OPEN ACCESS

Manuscript ID:
ECO-2023-12017030

Volume: 12

Issue: 1

Month: December

Year: 2023

P-ISSN: 2319-961X

E-ISSN: 2582-0192

Received: 05.10.2023

Accepted: 28.11.2023

Published: 01.12.2023

Citation:
Chitra, M., and S. Pradeepan. "Utilisation of Zero Priced Rural Healthcare System in India - A Review." *Shanlax International Journal of Economics*, vol. 12, no. 1, 2023, pp. 126–135.

DOI:
https://doi.org/10.34293/economics.v12i1.7030

Utilisation of Zero Priced Rural Healthcare System in India - A Review

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Abstract
Rural health is an important pillar of rural life for to return economic activity and using their muscle power. In India the rural healthcare system is supplying healthcare services at zero prices. As per the Economic Survey 2022-23, 65 percentages of India's population lives in the rural areas and 47percentage of the population is dependent on agriculture for livelihood.On 12 April 2005, the Government of India took a major welfare initiative by launching National Rural Health Mission (NRHM) in 18 states with weak public health indicators and infrastructure and extended it across the entire country. Nearly two decades the programme is executing by government in rural healthcare which may be influence the residents positively in their health status. In addition, many government programs have been launched with the aim of improving rural health, the effectiveness of these initiatives is depends upon the utilisation of available healthcare serviceswhenever needed by the rural in habitants. The other side of healthcare system, specifically private sector healthcare is mushrooming as clinic, dispensary, hospital and multispecialty hospital and people are also utilising the services and willing to pay for their health requirements. The research question is, when a service is available at zero prices to access why the people are utilising the priced one healthcare service.Hence, here is an attempt wasconducted to find the utilisation of rural healthcare system by rural population in India from the published articles.The summary of findings of the reviewed articles enlighten the need of increasing the rural healthcare working hours, number of medical personnel, strengthening healthcare infrastructure, ensuring availability of essential medicines, need of palliative care in rural PHC and investing in multispecialty workforce development in rural areas. It's crystal clear that any programme needs a continuous monitoring, evaluation and adaptation of strategies is essential. This kind of summation of findings from scattered articles about the accessing of healthcare will be an aid to the health policy maker. A concerted effort to raise the health status of rural communities will not only improve their quality of life but also contribute to the overall health and development of the country which is in the hands of rural healthcare system.

Key words: Rural Health, National Rural Health Mission, PHC, Health Status, Healthcare.

Introduction

Boasting the world's second-largest population, India accommodates more than 1.3 billion individuals. The average child births per woman in 2018 amounted to two, leading to a national birth rate of 18.6 per thousand people. Notably, the average life expectancy has exhibited a consistent rise since the 1920s, reaching 69 years as of 2019.In the six decades since India's independence, countless plans, publications, and recommendations have underlined how crucial it is to solve the nation's health issues. Unfortunately, despite great economic progress, guaranteeing good health continues to be a big barrier. Even WHO-endorsed catchphrases like "Health for All," "Millennium Development Goals and the more recent "Universal Health Care" have not resulted in significant on-the-ground initiatives. Rural India continues to grapple with age-old issues such as malaria and diarrhea, alongside emerging challenges driven by environmental pollution.

This pollution stems mainly from air contamination by vehicles and industries, as well as water pollution due to agro chemicals. The absence of adequate health care access profoundly affects rural communities, leading to elevated levels of maternal and infant mortality, malnutrition, reduced life expectancy, and inadequate vaccination rates.

In India, the availability and efficient use of healthcare facilities, particularly in rural areas, continue to be deficient. While advancements have been made, there is a growing consensus that the country needs to focus on strengthening its primary healthcare system to address these challenges and achieve further improvements in overall health status. By establishing primary healthcare facilities in rural and underserved areas, access to healthcare services can become more equitable, bridging the gap between different geographical regions and socioeconomic groups. Primary healthcare focuses on preventive measures such as vaccinations, health screenings, and health education. This can lead to early detection and management of health issues, reducing the burden on higher-level healthcare facilities. This can contribute to reducing the financial burden on individuals and the healthcare system as a whole.

