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# Rural Consumer's Behaviour and Decision Making Process for Acquiring Health Care Services ( An Empirical Analysis with Special reference to Uttar Pradesh)

*Vinay Sharma*, Piyush Seth***

## Introduction

**'Health is Wealth'. This simple equation like quote has a proverbial existence. Ask a person who is not well and needs medical attention and cure, and one realizes the reality of this proverb'**

The access to 'Health Care' also can be seen in terms of 'Freedoms and Unfreedoms' (Sen, 2000). A person who does not have access to 'Health Care' is not free. Looking at the importance of Health, 'Health Care' and Health Care System through the point of view of being 'Capable' (Sen, 2000) of avoiding premature mortality or preventable morbidity, we even can rationalize on 'Health' and subsequently 'Health Care' to be the epicenter of whole of the 'Socio-Economic' development and its process. We also can logically conclude 'Health Care' to be the initial most point of 'Poverty Alleviation Process'.

This paper while taking the vital importance of Health Care as the central most aspect of a society's development also analyses the same with a marketer's perspective especially for the rural and the poor population of the state of Uttar Pradesh and looks into rural and the poor consumer's behaviour towards the Health Care Services. The paper also analyses the Decision making process of the concerned consumer for acquiring these services.

Statistics and the empirical research conducted by the author suggest that the rural and the poor population of the state of Uttar Pradesh in the absence of a reliable Health Care Services system by default is resorting to get Health Care Services at a price, hence supporting the development of a market. The situation in case of Uttar Pradesh is so grim that the Court of Justice and the Government is struggling to assure the presence of medicos in the rural areas, but any exercise is not yielding the desired fruits especially with reference to an extreme shortage of manpower the doctor-population ratio standing at 1:4916. This paper while building a systematic case through giving a glimpse of poor health and health care indicators at the state (for the state of Uttar Pradesh) levels is not only suggestive of the rural and the poor population's perspective as a consumer but also demonstrates the market potential for Health Care Services for the concerned segment and finally based on empirical findings proposes a comprehensive model for the 'Health Care' to the rural population also raising some probable issues related to the application of such a model.

## The state of Uttar Pradesh

Uttar Pradesh is the most populous state in the country accounting for 16.4 per cent of the country's population i.e. 166 million out of which 111.5 million is the rural population. It is also the fourth largest state in geographical area covering 9.0 per cent of the country's geographical area, encompassing 2,94,411 square kilometers and comprising of 83 districts, 901 development blocks and 112,804 inhabited villages. The density of population in the state is 473 people per square kilometers as against 274 for the country. About 80% of the poor households live in rural areas of the state whereas the poor population of the state as a whole constitutes around 8% of the poor population in whole of the world. Apart from other issues ranging from uneven distribution of electricity, improper supply of drinking water, uneven disbursement of health facilities

** Professor, I.I.L.M. Academy for Higher Learning, Lucknow, vinnu871@yahoo.com*
*** Lecturer, Sahara Arts and Management Academy Lucknow, piyush21oct@rediffmail.com*

and medical supplies to social issues of gender inequality, casteism and political uncertainty. Tthe state of Uttar Pradesh suffers from an infant mortality rate of 84-85 per 1000 births, maternal mortality of 767 deaths per 100,000 live births and a literacy rate of only 57% whereas, female literacy is trailing at 43%, the crude birth rate in the state is 33.5, crude mortality rate is 10.3 and a very poor overall Human development Index of only 0.07%. Further, Agriculture is economically and socially vital to Uttar Pradesh, and so is the associated produce whether it is dairy products, the house hold produce or consumer goods, food products, handicrafts and so on. (Please also refer to Table no.1)

**Health Facilities and Use of Health Services: Reference:** Directorate General of Medical and Health Services of Uttar Pradesh, Annual Report 2005-2006.
There are a large number of public and private health facilities in the state of Uttar Pradesh.

1) As of March 2006, there were 371 community health centers, 3,640 Primary Health Centers, and more than 20,200 Sub Centers in UP.
2) The bed-population ratio in the state of Uttar Pradesh from the side of Government infrastructure (which is more valid especially as far as the rural population is concerned) is 1: 3424 (year 2005-2006) and for the rural population is 1: 4857 people per bed, where as there are atleast 42296 people for one Primary Health Center and the doctor-population ratio stands at 1:4916
3) According to the 52nd round of the National Sample Survey (NSS) (1995/96), the private sector in UP treated 91 percent of outpatients, and 53 percent of rural and 60 percent of urban hospitalizations were in the private sector.

Reference:lnweb18.worldbank.org/sar/sa.nsf/Attachments/chapt10/$File/10_Yazbeckfinal.pdf.

