South 24 Paraganas, and Bankura districts. The total span of this data collection was 3 months and the entire study confined to qualitative analysis. The responses collected from the in-depth interview and observation method subjected to detailed analysis with the help of Ishikawa Cause-Effect Fishbone Diagrams.

Analysis

The analysis starts with the definitions of the segments.

Segment 1:

The segment is literate and the average educational qualification of the segment is beyond the secondary level. The respondents by occupation are school teachers, rural doctors, government service holders, business persons, land owners etc. The age of the segment varies within 40-50 and family income per month is above Rs.10000. The average health care expense is not less than Rs. 250 per month. The number of dependents is not less than two.

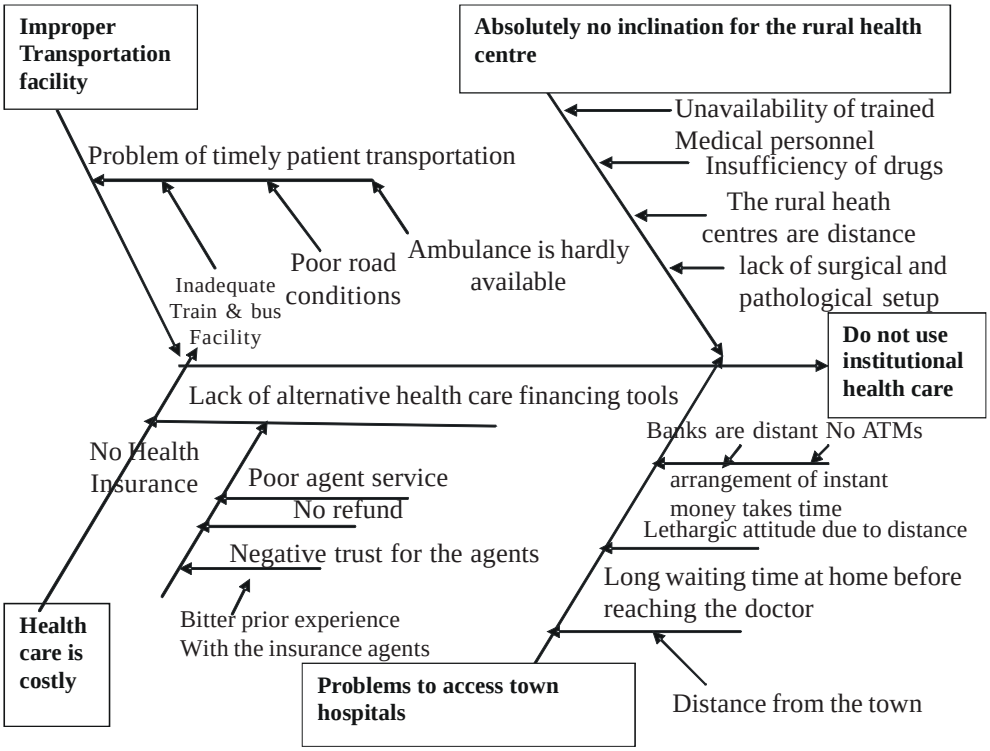
Segment 2:

The segment is semi literate and the average qualification of the segment is Class VII. The respondents by occupation are maidservants, casual labour, homemakers, small business persons etc. The age of the segment varies within 30-40 and family income per month is within Rs.2000-5000.The average health care expense is not more than Rs. 50 per month. The number of dependents is not less than one or two.

Segment 3:

Most of the respondents of this segment are illiterate. The maximum education level is class VI. The respondents by occupation are marginal farmers, farmers cultivating in other's land, artisans etc. The age of the segment varies within 40-50 and family income per month is below Rs.1000. The average health care expense per month is within Rs 0-50 per month. The average number of dependents is not less than three.

Analysis of Fishbone Diagram of Segment 1



Segment 1 lies on top of the pyramid of the rural population in West Bengal comprise 20% of the respondents. In this case, the entire Ishikawa Cause-Effect diagram can be explained with the help of 5A framework. 5A refers to availability, affordability, accessibility, appropriateness, and awareness.