Utilisation of Healthcare Services in Rural India

Garimella (1989) conducted a survey in Kerala and collected the information regarding utilisation of health services, illness pattern of the children below 6 years of age in the identified households, demographic particulars and environmental particulars, details of illness of the children, particulars of treatment sought, details immunisation, by usage of well framed questionnaire. The findings of the study were i) when the child was ill 66 per cent of the low income people sought medical help immediately in government sector in the study area of Kerala ii) perpetuating character of illness made the children not got immunised, iii) children of low income class had greater morbidity since they are not serious enough, iv) utilisatin of health care services was influenced by the general awareness of mother not completely based on educational status of mother, v) uneducated mothers preferred male children than the educated mothers.

Purohit and Siddique (1994) used the reports of National Sample Survey Organisation 1992 and National Council of Applied Economic Research 1992 for to study the utilisation of health services at micro level, and found the factors influencing the utilisation of healthcare services such as distance of facility from patients, type of care, availability of facility, cost of treatment, quality of care, awareness about existing facilities, as well as other socio-economic aspects of patients in a particular regional set-up. They had also tried to understand the utilisation of health care services under various systems such as Allopathic, Homeopathic, Ayurvedic and Unani.

Basu (1997) analysed the health care services provided to the people of Tamil Nadu State and the people of Uttar Pradesh at resettlement slumps in New Delhi, regarding i) Fever ii) Respiratory illness iii) Gastrointestinal illness, iv) skin diseases and v) Immunisation status of living children aging, 1- 12, had been collected from 1129 children for Uttar Pradesh and 777 children of Tamil Nadu. These two states were chosen because they were fairly representative of the northern and southern regions of India, which had been described as being culturally distinct by several observations.The findings of the working paper are: There was a uniform tendency to consider the private practitioner to be superior to the government one, even though the services of the latter are free. The second one is Tamil Nadu households had greater faith in home medication with modern drugs whereas Uttar Pradesh households relied on traditional home remedies, especially for coughs, colds and diarrheas.94 of rural Uttar Pradesh births had been attended by untrained dais while in rural Tamil Nadu, the figure was talent 50. These two ethnic groups believed in the antibiotic, especially if it was used for injection, because they had feared and mistrust in preventive vaccinations.

Baru (1999) had done an interstate analysis about the utilisation of healthcare services. In economically backward states like Bihar, Orissa, Uttar Pradesh, there has been very little growth of hospitals in rural areas. As far as the PHCs concerned, some states like Tamil Nadu, Bihar, Gujarat, Karnataka, Kerala, Madhya Pradesh, Orissa and West Bengal had shown significant progress during 1980's.Rural areas in Tamil Nadu, over 50 per cent of hospitalized cases

got treated in public hospitals. In Tamil Nadu high income people, using public hospitals constituted 36 per cent and the remaining 64 per cent used private hospitals.

Uplekar & George (2003) analysed the access to health care in India. Determinants of access to health care services are of two factors namely i) concerning the users and ii) those concerning the providers. Health infrastructure, namely bed per lakh population in 1989 was 254 highest in Kerala and in Bihar and Madhya Pradesh 35 and 36 respectively against India as 77. Surprisingly enough official records on Nagaland showed that this state did not have a single private hospital. Punjab has the best rural infrastructure with one PHC for above every 6000 population and the highest ratio allopathy of doctors that is 13.77 in Himachal Pradesh 4.26 and in Madhya Pradesh 4.26. In remote areas in Madhya Pradesh and Nagaland nearly one-third or more sub centres are working without ANMs. Kerala has 100 per cent of its villages linked by all roads followed Punjab 99 per cent and Maharashtra 53 per cent. In India as an average 20 per cent of the patients in rural areas had to travel for more than 10 kilometers for medical treatment. In urban 80 per cent of the episode located within a distance of 1-2 kilometer but in rural 39 per cent only. Villages which fall within a radius of 6 kilometer are found to make use of the service of PHC.The reasons for choosing the government hospital by 59 per cent of the low income group were: free treatment, better service and minor diseases. Those, who utilized private health service, had attributed the reasons; better service, major nature of disease and immediate treatment.

