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## Health Care delivery in Tribe Rajasthan

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**Summary-** There is surprising little information about the delivery of health care in Tribe india and about the relationship, if any, between health care and health status. Some, such as the commission on macro-economics and health of the World Health Organization (2022) have argued that better health care is key to improving health as well as economic growth in poor countries but there is little systematic evidence that gives us sense of how easy it is to impact the quality of health care delivery in developing countries and through these improvements to impact the health of the population. This paper reports on recent survey in a Tribe area of the state of Rajasthan in India intended to shed some light on this issue, where we use a set of interlocking surveys, to collect data on health and economic status as well as the public and private provision of health care.

**Key words** - health center, household, hamlets, facilities, public health, expenditure, Bhopas, NSSO,

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The existing evidence suggests that there is an extensive system of health care delivery which is however quite dysfunctional in many ways making reforming the system something of a challenge. A recently completed survey of absenteeism in public health facilities in several Indian states Chaudhury, Hammer, kremer, Murlidharan and Rogers, 2022) suggests a very high level of absence (43%) of health care providers in India's primary health centers, a survey of private providers in Delhi (Das 2022) showed that 41% of the providers are unqualified . According to British medical report in India, nearly 5.5 Crore to people are below poverty line because of spending too much money on health issues. Out of which 3.8 Crore people have become poor because of spending money only on medicines. According to the data given by NSSO, nearly 85.9% villagers and 82% Urban families dont have access to the health care insurance schemes. 17% of the total population spend annual 10% of their earning on health treatment. This paper confirms these patterns and deliver's deeper into these phenomena and their relationships with health status.

### **The Udaipur Tribe health survey**

The data collection took place in 100 hamlets of Udaipur district, Rajasthan.

Udaipur is one of the poorest districts in India, with a large tribal population and high level of female illiteracy. The survey was conducted in collaboration with two local institutions Seva Mandir a NGO that works among other things, on health in Tribe Udaipur and Vidhya Bhavan a consortium of schools teaching colleges and agricultural colleges who surprised the administration of the survey.

The sample frame consisted of all the hamlets in at least are hamlets. This implies that the sample is representative only of the population served by Seva Mandir, not of Tribe Udaipur as a whole, Seva Mandir tends to operate in poorer villages with a large tribal population. This sample frame presents several important advantages however. It represents a population of interest to this paper household in India who are among health care system.

### **Health status**

The households in the Udaipur survey are poor even by the standard of Tribe Rajasthan. Their average per capita household expenditure (PCE) is 470 rupee and more than 40% of the people live in households below the official povertyline compared with 13% in rural Rajasthan in the latest official counts of 2021-2022 only 46% of adult (14 and older) males and 11%

of adult females report themselves literate of the 27% of adult with any education, three quarters completed standard eight or less. These households have little in the way of household durable goods and only 21% of households have electricity.

In terms of measures of health 80% of adult women and 27% of adult men have hemoglobin levels show 12 grams per deciliter, 5% of adult women and 1% of adult men have hemoglobin levels below 8 grams per deciliters. Strikingly using a standard cut off for anemia (11 g/dl for women and 13 g/dl for men) men is almost as likely (51%) to be anemic as women (56%) and older women are not less anemic than younger ones suggesting that diet is a key factor. The average body mass index is 17.8 among adult men and 18.1 among adult women 93% of adult men and 88% of adult women have BMI less than 21, considered to be cut-off for low nutrition in the US

Symptoms of disease are widespread and adults (self) report a wide range of symptoms; a third cold symptoms in the last 30 days and 12% say the condition was serious, 33% reported fever (14% serious), 42 (20% serious) reported "body ache", 23 (7%) reported fatigue, 14 (3%) problems with vision, 42 (15%) headache, 33 (10%) backaches, 23 (9%) upper abdominal pain, 11 (4%) had chest pains and 11% had experienced weight loss. Few people reported difficulties in taking care of themselves such as bathing, dressing or eating but many reported difficulty with the physical activities that are required to earn a living in agriculture. Thirty percent or more would have difficulty in walking 5 kilometers, drawing water from a well or working unaided in the fields, eighteen to twenty percent have difficulty squatting or standing up from a sitting position.

Old people report worse health and women at all age also consistently report worse health than men which appears to be a world wide phenomenon (sadana et al 2022) and richer people report better health than poorer people but most people report themselves close to the middle. Nor do our life satisfaction measures show any great dissatisfaction with life on a five points scale, 46% take the middle value and only 9% say their life makes them generally unhappy such results are similar to those for rich countries; for example in the united states, more than a half of respondents report

themselves as a three (quite happy) on a four-point scale, and 8.5% report themselves as unhappy or very unhappy. These people are presumably adapted to the sickness that they experience in that they do not see themselves as particularly unhealthy nor in consequence, unhappy yet they are not so adapted in their reports of their reports of their financial status, which was also self-reported on a ten rung ladders. Here the modal response was the bottom rung and more than 70% of people live in households that are self-reported as living on the bottom three rungs.

#### **Pattern of health care use**

In the household adults visit a health facility on average 0.51 times in a month. The poor visits a facility 0.43 times in a month while an adult in the middle visits a pattern 0.54 times a month and an adult in the highest group visits the facility 0.55 times a month. The difference between the top third and the middle third, on the one hand and the bottom third on the other, is significant and remains so with village fixed effects of these 0.51 visits, only 0.21 visits (i.e. less than quarter) are to a public facility. The fraction of visits to a public facility is highest for the richest group and lowest for the other two groups, but about the same for each overall the rich have significantly more visits to public facility than poor. No one uses public facilities very much and if anything, the poor use them less than non-poor.