**Private Health Provision in Uttar Pradesh, India, Inferences and Imperatives: Reference:**lnweb18.worldbank.org/sar/sa.nsf/Attachments/chapt10/$File/10_Yazbeckfinal.pdf.
This study, noted that;

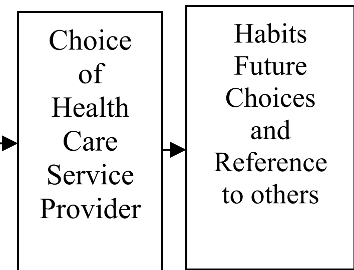
1) The primary motivation of providers, particularly the owners of facilities, is profitability and income generation.
2) Choices about where to locate their facilities and what types of service to provide appears to be primarily demand driven.
3) Private providers are unlikely to be willing to operate in remote areas where there is little chance of making a profit. The state could spend its health funds by providing services itself or purchasing services from private providers.
4) As of now, the quality of medical services in U.P. is not what it should be and there are very few institutionalized processes to ensure that care is of the highest quality.

**Rural Consumer's Behaviour towards the Health Care Services and the Consumer's decision making process for the acquisition of the same:**

**Pictorial Demonstration No.1**

**Factors Leading the Decision and Opinion Making**

- Degree of Emergency
  (Level of Pain/Anxiety or Trauma as experienced by the patient and the people associated)
- Faith
  (Past Experiences and reliability associated with the Health Care Service Provider or Health Care Service Facility)
- Costs (As perceived with reference to the Buying Power, past low cost experiences with the Government Services and Emotions associated i.e. patient in vulnerably dependent and should be charged with consideration)
- Availability of the Health Care Services Providers (Availability as per the need)
- Approach (Accessibility – Direct interaction)
- Reference (Reference of a known influential person)
- Felt intentions of the Service Providers (It becomes understandably clear that if the Service Provider/Medico wants to help)
- Fear related hesitation to ask for the Services as a Consumer (Would I offend the Doctor/Medico if I ask for the services as my right?)
- Awareness Levels (Awareness about the categories of services and the service quality)
- Availability of Alternatives (Alternative treatment/medicine/medicos and facilities)




**Health Care To The Rural Population In India - A Study With Special Reference To Uttar Pradesh:**

The rural health system is predominantly State-Owned. To a large extent it is also true that this system is inadequate and suffers from many in-built weaknesses. Subsequently, it has miserably failed to deliver the health services to the rural area and poor people alike.

Therefore, based on the empirical findings suggestive of the rural poor's desire for better health care services, willingness for health-insurance cover, willingness to pay and the expanding gaps in the provision of 'Health Care' services this study/paper suggests an alternative prospective model/a proposition for the provision and disbursement of 'Health Care' to the Rural and the Poor of the State of Uttar Pradesh (a province in India). The study emphasizes on the role of technology and the large private organizations to develop the strength of the proposed alternative model, which is based on the premise of **'**Affordability for the Poor & Profitability/Feasibility for the Provider'. It also raises the prospective issues and constraints associated with the development of such a model/proposition.

**Limitations:**
**The study also wishes to accept certain limitations, especially with reference to:**

a) The Exploratory character of the research design. There are several aspects, which can only be tested with the support of cause, and effect analysis, which only can be done through atleast the part implementation of the model proposed by this study. Though, the study has been compiled with the support of extensive primary and secondary data analysis that few aspects seem to be deemed proven but still some aspects remain to be analyzed separately, which actually are beyond the framework of the study.
b) The study has developed proposition especially with reference to the State of Uttar Pradesh wherein the proposition may have to be customized while being suggested for the other parts of the country.

c) A major limitation is a very large population size of the state but tried to be catered with a judicious sampling approach and the choice of an appropriate research approach and design.

**The Premise of the Proposed Model and the Basis of Research:**
The premise of the proposed model and the context of 'Affordability for the Poor & Profitability for the Provider' is appropriately supported by the expression of (Prahalad and Hammond, 2002) that "What if it were possible to expand the global market system to include those who now have no stake in it to grow i.e. the market at the bottom (expressed as the Bottom of the Pyramid) providing direct benefits and expanded opportunities to the poor communities?" This expression is further aptly explained in *The Fortune at the Bottom of the Pyramid: Eradicating Poverty through Profits* (Prahalad C.K., 2005). The concept actually stresses on the factor of Co-creation of Value.
Therefore, this study seeking to learn about the probable response the rural and the poor population of Uttar Pradesh would give to the concept of 'serving the poor profitably' (Prahalad and Hammond, 2002) in relation to the Health Care Services went to the rural poor themselves and tried to find about their;

a) **Opinion and desire for better health care services through alternative means,**
b) **their willingness to pay for the services and**
c) **their opinion and willingness for health – insurance cover.**

**Research Methodology and the Findings:**
Depending upon the major characteristics of the respondents with regards to the language barriers, cultural uniqueness, male domination, complacent nature, emotional--social organization structure, a very limited role of women in these societies and so on, this study chose to give a major thrust on qualitative research approach by utilizing 'Focused Group Approach' for finding the necessary and the relevant facts and collecting data.