Anand (2008) aimed to find out the determinants with respect to utilisation of public-private health facilities for reproductive health care. The analysis was carried out by IIPS questionnaire for primary data, it considered of 3666 women from unified Bihar (2843 from Bihar, 823 from Jharkhand), 1117 from Maharashtra and 1520 for Tamil Nadu. A schema for PPPs (public-private partnerships) schema is based upon the key constructs which have emerged as critical issues in the study. The success of health care organisations in primary health care seems to be dependent upon their ability to create an environment for the clients where irrespective of the socio-economic inequality, equity at the level of cognition can be delivered in terms of quality of care.

Srinivas et al., (2002) analysed the treatment of diabetic patients in a rural primary health centre area near Chennai in order to better understand treatment-seeking behaviour, compliance patterns and reasons for noncompliance among rural diabetics. Compliance was indirectly measured through patient interviews and drug use charts. Of the 112 patients interviewed, 72 per cent had some symptoms at the time of diagnosis, and the majority of them were diagnosed in government health centres. Non-compliance was seen in 57 per cent of the 112 patients interviewed, and reasons were elicited. Interruption of treatment was significantly associated with lack of education. The study identified the lack of a patient-friendly, flexible health care system as the primary reason for non-compliance.

Roy et al., (2013) explored the weekly activities of a doctor in a large teaching hospital in southern India, where the doctor's daily work load has grown primarily due to large patient volumes (during the year 2010-11, the hospital handled a daily load of 5,000 outpatients, 2,000 inpatients, and 125 surgeries) and large student in take per year (about 2000 students in various health disciplines). Ineffective doctor activities plan often resulted in missed activities, long patient duration of stay (3 days between successive visits), long doctor hospital hours (more than 10 hours per day), and low patient satisfaction levels. Authors suggested that to doctors' activities without compromising their involvement in other activities and maintaining the quality of patient service by prior planning.

Lavanya and Thomas (2013) studied the utilisation of Primary Health Care Services among Rural Women in Coimbatore. The study was done in Thondamuthur block, Coimbatore and it was planned to give representation of the Kalveerampalaam Primary Health Centre where the medical facilities are available in 24X7 services. The results showed that age, education, occupation and monthly income emerged as a significant factor and had positive impact on utilization of health care services among

the respondents. The pattern on utilization of health care also varies with age. Only household size had negative impact on accessing the health care services because in a large family if the income is less it will reduce chances of utilizing private health care services. Utilization of medical facilities has to be brought home to the rural people through the primary health care services which plays very important role in protecting the rural health specifically health of women.

Pandian et al., (2013) found high utilization of primary health centers for antenatal care in Tamil Nadu, India. The study is derived from a comprehensive review of Government of Tamil Nadu (Govt) policies, documents and published reports. The study revealed that improving 24/7 services in all Primary Health Centers (PHCs), infrastructure, human resources and introducing women-friendly services have significantly enhanced the reputation of PHCs. Furthermore, the results of this study show that the implementation of pro-women policies such as maternity welfare programs, birth attendants, feeding and mandatory 48-hour post-partum stay have been successful in attracting women to seek services at PHCs. This model will serve as a model for other states looking to replicate and expand primary health care services.