Awareness: They are well off and literate. They are quite aware about the immunization measures. They are also aware of the diseases mostly prevailing in their locality and know very well the precautionary measures to prevent these.

Appropriateness: The rural health centres are not that far from their residence. Therefore, timely transportation of the patients to the health centres is not that difficult. Nevertheless, the most important cause of non-receipt of institutional health care in the segment is non-inclination for the rural health-care centre. The quality of care they expect is hardly available in the rural health centres. This cluster resides in fringes of the towns and has high connectivity with the town for either business or job

purpose or some relatives stay over there. Therefore, they are aware about the quality of city based private health care and become inclined to it. So the appropriateness of the rural health centres for the health care of this cluster is highly challenged.

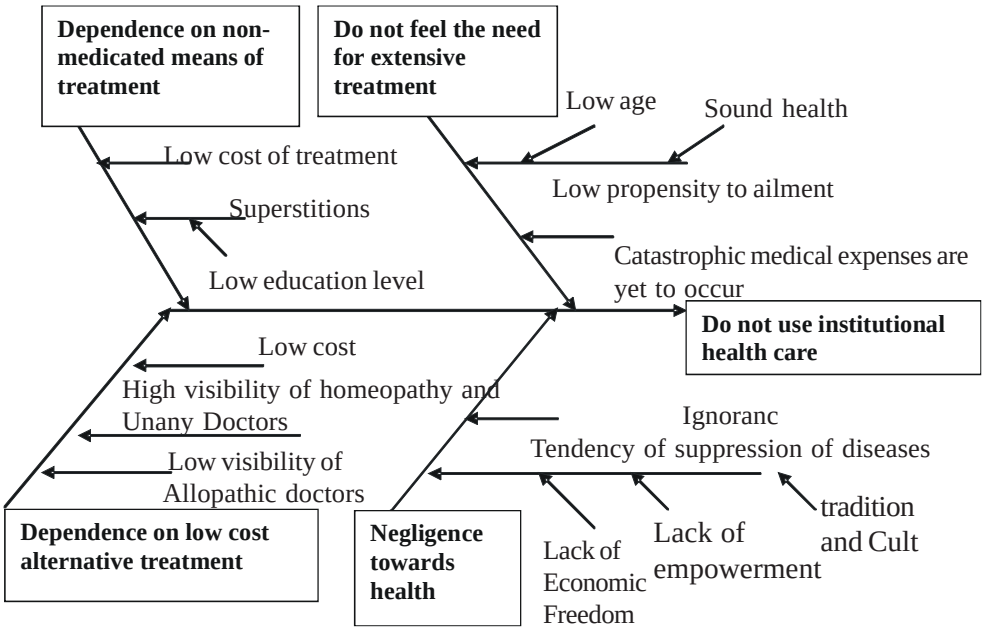
Accessibility: Besides the distance factor, inadequate train, or bus service, poor road conditions prevent patients' transportation in the fringes to the urban hospitals. Ambulances facility is almost always fictitious. Even if the respondents are ready to pay three times the normal rate the service is not available. This is because one ambulance serves an average of five villages and the immense pressure of patient transportation often means that they are not available when required.

Availability: One respondent Netai Banerjee (Siakhala, Hooghly) made an interesting comment. He says, "Even if we transport the patient to the rural hospitals who is going to treat him and by what means?" This is not an isolated example. Most of the respondents in this group are in a view that the rural health centres are devoid of trained medical personnel. Doctors are not interested in visiting the rural health centres. Some of the health centres are reported to be finding it difficult to provide proper health care because of the vacant posts of doctors. The second problem with these health centres is regarding medicines. Majority of the respondents claimed that the health centres not sufficiently stocked, even with life saving drugs.

Affordability: In this situation, the people who can afford treatment from city/town based hospitals (mostly private) are inclined towards such treatment. However, this approach is also not without its problmes. Apart from the as usual transportation problem, due to distance from the city/town, the respondents go for such treatment only when the treatment becomes unavoidable. Besides, removing patients from residence to the city/town hospitals requires availability of cash. The banks are in the nearest town and there is often no ATM facility to access cash.