Taking deep influence from the 'Reflexive Approach' (Alvesson, 2003) this study characteristically used 'Reflexivity' (Alvesson, 2003) as a methodology for conducting primary research.

Survey Area & Sample Size taken: Rural population of the districts of Saharanpur, Bijnor, Lucknow, Barabanki, Allahabad and Faizabad in the State of Uttar Pradesh.
(Please See Table No. I)

**Description:**
The group discussions based surveys were conducted in 3 different regions of the state of Uttar Pradesh dividing the State into three regions i.e.

a) The Eastern Uttar Pradesh, where the districts of Allahabad and Faizabad were selected.
b) The Central Uttar Pradesh, where the districts of Lucknow and Barabanki were selected.
c) The Western Uttar Pradesh, where the districts of Saharanpur and Bijnor were selected.

In case of all the districts, one sub-district was selected and subsequently 2 villages in each of the sub-districts were selected. These selections were made on the basis of the recommendations of the Village Panchayat Development Officers (the Government Official responsible for implementation of development programmes and schemes at the village levels). Their recommendations were on the basis of the major factor of probability of responsiveness of the respondents in these villages. The procedure adopted was that the proponent collected the villagers with the help of influential people of their areas such as the village heads (The Gram Pradhans), the local official available, the doctor in the area, the teacher of the village school and the likes. Further, he took great care of the factor that he initiated the discussion in an informal

manner and then took it to deeper levels, while letting smaller groups to emerge on the basis of similarity of opinions from the initially larger groups of 60-70 people in each case. Every discussion took more than 6 hours each and then subsequent discussions to develop a deeper understanding of the queries were held with the people through whom the proponent contacted the villagers. The basic reason for such types of group discussions to be organized, instead of going for individual interviews was that as per the recommendations by the influential people mentioned above, and also as per the proponents initial observations, he found group discussions to be more effective to bring in proactive discussion as well as the responses. Thus, the sample size that emerged was of more than 400 respondents. Interviews were also conducted with gram pradhans (the village heads), village schoolteachers, government and private doctors of the area, government officials of the area, policy makers, non-medicos, project officers of various schemes run in relation to Health Care and poverty alleviation, non-government organizations and insurance service providers.

**Place and Environment where FGDs were held and the Participation Highlights of the FGDs:**

As described in the preceding paragraphs that the Focused Group Discussion were called upon with the support of locally influential people. So, these people like in the case of Chetnagarhi Mr. Manoj Dixit, the village development officer was deputed by Mr. Rajat Yadav the then Block Development Officer to organize the FGD and Mr. Manoj had passed on this information to the Gram Pradhan the Village Head. The day when the researcher reached there, the Village Head took the researcher on a round of the village where he informed the people that a discussion is going to be held at his house and they should come and simultaneously the researcher also got the benefit of suggesting the purpose of the discussion to the prospective respondents while telling them about their required profile for this discussion. Here, it is imperative to suggest that even the most well off villagers were found eligible to participate in the discussion because a) those were not too many in numbers and b) they were also found short of information and money after an extent as compared to their poorer counterparts.

Once the people gathered in the premises of the Village Head, an informal chat about their Health, their understanding about Health, Health Care facilities in the area and the related subject was initiated which got converted into a debate soon and on the basis of the difference of opinion (this difference of opinion was usually based on the personal experience, which finally in almost all the cases converged into common basis of dissatisfaction and satisfaction as applicable finally producing common findings to a larger extent. About 5 discussion groups having around 5 respondents each polarized out of around 35 people sitting, where in about 10 people did not participate so much to called as the parts of the group.

Again, as a very usual practice the older people were always proactive in the discussion in the early rounds of the discussions and later the younger lots always emerged the discussion leaders. Once the groups polarized the discussion was made more systematic as per the predefined sequence of the queries and questions and only constructive debates were allowed amongst the participants. Here was the time where few deeper narrations also came upfront and few of those are presented in the forms of the case studies/case descriptions in this study also.

**A brief about the villages selected**

All the 12 villages (Please refer to TABLE-II for the details), where the Focused Group Discussions were conducted had a range of 140 to 496 households and a population range of 804 to 3292 people. The other indicators, chosen for analysis are illiteracy, Total number of workers

in every village, main workers and the marginal workers, the average household size and the sex ratio.

The broad interpretation of these parameters chosen is in accordance with the definitions given by the office of the Registrar General of India in the census of India, 2001.