Mahapatro (2015) study examined the individual and social factors influencing women's willingness to use maternal health services in a district in southern Odisha. The study was carried out in a rural area of Gajam district of South Odisha. The study found that key factors affecting women's utilization of health services included challenges related to transportation and financial limitations. Furthermore, this study highlights the importance of differing beliefs about the causes of illness as significant determinants of the limited benefits of hospital care among both women and the community. It is important to focus on improving the functioning of the transport system. Also, it is essential to involve husbands and family elders as significant stakeholders in the decision-making process. Furthermore, the study suggests that personalized antenatal counselling should consider women's risk perceptions and their unique interpretive models.

Singh et al., (2014) study to examine factors associated with maternal healthcare utilization in nine high focus states in India. Multilevel analyses were applied to three maternity outcomes, namely, four or more antenatal care visits, skilled birth attendance and post-natal care after birth. At the community level, the odds of maternal healthcare utilization were lower in rural areas and in communities with a high concentration of poor and illiterate women. Moreover, the average population coverage of primary health centres (PHCs), availability of labour room in PHC and percentage of registered pregnancies were significant factors at the district level that influenced the use of maternity care services. The study also found a strong association between the extent of previous use of maternal healthcare and its effect on subsequent usage patterns.

Ghosh (2014) examined equity in utilization of healthcare services in India: a national sample study. It aims to examine horizontal disparities in health utilization, including outpatient and inpatient care, in 15 major states and North Eastern regions of India. The study was conducted using cross-sectional data extracted from the 60th cycle of the National Sample Survey Organization (NSSO). The study found considerable variation in inpatient treatment utilization, particularly in both outpatient and inpatient settings, favouring the rich and consistent across rural and urban areas in most Indian states. The study concludes that it is necessary to address existing inequalities in health care by significantly reducing public expenditure on health and achieving universal coverage of health care in India. The study emphasizes the need to address existing health disparities by significantly increasing public investment in health care and striving for comprehensive and efficient health care across India.

Sharma et al., (2014) studied patient satisfaction with hospital services in Jabalpur, Madhya Pradesh. The objective of the study is to assess the patient satisfaction regarding the services provided in outpatient department. The service attendants, professional care, waiting time, consultant, and nurses' behavior were all considered satisfactory by most of the respondents. The result revealed that the toilet facility was not satisfied by 68% of all respondents; while the drinking water facility

was satisfied by 56%.Outpatient department (OPD) services are an important component of hospital health care, especially improving toilet facilities, availability of drinking water and access to pharmacists.

Dar (2015) found that in the rural areas significant percentage of people seek treatment from the public health facilities and hence strengthen the argument that people trust the public health providers. In the surveyed PHCs the number of inpatients is very low the possible reasons for this could be inadequate infrastructural facilities to provide a complete package of treatment, hesitation of people to come for treatment for complicated ailments and the casual attitude of the PHC staff towards inpatients. Among the patients seeking treatment from PHCs, 46 % came for maternal and child care services. This significant percentage can be attributed to the fact that these health centres have been strongly connected to the NRHM, which mainly deals with improving the maternal and child health. An important finding of the study is that the major beneficiaries of the services of PHCs are the most vulnerable and illiterate sections of Indian society.

Prasad et al., (2015) Scrutinized to know the pattern of utilization by rural community on availability, utilization and perception of facilities at primary health centre. The study was conducted from September to November 2014 in Ganapathy village, Pondicherry. More than 80% people were aware of Primary Health Center (PHC) and its location, while more than 75% were aware of availability of free medicines and laboratory tests at PHC. Due to average waiting times of less than 30 minutes, a significant majority of individuals preferred to seek medical assistance at a PHC. The findings of the study illustrate that people go to PHC for health concerns such as respiratory problems, febrile episodes and accidental injuries.

Pakhare et al., (2015) investigated primary care facilities for cardiovascular preparedness in Madhya Pradesh. The study was taken up in 24 districts of Madhya Pradesh. The availability of facility in laboratory services and human resources was very low, while the availability of essential medicines for diabetes, hypertension and their acute complications was at intermediate level. The study recommends prioritizing significant strengthening of human resources and laboratory services at the primary care level, ensuring constant availability of essential drug classes, equipment, and supplies and improving point-of-care testing.