One question that arises is why they do not opt for health insurance. The interviews reveal that the basic reason behind the low penetration of health insurance in the financially solvent section of rural India is the improper delivery network of the non-life insurance companies. In the rural areas, it is often unemployed youth who are engaged as insurance agents. They are not properly trained and hence cannot explain the features of the product properly which subsequently results in delays and problems in claim settlement. Another serious consequence is that the agents due to lack of profitability quit the business shortly and do not provide any sort of service at the time of claims settlement. Moreover, as there is no provision for refund in the case of no claims for non-life insurance, it keeps the affluent rural populace away from any sort of health insurance.

Analysis of Fishbone Diagram of Segment 2



Segment 2 lies on top of the pyramid of the rural population in West Bengal comprising 15% of the respondents. In this case, the entire Ishikawa Cause-Effect diagram can be explained with the help of 5A framework. 5A refers to availability, affordability, accessibility, appropriateness, and awareness. However, for this segment the reasons for non-utilization of institutional health care can be broadly termed as ***lack of economic and social empowerment***.

Availability: Rural health sub-centres are at least 10-15 km away from the surveyed areas. In sub-centres only one Assistant Nurse cum Midwife (ANM) staff nurse reports. In most of the cases, the doctors are never available in these health sub centres. The concept of specialist doctors in the sub centres is really a daydream. In this situation, the poor villagers have to depend on local quarks, unany practitioners, and non-medicated means of treatment, which results in disaster. Most of the essential drugs (like medicines for snakebite, dog bite, diarrhea, viral fever etc) are not available in the sub centres.

Awareness: The segment comprises of middle or lower- middle-income population belonging to very low age group. Due to low age, they have sound health and comparatively low propensity to ailment. Until the interviews were conducted, they

have not borne any sort of catastrophic medical expenses. This segment consists of a considerable number of homemakers. First, these homemakers do not care for their diseases. They only take care of the diseases when it becomes irresistible. This is mainly because of three factors-

a) they normally are not the earning members of the family

b) they themselves feel that girls should suppress their diseases

c) From the time immemorial, they are forced to believe that they are the most negligible part of the society.

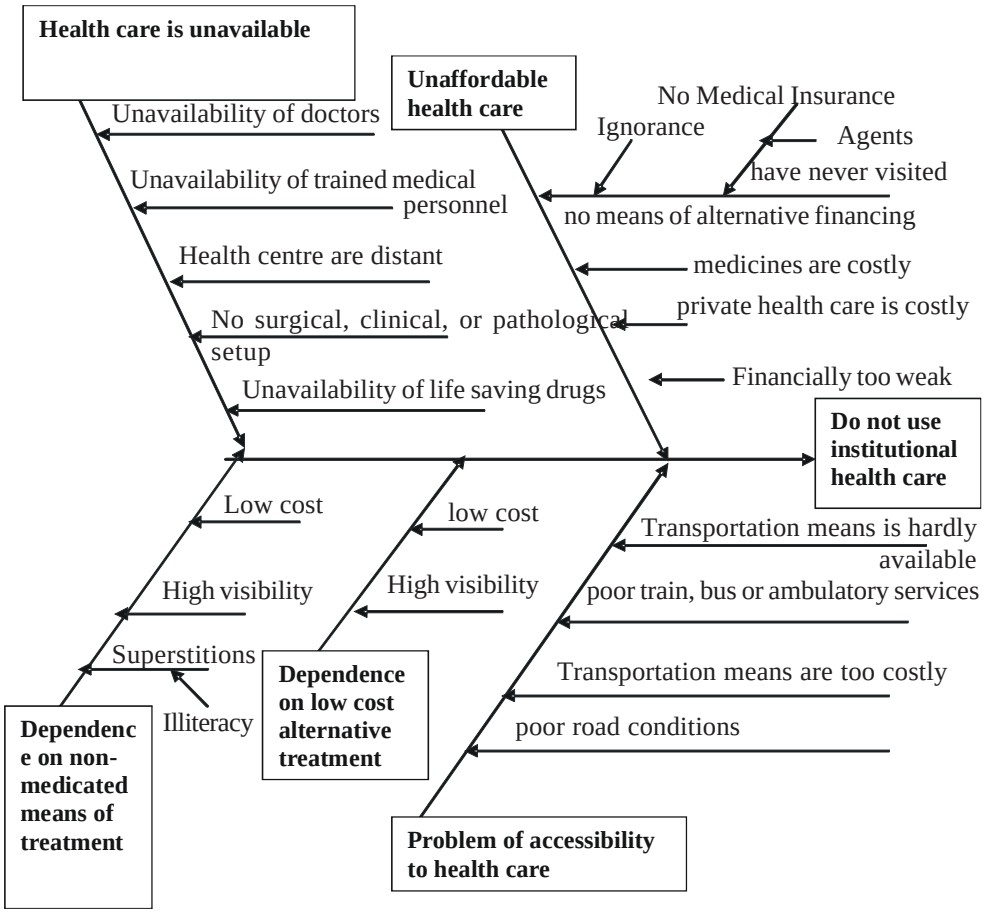
Affordability: In general, an Indian woman is less likely to seek appropriate and early care for disease, whatever the socio-economic status of family might be. As more women survive into old age, the role of gender differences among older adults becomes more important. Women experience greater ill health and a loss of activities of daily living as they age. They are also more vulnerable because they are likely to be illiterate, unemployed, widowed, and dependent on others family. The combination of perceived ill health and lack of support mechanisms contributes to a poor quality of life partly because of huge financial dependability on the male members of the family.