**About the respondents:** On the basis of the questions asked in relation to what the respondents do specifically and their daily lives, few factors, which appeared, are that 60-70% of the respondents were illiterates, 2-5% of the groups were marginal workers and around 3% were females. Only two cases occurred when females joined in the discussion. (Therefore, the proponent actually tried for a separate discussion with a female group of around 35 at the village hamlet called Chetnagarhi under the Sub-District of Nawabganj in the District of Barabanki under the Central Region of Uttar Pradesh.
Females, not joining in the discussions have obvious reasons in relation to the cultural factors in this part of the country. Females in this region are not usually considered to be the part of the decision making process (decisions in relations to the family, community or society).
The only additional factor in discussions with the females that appeared apart from the discussions held with the male groups was that the females do wish and want to become the part of the decision making process and they definitely wish to gain economic independence and strongly feel that their children may grow better with the involvement of the factor of their economic independence. (Pictorial demonstration no.2)

**Summary Analysis of the Discussions held**

The discussions were held with four categories of respondents as suggested below. Summary analysis is presented in the following sequence:

a) Analysis of the Focused Group Discussions and In-Depth interviews held with the rural and the poor population in the sample districts of Lucknow, Barabanki, Faizabad, Allahabad, Saharanpur and Bijnor.
b) Analysis of the In-Depth interviews conducted with the officials of the Government agencies, doctors of the Government Uttar Pradesh, the Central Government and the insurance service providers.
c) Analysis of the questions asked and In-Depth interviews conducted with Individuals and organizations providing 'Health Care' privately and commercially.
d) Analysis of the detailed Interviews conducted with the influential people in and around the sample villages; these people included schoolteachers, village heads.

**The findings and the analysis based on the focused group discussions with the rural and poor people**

**Summary Analysis of the Questions asked and the Discussions held:**
The questions the proponent asked during the focused group discussions were oriented towards the objective of gaining a deep insight of the attitude of the respondents towards the 'Health Care' services provided to the respondents and which they desire for, their awareness levels, their willingness to pay for the services, their opinion and willingness for health – insurance cover and their opinion and desire for better 'Health Care' services especially through alternative means.

**1. Health Related Awareness of the Respondents: (The Concept of Health):**

a) 100% of the respondents were fully aware that Nutrition, Healthy life style, viz. food habits, cleanliness, healthy and clean surroundings good cooking determine and lead to a healthy life. However, this awareness was marked with a big difference of practice. It was observed

that cleaning hands every time before eating though understood was not practiced and awareness about the factors responsible for health seemed to be the derivatives of culture.

b) Health workers, posters, local Government and Non-Government agencies with proper support of teaching professionals and educationists, medical staff, village development officers and people having touch with cities have quite done their jobs. Radio is a good source (for 100% respondents), Newspaper through its readers (around 15% of the respondents) though lesser in comparison to listeners and occasional TV viewer ship (3%) has spread word and partial awareness about Healthy life factors, disease prevention, immunization, contraception even HIV and most strongly POLIO but not being able to generate HABITUAL ACTION.

c) PULSE POLIO (The Anti Polio Drive of the Government) has done quite a good job, contraceptive measures, HIV, TB (Tuberculosis), awareness about water borne diseases, immunization, Antenatal Care is the sequence which emerged in terms of the recall value of the information which has been passed in recent months. Awareness programmes are doing their jobs but require more frequency to generate regular action.

d) Though the percentage of affirmative answers on the above is **88%** but this answer has an amalgamation of actions being taken by the respondents in response to many types of messages and that too not very regularly. Anti polio drive is highly supported through drops of the medicine received (but here the reach of the workers is higher) Contraception has received attention and response and similar to the pattern of recall Value Antenatal Care was proportionately at the least levels (22%) preceded by water borne disease factors (prevention) and immunization. ANTENATAL CARE came out to be one of the least attended factors because of the female (social) factor involved. As females are not involved in the decision making and have to render all the duties related to House management and rearing of the children.

**2. Respondents' Perception on Availability, Reliability and Comparative Effectiveness of the Present Health System they are using or the Present Health Facilities in their Vicinity Availed by them:**

a) Though 55.2% of the respondents believed that doctors, medical, and non-medical staff of the Government hospitals are skilled but at the same time 85.9% stated that they are not available as per the need.

b) 96.5% of the respondents had been denied services because of the non-availability of equipment. Further only 34.3% of the respondents managed to get generally prescribed medicines.

c) Only 11.5% of the respondents felt that the doctors and medicos are dedicated and ready to provide the services, which definitely corroborates with their (low) availability factor, but defies the factor of (high) skills and that is because the Government related medicos still are more skillful than the their private counterparts available in the rural vicinity and the Government machinery still enjoys more faith from the side of the rural and the poor as they believe that the provision of 'Health Care' is the responsibility of the state and the state belongs to them. But, this faith is diminishing fast because of the unwillingness and the loss of dedication amongst the doctors and the medicos related to the Government machinery.

d) Further, in response to a question that if they have to pay for the services, around 60% of the respondents had to pay or were motivated to pay and of course used private services and hence paid for the services they availed which, strengthens the fact expressed by other questions wherein 75.6% of the respondents suggested that they were not satisfied with the private services, but at the same time 87.3% suggested that they were definitely satisfied in comparison to the government services mainly because of the availability of the services and the availability of the service providers factors.

e) The opinion changed when the satisfaction level was discussed in correlation to the expenses incurred on the private services, wherein 50.2% suggested that they were not satisfied and finally, 96.5% of the respondents suggested that the charges levied by the private 'Health Care' Services providers were not justified as it was exorbitant and beyond their capacity to pay.