Vora (2015) had donea cross-sectional study, for to examine the utilisation of maternal healthcare services and role of JSY/CY in Gujarat and Tamil Nadu. Tamil women reported greater use of maternal healthcare services than Gujarati women. JSY/CY participation predicted institutional delivery in Gujarat (AOR = 3.9), but JSY assistance failed to predict institutional delivery in Tamil Nadu, where mothers received some cash for home births under another scheme. JSY/CY assistance failed to predict adequate antenatal care, which was not incentivized. All-weather road access predicted institutional delivery in both Tamil Nadu (AOR = 3.4) and Gujarat (AOR = 1.4).

Dodd et al., (2016) observed the self-reported morbidity and health service utilization in rural Tamil Nadu. The objective of this study was to health care preferences, utilization, and experiences in order to identify priority areas for government health policies and programs.The study was conducted in 26 villages in Krishnagiri district of Tamil Nadu. The study found a high burden of no communicable diseases, with connective tissue problems, nervous system and sensory organ diseases, and circulatory and respiratory diseases being the most common. Although government facilities were common, they faced mistrust due to poor treatment protocols and corruption, while high treatment cost was a significant barrier to accessing private facilities, the study emphasizes the need for tailored health policies and village-level programs in rural areas.

Rushender et al., (2016) carried out a research study at the Orathur Primary Health Center (PHC), located in the Cuddalore region of Tamil Nadu. In this study, 71.2% were satisfied with the health services provided at the primary health center (PHC), and within the group of individuals with health conditions, 45.40% and 58.80% of families especially those facing acute or chronic diseases used PHC services. The study result indicated that 81.65% of expectant mothers used PHC services for antenatal care (ANC), 77.98% for tetanus toxoid

(TT) vaccination, 75.24% for delivery assistance and 75.76% for postnatal care. This study highlights the significant role of PHC in providing essential health services.

Saikia (2018) studied the shortage of nurses in rural public health sector in India. The purpose of this paper is to examine the situation and shortage of nurses in public health sector in rural India. This study based on secondary data passed. To end this nursing shortage and improve public health care services in rural regions, it is recommended that adequate nurse staffing in rural health centers be implemented. Compared to international norms, nurse density and doctor-nurse ratio are very low and vary greatly between states and union territories.

Barman & Roy (2018) examined the regional differences in health care infrastructure in Cooch Bihar district in the state of West Bengal. Objective of the study is to identify the infrastructural facilities of the healthcare facilities. The study found that most centers do not have a strong link between transport and communication and health infrastructure is poor. Access to efficient healthcare is actually present and providers obstetricians must ensure quality healthcare.

Sudarsan & Saravanabhavan (2019) monitored the availability and utilization of Primary Health Care Center in Thanjavur district in Tamil Nadu. The objective of this study is to know the utilization of primary health care services in Thanjavur block wise rural areas.The study found that 50.54 per cent of PHCs in Thanjavur district were satisfied with medical services and about 48 per cent of block-wise PHCs in the district were satisfied with medical services provided in rural areas.Vulnerable populations can benefit by raising number of physician to guarantee high-quality care.

Krishnamurthy et al., (2019) conducted research on screening for mild cognitive impairment among infectious disease patients attending a rural primary health center in Puducherry. The objective of this study was to identify mild cognitive impairment among NCD (Non-communicable Disease) patients in a rural primary health center in Puducherry. The most common NCDs were hypertension (71.2 Percentage), diabetes (56.2 percentage) and bronchial asthma (15percentage). At a rate of 10.8 percentages, cognitive impairment is three times more common in older adults. According to the study, cognitive impairment is more common among the elderly and the illiterate. Consequently, primary health care settings should increase opportunistic cognitive impairment screening.