Accessibility: Reproductive health hazards are borne by women alone. Poor outcomes for both mother and child are inevitable for a large proportion of the population as long as mothers are too young, receive minimal antenatal care, and are malnourished or anemic during pregnancy. Poor vital registration systems in rural West Bengal pose a challenge to measuring maternal mortality at the national level. Maternal deaths—most commonly from haemorrhage, sepsis, and eclampsia—continue to exact a high toll; unsafe abortions also contribute to deaths from haemorrhage and sepsis. Home deliveries by unskilled attendants, a paucity of knowledge of intrapartum danger signs, and poor transport mechanisms to and lack of appropriate care at health facilities all contribute to this burden. Women cite economic circumstances and spousal or familial opposition to delivery in hospital as the most common reasons for delivery at home. Decisions about seeking care in such emergencies are made largely by the husband or the elder members of his family.

Appropriateness: Apart from these two other factors fuelled the non-utilization of institutional health care services. The first one is dependence on low cost alternative treatment and the second one is the dependence on non-medicated means of treatment. The first factors have arisen due to the visibility of non-recognized homeopathy or Unani practitioners. The costs of such treatment is quite low and these are widely available. As this group cannot be called as the most vulnerable group (the disease burden is considerably less), their dependence towards this kind of treatment is quite

high. The Muslim community in particular is immensely dependent on Unani treatment. Apart from these, too much dependence on non-medicated means of treatment like *jari butti, maduli, tabij etc* arises out of the low cost of treatment and superstitions generated from very low levels of education.

Analysis of Fishbone Diagram of Segment 3



Segment 3 is the most vulnerable group and comprises of majority of the respondents. In this case, the entire Ishikawa Cause-Effect diagram can be explained with the help of 5A framework. 5A refers to availability, affordability, accessibility, appropriateness, and awareness.

Affordability: The most important A here is affordability. The nature of rural poverty is quite different from the urban poverty. The rural poor are mainly the landless farmers and artisans. Their per-capita income is less than Rs 1000. Although ensuring health care for all is one f the priorities of the government its means are limited and the private health care is costly and beyond the reach of the average rural household. In most cases, they do not have money for buying allopathic medicines that are not available in rural hospitals. Because of acute poverty, they are not able to buy medicines or even arrange for oxygen. Blood transfusion facilities are also unavailable. The infrastructure of rural hospitals is inadequate for conducting surgeries and the small nursing homes of semi urban areas are totally out of reach because of high price. Similar is the case for the new clinical laboratories that have been set up in rural areas. In this scenario, it might seem surprising that they have not enrolled in any type of health insurance scheme. However, the fact is that they do not even know of the concept of health insurance and insurance agents have never visited them.