As already mentioned this discussion was being held in the form of focused groups, the questions were broken in the several parts and were asked in YES & NO form so as to judge the universality of the views of the respondents if any, as they were divided in small/various opinion groups. (And though they were having similar conclusions on various aspects but had different point of views for e.g. few had an experience that Doctors and Medical staff wish to/ (are ready to) provide services but, once correlatively asked with other factors the conclusion came to be 'No' with reference to their availability especially with reference to the requirements of the respondents. (When corroborated with other reports (UPHSDP report, 2004) and interviews conducted this fact was found to be true that they are usually (more than 80% of the times) not available and their desire to provide service was expressed in terms of their pleasant and positive attitude felt by some respondents.

Further, the discussions were led towards the understanding of the respondents about the role of Information and Communication Technologies and other innovations with respect to Health Care Services wherein it was observed that Information and Communication technology is gaining roots.

**Further** questions were related to various diseases in a family and about the recurrence of a disease in one person, thereby suggesting the accuracy and effectiveness of diagnosis while corroborating it with reported/unreported age, gender through later questions (though broader statistics through various data are available) the time of treatment, the factors of awareness about right doctors, their reach, money as a hindering factor, **willingness to spend, availability of micro finance, availability of insurance cover, awareness about the same, willingness to use it** (here emerged various cases, which suggested that right diagnosis at right time could have done much better not only in terms of expenditure being less but, also the trauma faced) along with **other factors like awareness about the usage of technology and imagination about its prospective effectiveness on the Health Care** discussed conclusively;

**Conclusions, Which Emerged in the interpretive form, are as follows:**

a) None of the respondents was prepared for future medical ailments. But, they don't have any marked segregation of their earnings or sources of financing on their health related expenditures, not even in relation to the available insurance options.

b) On the other hand they do want to buy better health services but as per their affordability, which they explained as at par with government supported services of slightly higher status as they feel that better services will definitely ask for higher prices.

c) All the respondents had strong belief in the co-relation of education and better health and thus health education is the brightest selling object/product. In addition to this all of them would like to go for insurance if it comes to them.

d) The rural and the poor population of the State of Uttar Pradesh needs and is asking for a change at all the levels of 'Health Care' provision system.

e) They wish for radical changes, though still have high regard and trust for the Government Machinery.

f) They do not save for Health Care expenses and it is a matter of generating habit (which actually has large constraints due to other priorities).

g) They are willing to have a provision of medical insurance and agree for a minimal premium of **Rupees 5-10 (US $ .11-.22)** per month for the same.

h) They are willing to pay for the better Health Care Services though definitely in consideration to their buying capacity limitations.
i) They are aware of the name of '**computer**' as a proverb though does not exactly know about the role of technology in the development process. But do feel that the technology will support the change related to the betterment and the development.

**Analysis of the focused group discussion held with a specially organized female group, at garhi chatena, in the district barabanki:**

**Though Collectively, the Conclusion Emerges that:**

i) Those females have conformity with the thoughts of males even if they cannot comment independently on anything they ditto the statements of their family's male members or leave the answers entirely for them.
ii) They feel helpless about any decision-making aspect.
iii) The only and the major aspect which complimented the male dominated FGDs was the first hand information about the disease related trauma the females face in their own cases as well as in the case of their family members, because it is the females of the house who are directly involved in the care-taking process of the effected person(s).

**Analysis:**

With regards to the **awareness**, females are equally aware, rather more practical as far as approach is considered with regards to healthy life and keeping the life healthy, especially the nutrition and its role in healthy life. They are aware about immunization programmes and various drives like pulse polio (Anti Polio Drive of Government of India) etc. But as far as hygiene is concerned they have a fairly poor concept especially in the case of washing hands and eating hygienically cooked food with hygiene.

**The Major Factors which Emerged During this Discussion are that:**

a) Females wish to have pivotal and strong role in the decision making with regards to their health related matters especially in relation to childbirth and birth control.
b) They are equipped with the knowledge of child birth process and try to take care of things by themselves through age old transferred knowledge, but are in a dire need of regular health related attention.
c) They feel that regular medical attention should be provided to them and though they are not very much convinced on the second child factor (especially girls) but still emphasize on appropriate birth gaps with 3 or 4 children mostly boys.
d) All the female respondents are highly fearful of the;
    i) Pregnancy related Traumas.
    ii) Regular Pregnancy.
    iii) Improper Antenatal Care.
    iv) Maternal mortality and
    v) Involuntary Abortions.
e) One of their major concerns is the safe birth and growth of their children.
f) All of the females wish for financial independence.
g) They wish to support actively in the process of earning and economic development.
h) They all wish for at least some basic education.
i) They duly understand the relation of being educated and being healthy.
j) All of them wish for their children's complete education, health and prosperous lives.
k) All of the females do admit that the male though are dominating in every aspect and this is some what acceptable also, but, becomes suffocatively bothering when they do not

devote their financial and other resources for house hold and child care; leave apart the care of females which is not much expected due to so many cultural factors.

l) Most of them (Around60%) have faced prolonged illness because of;
   i) Ignorance.
   ii) Social Constraints.
   iii) Financial Constraints.
   iv) Spread of Services (primarily) because this factor could have eliminated the above 3.