Jain & Rao (2019) investigated the role of outpatient department performance laboratory services in primary health care (PHC). This study was conducted based on 42 PHCs in Osmanabad district of Maharashtra state. In this study, daily OPD visits ranged from 40 to 182, but 45.24% lack of laboratory technician (LT), malaria and tuberculosis tests were not performed. Of the 23 PHCs with LT, all offer malaria blood testing. Of these, 9 PHCs are trained to diagnose TB and perform sputum testing in addition to other tests, the results of this study suggest.

Bakshi et al., (2019) analysed the study on availability and utilization of services at a government health facility in Nakkalan village, Amritsar district, Punjab. Objective of the study is to extent of utilization of services of government health facility and the factors impeding the utilization. The study found that most of the participants (98.8%) were aware of a government health center in their village, while 657 individuals (59.2%) were well aware of a government health center in their village where one or more of their relatives received health services and with 453 households (40.8%) reporting that they had never availed themselves of the health center's services.The study suggests that regular dispensing of prescribed drugs, presence of a doctor and appropriate operating hours are essential factors for effective utilization of health services in a government health centre.

Rout et al., (2019) studied the utilization of health services in public and private health services in India. The objective of the study is to improve public health services, where the private sector dominates in most Indian states. A sample representative of the entire country, including various states and union territories in India, the survey was conducted between January and June 2014 and included 65,932 households comprising 3,33,104 individuals. The results of this study suggest among the larger states, Assam has the highest outpatient treatment utilization in public health (78.8%), while Punjab has the lowest (8.5%).

The use of the private sector for inpatient care was high across the country, except in Assam and Odisha. Quality issues were perceived as the main factor (43%). The second most common reasons include long wait times.The results indicated that nationwide, the utilization of private sector services is nearly three times greater than that of the public sector.

Yadav et al., (2020) addressed trends, disparities and social determinants of maternal health services utilization in rural India. The study was conducted from the National Family Health Survey. Despite an increasing trend in utilization of maternal health services from 1998-1999 to 2015-2016, illiteracy, maternal age of 40 years or more, and five or more children, Scheduled Tribes, rural residence and lack of health card declined significantly. Utilization of maternal health services is linked. Conversely, the study suggests that a well-educated partner, good economic status, women's autonomy and access to village-level infrastructure are associated with higher chances of accessing these services. This study underscores the importance of fostering collaboration among various stakeholders when developing maternal health policies to effectively implement health reforms at all levels.

Sivanandan et al., (2020) studied the awareness and willingness to use primary health care services in a rural first health center. The objective of this study was to estimate the proportion of individuals accessing health services from a rural health center (RHC) as an FPC and to identify the reasons for non-access. The study was conducted from July 2017 to February 2018 in Pondicherry, India. At the end of the study it was found that 70.4 percentage of health facility users used RHC as FPC. Also (24.6 percentage) cited lack of accessible medical facilities as the reason for not seeking treatment for FPC at RHC. The results suggest that PHC services can be expanded with better health facilities.

Shaw & Sahu (2020) studied access to primary health care in a tribal district of Gujarat, India. Objective is to measure the extent of primary health care facility. The study was conducted in Dahot district of Gujarat. Due to lack of adequate road infrastructure to 66 PHCs, people in tribal areas have to travel long distances to access healthcare. PHCs in tribal areas should function better if infrastructure and road facilities are strengthened.

Ghosh & Ghosh (2020) conducted a reflection of 10 years of National Health Mission on the Indian maternal health scenario. Objective was to assess the impact of NHM since its inception as NRHM in 2005 on maternal health. The study was conducted using data from the Indian National Family Health Surveys between 1992-93 and 2015-16. Institutional distribution increased by 12.6% between 1992-93 and 2005-06. 40.2% from 2005-06 to 2015-16 due to NHM. Disparities persist, with 51.2% of pregnant women having at least four ANC visits, favouring wealthier families in particular. Future public health efforts should aim to eliminate intra- and inter-state disparities in institutional delivery and ensure at least four ANC visits for pregnant women.