The majority of the rest of the visits are to private facilities. The rest are to Bhopas who are the traditional healers. For the poor the fraction of visits to a Bhopas is well over a quarter of all visits, while for the richest group it is about an eighth of all visits.

In terms of expenditure, the average household spends 7% of its budget on health. While the poor spend less in absolute amount, they spend the same amount as a share of their budget. The average health expenditure for adult it is about 60 rupees, or 13% of the monthly PCE of his family. This fraction is the highest for the poorest (15%) and lowest for the richest group (11%) poor, adults spend 13% of their total health expenditure at public facilities 23% on Bhopas and the rest at private facilities. The rich spend 23% of their total health expenditures at public facilities and less than 10% on Bhopas while the middle group spends more than 17% of their health

expenditures on Bhopas and 13% at the public facilities. The rich therefore spends a significantly large fraction of their health rupees on public facilities than do the poor and a significantly smaller fraction on Bhopas, part of the difference in the consumption of public care can be attributed to where the rich live since, once we control for village fixed effects, the difference is smaller (5%) and insignificant.

#### **Public health care facilities in Tribe Udaipur**

Official policy provides for a sub-centre staffed by one trained nurse (ANM) for every 3000 individual sub-centre and Primary Health Centers (PHC) or Community Health Centers (CHC) which are larger than PHC are supposed to be open 6 days a week 6 hours a day. The system is intended to provide more or less free and accessible health care to anyone who chooses to use the public health care system, with the sub-centers, staffed by a trained nurse (ANM) providing the first point of care, the PHC or CHC the next step and the referral hospital dealing with the most serious health problem. As per the study each sub-center serves 48000 individuals and has on average 5.8 medical personnel appointed, including 1.5 doctors.

Why then do we see people not making use of the public health system and relying on private health care and Bhopas? This is a population of whom almost no one is really rich and the poor, who are just as reluctant to use the public health system as anyone else, are actually extremely poor.

In part the answer must lay in the way the public system actually works. Over the survey it conveys the impression that things are not working as the way they are supposed to be. On average 45% of medical personnel are absent in sub-centers and aid posts and 46% are absent in the large PHC and CHC. Since sub-centers are often staffed by only one nurse, this high absenteeism means that these facilities are often closed as per the study sub-centers closed 56% of the time during regular opening hours. Only in 12% of the cases was the nurse to be found in the catchment area of her sub-center. This situation does not seem to be specific to Udaipur these results are similar to the absenteeism rate found in representative surveys in India (where absenteeism in PHCs was found to be 43%) and Bangladesh

(where it was found to be 35%) (Chaudhury et al (2022) Chaudhury and Hammer (2022))

The 6% of sub-centers that are far from the road have only 38% of the personnel present compared to about 55% for the average. Facilities that are closer to Udaipur or to another town do not have lower absenteeism. The available amenities (water, electricity) do not seem to have a large impact, except for the presence of living quarters, which has a large impact on the fraction of personnel present, particularly in sub-centers. Reservations of the position of chairperson (sarpanch) of the panchayat to a woman have no impact on sub-centers and seem to be associated with increased presence in PHCs.

The public facilities open infrequently and unpredictably, leaving people to guess whether it is worth while walking for over half an hour to cover the 1.4 miles that separate the average village from the closest public health facility.

On open days public facilities where the personnel are present more often have significantly more patients than those where the personnel is present less often, the poor (though not the middle class or the rich) are less likely to visit the public facilities and more likely to visit the Bhopas. Of course, the causality could be running eight ways, from utilization of personnel to utilization. Visits to the public health to a public facility costs Rs. 71 compared to Rs. 84 for visiting a private doctor and Rs. 61 for going to the Bhopas. In other words, visits to the public facilities are not much cheaper than going to the private doctor, who moreover is probably easier to find. The gap is large for the middle group who actually spend less per visit to public facility in absolute terms than the poor (although the difference is not significant) and about 50% more per visit to a private facility, but about the same size again (in proportional terms) for the rich. The larger expenditure per visit for the rich disappears completely when village fixed effects are allowed for and is likely attributable, as before to the location of the rich relative to the poor.

Given the public facilities are meant to be free, why do they cost about as much as the private facilities? It is true that lab tests are not free but only 4% of all visits lead to lab tests. A more plausible explanation is that in practice, the public facilities do not always provide, free

medicines. Government stipulates that medicine must be supplied for free as long as they are available; the medicine needs to be purchased from the market. Another possibility is to purchase the medicine from the private stock of the health provider at the public facility but people pay for medicine purchased inside the facility. Even a scheme to help those who are officially designated as "below the poverty line" to avoid even these costs (the doctor or the nurse is supposed to purchase the medicine for them) does not appear to adequately cover the poor and they too end up paying only 40% less.

It is also possible that the public health official charges for his services. This is not necessarily illegal, since they are allowed to practice outside office hours and it is possible that respondents are not always making a distinction between what the public official does after hours. The fact remains however that they are not getting free health care at the public facilities.

#### **Private health care facilities**

The main sources of health care in the system are the private practitioners. The public health professionals are required to be qualified and there are precise rules about what they can and cannot treat (ANMs are not allowed to treat malaria for example) by comparison the private sector is often untrained and largely unregulated even if exclude the Bhopas as by the data 41% of those who call themselves "doctors" do not have a medical, college degree 18% have no medical or paramedical training, whatever 17% have not graduated from high school. Given the symptoms reported by the villagers, the treatment they report receiving appear heterodox.

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