Availability: Rural health centres are at least 5 km away from the surveyed areas. Nursing homes are hardly to be found. In some of the villages, new private clinical laboratories have just opened. Medicine shops are found in more developed villages. Some important emergency drugs, saline bottles, oxygen cylinders are, however, not found in these shops. There are no blood banks in the rural areas. The health centres ensure the establishment and implementation of a comprehensive Human Resource Strategy, which includes the development, and training of staff in health promotion skills. In sub centres, only one ANM staff nurse reports. In many occasions, the health centres do not have adequate number of doctors. Doctors staying in the cities and posted to the rural health centres visit hardly once or twice a week. Moreover, there are no specialist doctors in the sub centres. In this situation, the poor villagers have to depend on local quarks, which results in disaster. The equipments available are just the delivery kits etc. Beside this, health centres fail to provide basic facilities and drugs to the patients due to short supply. This fact has been accepted in the West Bengal Human Development Report, 2004, where it has been reported that there is an increasing problem of inadequate access to drugs in the BPHC and hospitals, and the patients are required to buy the essential drugs from the open market. The government's concern is understandable given the fact that 36.68% of the rural population of the state belong to BPL cluster [14] and therefore, mostly depend on free health care institutions run by the state**.** The health centres have no provision for basic clinical tests like X-Ray, blood tests, or ultra sonography either. . This corroborates the statistical evidences provided in earlier sections. In addition, there is no proper infrastructure for surgical cases.

[14] www.wbgov.com

Accessibility: It is very difficult for the poorest class to transport patient in absence of and ambulance. The only mean of patient transportation are the rickshaw vans by which it is difficult to transport serious patients in poor road condition, particularly in the rainy season. Money involved in transportation of patients further adds to the problem. The survey corroborates the facts that until date, in rural West Bengal, 30.43% of the villages do not have Block Primary Health Centre (BPHC) within the 10 kilometers of the village**.**[15] This put forward the existence of huge inaccessibility problem to the nearest block primary health centre by the villagers

Awareness: The rural poor in most of the cases have resigned to their fate. In some cases, too much dependence on non-medicated means of treatment is a major source of the problem. They believe in superstitions and seek relief from non-medicated means like 'jalpara', 'telpara' etc. Many children did not get polio vaccine because their parents are suspicious about the effect of the vaccine. This psychological inertia is possibly due to high levels of illiteracy and ignorance.

Appropriateness: The Government of West Bengal is increasing its budget provision for rural health care services every year but the health related problems of the rural poor persists. The Government of India had announced a Universal Health Insurance Policy exclusively for the people below the poverty line. The Universal Health Insurance Policy, at a premium ranging from Rs 1 to Rs 2 per day, is available to groups of hundred families or more. The family under the scheme means the earning head, spouse and a maximum of three dependent children and dependent parents. The policy covers people from the age of 3 months to 65 years. The scheme provides reimbursement of the hospitalization expenses up to Rs.30,000, a cover Rs.25, 000 for death due to accident of the earning head of the family, and a disability cover if the earning head of the family is hospitalized due to an accident or illness at the rate of Rs 50 per day of hospitalization up to a maximum of 15 days after a waiting period of 3 days. However, this lucrative policy had not made much headway in rural West Bengal. To date health insurance has not covered even 1% of the rural population of West Bengal. The interviews revealed that those below the poverty line are not capable of paying even Rs. 165 at a time. Its appropriateness has been challenged. Javid A Chowdhury (2004) has criticized UHIS in various aspects. He feels that the premium charged under UHIS is likely to make scheme unviable. To have any impact, the government subsidy would have to be substantially increased and that too not limited to the poorest sectiona. The composition of the subscribers would be steeply skewed towards those with very high health risk if the increased subsidy were limited to only the poorest section. He argues that the insurance scheme is most required for the