Raj et al., (2021) examined whether primary health centers are ready to map facility-based gaps in non-communicable disease management in coastal Karnataka. The purpose of this study was to assess the status of health promotion activities and the availability of resources for screening and on the treatment of NCDs in PHCs of Dakshina Kannada District, Karnataka.86 percentages of PHCs had bans and restrictions on public smoking. Availability of diabetes and hypertension drugs was found in all PHCs. Pioglitazone was not available in any PHC, whereas insulin was available in 64 (98 percentages) PHCs.The study recommended that a need of increased staffing, laboratory support and availability of emergency drugs for treatment of NCDs.

Gandhi et al., (2022) examined the predictors of utilization of continuity of maternal health services (CMHS)in India. A total sample of 1, 70,937 pregnant women during 2015-16 was used in the study based on the latest data from the National Family Health Survey (NFHS). The research findings revealed that merely 17% of expectant mothers availed themselves of comprehensive care, while a significant 83% refrained from seeking any such services. Additionally, a noteworthy 79% of women who enrolled for antenatal care services (ANC) did not receive adequate assistance.This study suggests that media exposure and maternal

access to community mental health services (CMHS) are the primary factors influencing the use of CMHS.

Sahoo & Rout (2023) studied public health facilities in rural India. The primary objective was to assess the status of infrastructure, staffing and basic facilities in these rural health facilities and compare them with their urban counterparts. The study relied on data from the National Sample Survey Office report for the period 2019-2020, in which the survey was conducted at sub-centres, primary health centers and community health centers (CHCs). These findings highlight the higher concentration of public health centers in rural areas compared to urban areas, although not all of these rural facilities meet essential needs. Also, there is a significant shortage of health specialist posts in Community Health Centers (CHCs) to meet the overall demand, and most rural public health facilities are not compliant with Indian Public Health Standards (IPHS) guidelines.

Srivastava et al., (2023) studied the utilization of outpatient services in rural primary health centers in the state of Rajasthan. The study was conducted in 72 primary sampling units of 11 out of 24 Primary Health Care Centers from November 2019 to January 2020 in the districts of Rajasthan, India. Among the studied PHCs, non-communicable diseases (NCDs) were highest at 64.1%, followed by communicable diseases (CDs) and injuries at 30.7%. 5% were also found. In terms of facility utilization, more patients are treated for CD, NCD or injuries in private health facilities compared to public health facilities. The results of the study revealed that 35% of those with CDs, 26.4% of those with NCDs and 29% of those with injuries did not seek OPD treatment.

Conclusion

Utilisation of zero priced or public healthcare services in rural Indiais not fully or cent percent of rural population. The factors determining the utilisation of rural healthcare services were identified by researchers with usage of secondary and primary data. The summary of findings of the reviewed articles enlighten the need of increasing the rural healthcare working hours, number of medical personnel, strengthening healthcare infrastructure, ensuring availability of essential medicines, need of palliative care in rural PHC and investing in multispecialty workforce development in rural areas. At the same time, community engagement and awareness campaigns can empower rural individuals to take control of their health seeking behaviours and make informed decisions for accessing public healthcare services for their acute and chronic disease. Collaboration between health professionals and local panchayat raj, self-help group's will play a key role in bringing about what kind of equipment's and speciality need for which location can be identified scientifically to lead positive change in accessing rural healthcare. By addressing the root causes of health disparities and tailoring interventions to the specific needs of rural areas, India can strive to achieve equitable access to health and improve the overall health status of its rural population. A concerted effort to raise the health status of rural communities will not only improve their standard of living but also contribute to the overall health and development of India's in primary sector.

Acknowledgment: This paper is a part of research project funded by Rashtriya Uchchatar Shiksha Abhiyan (RUSA)

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