**Findings From The Interviews Conducted With The Officials Of The Government Agencies, Doctors And Other Individuals Involved In The 'Health Care' System Of The Government Of The State Of Uttar Pradesh And The Central Government:**

**The analysis of the facts discovered suggests that:**

a) An amalgamation of;
   i. Better health education,
   ii. Regular visits of the specialists and the 'Health Care' providers,
   iii. Regular vaccination programs,
   iv. Better infrastructural support,
   v. Better allowances and the facilities to the doctors and the 'Health Care' providers; and
   vi. Special emphasis on the female and the child health through sole or the complimentary support of NGOs, may improve the health services for the rural and the poor segment (The facts mentioned in the point 'a' are in the preferential order as perceived by the respondents).

b) Again, if according to the preferential order few steps are taken then the practical realization of the health services for the rural and the poor population can be achieved. The steps/actions suggested are as follows:
   i. Basic health services are provided/dispersed properly.
   ii. NGOs increase their role in the awareness and eradication campaigns other than polio and AIDS.
   iii. By raising the standards and the distribution levels in addition to the frequency of the distribution of medicines through camps.
   iv. Regular vaccination programs for children as well as pregnant women and
   v. Cost minimization of the services along with other well-crafted health services distribution programs.

Further, overwhelming majority of the respondents suggested that through proper salary and intrinsic and extrinsic motivational factors along with infrastructural support individuals and organizations privately providing 'Health Care' can be motivated to serve the rural and the poor markets.

Rural and the poor population are willing to pay and reduce the levels of ailments and poor health.

And yes, there is a scope of handsome profitability (levels yet to be tested).

**Findings From The Interviews Conducted With Individuals And Organizations Privately And Commercially Providing 'Health Care':**

**The analysis of the facts discovered suggested that they are highly unaware and ignorant of the facts such as:**

a) That poor population in rural areas has a cumulative buying power.
b) There is a demand supply structure, which supports volume business with innovation and customization of the services.

c) Most of them (around 85%) are unaware of the extensive role of technology in the provision and the spread of 'Health Care' Services to the rural and the poor for example 'Narayan Hrudayalaya' model of Dr.Devi Shetty. (Reference: www.**hrudayalaya**.com).
d) Almost all are targeting a limited market with perceived buying capacity and
e) They still perceive that providing services to the rural and the poor population is a social service and their duty as per the oath taken by them.

However, at the same time they stated that individual doctors or 'Health Care' providers have a scope of profitability by providing these services to the above said markets.

*Several individual cases emerged during the study, which categorically suggested that the whole of the system requires a replenishing act. Simultaneously there are several examples existing in India, which through their effectiveness emphasizingly suggest that radical changes can be brought.*
*Finally*