[15] www.bankura.nic.in

poor in the unorganized sector, and the exclusion of all pre-existing diseases would effectively defeat the principal purpose of the scheme. P. Chidambaram, Finance Minister of India (Budget Speech, July 8, 2004) also supported this. He said, "The UHIS now in operation is skewed in favour of the non-poor. As a result, only a small number of families below the poverty line (BPL) –actually 11,408 until May 2004 - have been covered. ……..In its present design the scheme may not be sustainable." Therefore, the premium was revised. In its revised form, the premium would be Rs 165 for individuals; Rs 248 for a family of five and Rs 330 for a family of seven, keeping all the benefits intact. Now the government subsidy in this scheme is increased from Rs 100 per premium to Rs. 200 per premium. The latest announcement of the Finance Minister had not improved the situation substantially.

Conclusion

From the above discussions it can be concluded that the rural population of West Bengal have access to different types of health care based on their socio-eonomic status. The first group are quite affluent and stays in fringes of town. Altough the health centres or sub-centres are available in their vicinity they are more inclined towards town-based treatment.This is partly because of the poor treatment quality of the health centres and partly because these people find it inadequate as well as inappropriate for them. In the present study, the second cluster is the middle or lower middle-income population and partcularly the homemakers. Their accessibility to the hospitals largely depends on their husbands or elderly members of the family as they are financially dependent on them. However, the third group, which is the most vulneable group suffers most in terms of the 5As discussed in the paper. From the discussion it is evident that the public and private health care setup needs to provide high quality, accessible health care services. Indeed, the state must strive to improve the health care system by creating an environment that encourages and rewards quality of care by the professionals who are providing the services. Ideally the entire rural populace of West Bengal should be able to afford and access health care and supportive services. Efforts are required to go beyond mere maintenance of the status quo and improve the health status of all concerned. Through tightly coordinated partnerships with medical, social, educational, business, civic, and religious organizations of this country, it is essential to develop a comprehensive and coordinated health care system - a system, which relies on governmental leadership and community input and focuses on preventing disease rather than treating avoidable complications. By tapping into interdisciplinary services, concentration must be on the prevention of common public health problems, such as Diarrhea, Kala Azar, Malaria, Arsenic problems, Jaundice and other problems, thereby reducing the incidence and complications of disease and illness. Health care for the rural populace of the state of West Bengal should be

prioritized, within the realm of development of the government's infrastructure and guidance from the various ministries involved in education, health, community development. Quality health care must be a right of the entire rural populace of West Bengal. Community based health insurance is perhaps the most appropriate insurance arrangement for the poor. Nonetheless, it may take different forms and each of these forms must be suitable depending on the characteristics of the target population, their health profile, and health risks to which they are exposed. Indeed, for a country as diverse as India there cannot be any pan-Indian model and all different forms need to be explored. To fine-tune, the design of the scheme needs information on who is enrolled and excluded, rates and causes of hospitalization and barriers that prevent enrolment in the scheme and use of the scheme by the insured. Moreover, the successful inclusion of the poorest of the poor cannot depend one community structures alone. This suggests that further research is needed on how theses schemes can be scaled up and replicated as well as how they could be linked to social risk management instruments, e.g., social funds to broaden the risk pool and increasing coverage rates. In many of the underdeveloped nations, different innovative forms of risk sharing at the local level are emerging, community financing schemes being an example. In many studies, it has been reported that although these schemes can substantially reduce transaction costs and help to better protect people against health shocks, the participation of all segments of the community is not ensured. Participation in community financing schemes requires resources, i.e. time and money, which the most disadvantaged group in societies often do not possess. Donors and policy makers should hence be aware that it might be very difficult, even impossible, to reach the poorest part of the population when promoting participation in these kind of local organizations. In order to promote such initiatives further research is required to identify avenues for lowering barriers to participation, designing well-targeted subsidies, and a developing linkage to social funds.

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