**The Model**

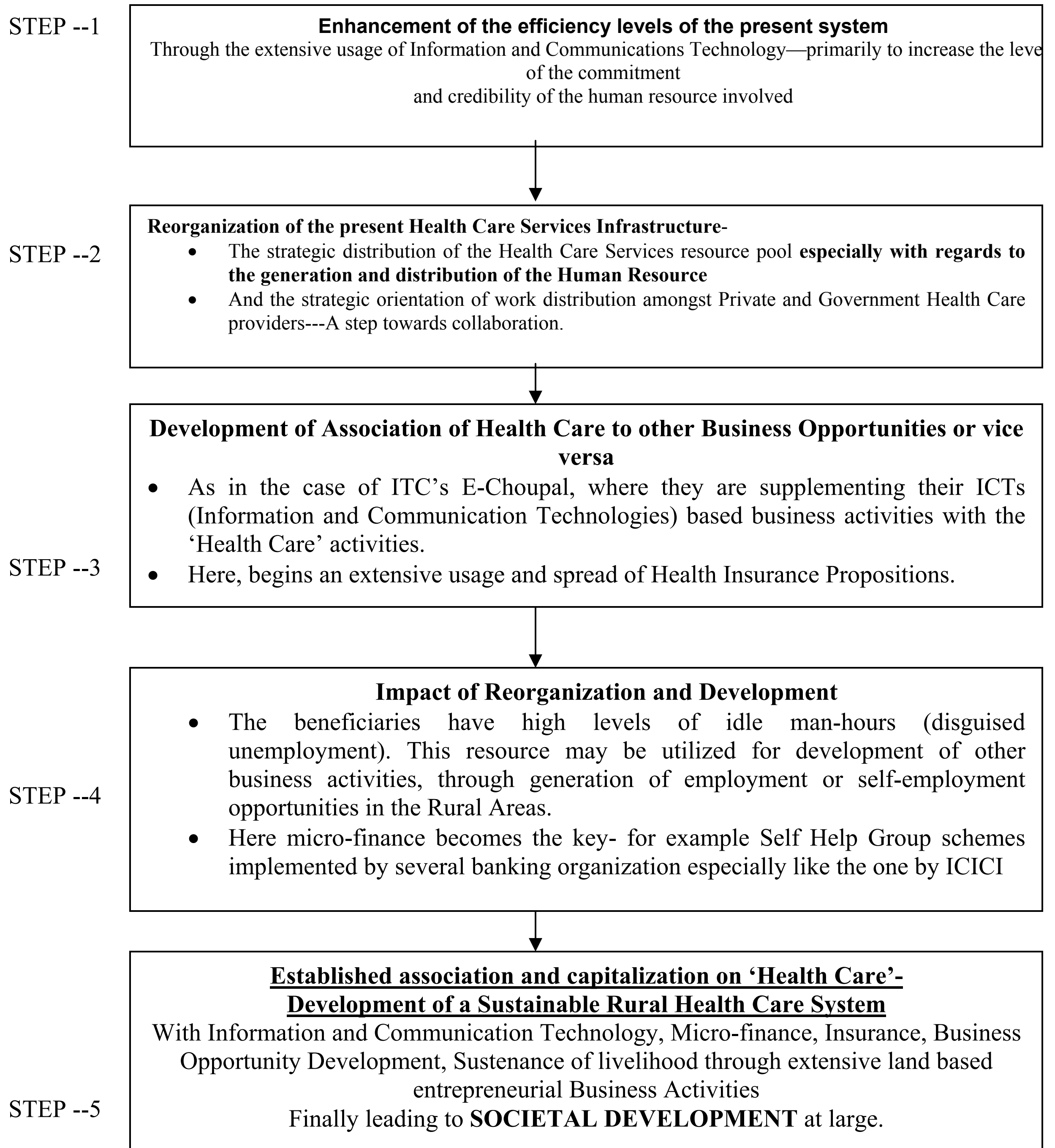
This paper put forward a model/a proposition based on the premise of 'Affordability for the Poor & Profitability for the Provider', which suggests that Business strategies and marketing skills have been concentrating on fundamentals, especially on buying capacity. The paper argues on the following major aspects:

a) The 'Size' of the market and not the buying capacity should be looked upon as a fundamental aspect in the case of highly populated developing and the underdeveloped nations.
b) Technology can play an extensive and a very positive role in the Health Care provision and disbursement to the Rural Poor.
c) Better health services are the human right of the masses and should also be seen as a social responsibility by the marketer along with being seen as a business opportunity.
d) This paper is also suggestive of the proposition that, by looking at the size of the market as an asset, the same can be complimented with the strategic generation of buying power i.e. by 'creating buying power'. So as to

**(This model comprises of five strategic elements in the form of sequential steps, wherein two of the strategies are based on the basis of the marketing logic & feasibility and two of them are based and supported by the fundamental aspects of the generation of buying power and integrating the same with providing the health services with profitability and subsequently reaping the benefits of business development, market development, the social development and subsequently the 'Societal Harmony' as a whole. But, the very first step would be the infusion of technology in the present system with the perspective of generating commitment and credibility through information Technology).**

**Pictorial Demonstration No.2**
**The Model**

**'Affordability for the Poor & Profitability/Feasibility for the Provider'**




**The Model**

a) At first, the paper proposes to look at the factors of enhancing the efficiency levels of the present system, and for this it proposes the utilization of Information technology not just for enhancing the working efficiency of the system, but basically for developing the efficiency levels of the human resource involved in the system through increasing the levels of their commitment and credibility through the utilization of Information technology.

**A clue about the practical implementation of the Proposition:**

A Prospective Association of ITC's e-Choupal (http://www.itcportal.com, http://www.itcportal.com/sets/echoupal_frameset.htm) with the Department of Health and Family welfare of the State of Uttar Pradesh:

Although, the restoration of faith definitely is a complicated factor but the interconnectivity of all the units with satellite link and Intranet will first of all increase the levels of monitoring, feedback, follow-ups, logistics management and interconnectivity among the medicos apart from the generation of the database, which may help in realizing "the objective of Health For All (HFA) (national health policy, 2001)".

b) Secondly, it supports a proposition, which is a strategic marketing based structure. Though this structure uses marketing based principles and logic as its basis, but still depends heavily on the 'will' of the prospective promoters of the concept. This is the initial most step called as "**The strategic marketing for competitive advantage, the expansion of the market and the services as well".** It emphasizes on the unification of the strategic resource based services in a pool in relation to providing health.

Both the preceding two steps can later well be utilized in increasing the investor confidence, especially the multinational company's, who would be the basic carriers of the success of the model, proposed.

c) The third step, which is primarily based on the effective and the strategic distribution of services also emphasizes on the integration of some other business propositions and the services specifically relevant to the rural and the poor population of India and similar nations. Here, also as and when we perceive the MNC's to effectively look towards the markets mentioned as profitable business propositions, the usage of Information technology would become an effective part of the success of this third step.

d) The fourth, which, is primarily, based on the fact that India and the similar nations have a large pool of unskilled and semi-skilled manpower with an effective levels of primary education. This step basically, emphasizes on the business generation through entrepreneurial development programs first in relation to the women/orphans/needy/masses and then integrating it with the health services and their multiplication, henceforth. This step, which primarily talks of enhancing the buying power of the population and the markets concerned also, would be looking towards an extensive utilization of the Information technology for fulfilling its objectives.

e) The fifth and the last proposition is a land based entrepreneurial development program. As they say India is a land of agriculture and farmers. This strategic business proposition emphasizes on the integration of the export oriented agriculture development of pharmaceutical and the medicinal plants and herbs with specific development of scientifically oriented human resource through the development education in the field of pharma and medical research integrating the same with the development of health services.

Observing the sequence of the steps defined above, the reasons for their occurrence in this particular manner have to be suggested, and these are:

The scenario in the case of the health industry suggests that it is not so organized i.e. "the service providers and the facilities in relation to the same are highly disorganized and have high concentration levels in the urban areas where the facilities in relation to the status of living for the individuals are good and also there is a perceived buying power in the urban areas as compared to the rural areas.

Now, looking at the five major aspects on which this paper is trying to argue, the objective comes out to be the capitalization of the size of the market and to give value addition to the marketing of the health services by considering the social responsibility aspect of these services also, considering the realization of the profits to enhance the life and the replicability of the process.
Thus, in lieu of the same, at first this paper has given the introduction of the strategic component in dissipation of the health care services in and through the existing system itself. Subsequently it has suggested the addition of value to the business as a whole through integration of the services and the products, which, address to the same customer segment. Once the entrepreneur will start believing in the viability of such markets and would feel comfortable in relation to the expansion of the markets, the integration of a step, which will enhance the buying power of the customer itself, would add to the spending of the same on the core services offered by the entrepreneur. Now, this development can further be capitalized by the step five, which is based on the factor of further entrepreneurial development through agricultural/non-agricultural development activities with the objectives of relevant integration of research and development in the field of medicine, which further would support medical care itself, ultimately supporting the cycle of economic development as a whole.

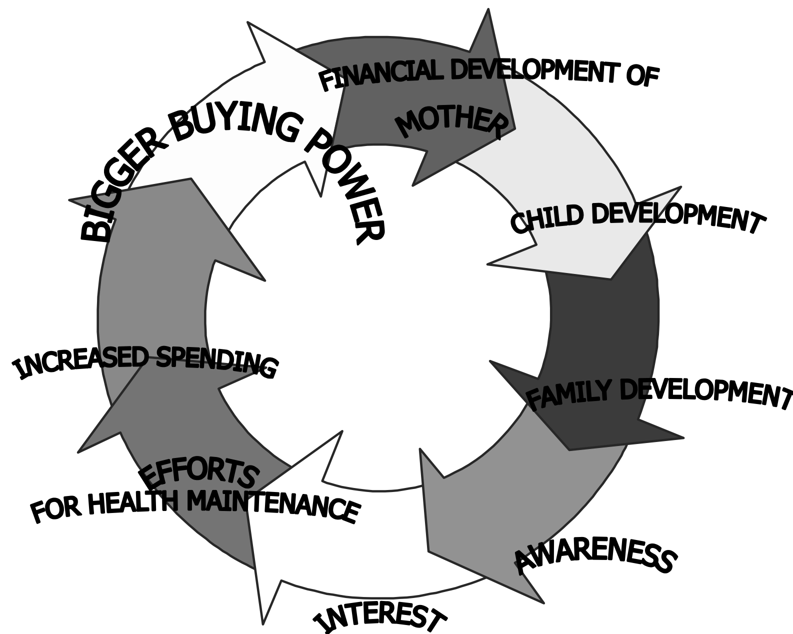
*Here, this paper suggests that keeping in mind the requirement for the replicability factor, these steps may be bifurcated into self-reliant separate profit generating businesses at the peak of their development.*
*One more reason for this is that, as evident all the steps require human will and efficiency, we also should consider the human need of independence supported by the factor of ambitions and also the basic characteristics of humans to become slaves of their superiority once they achieve something.*
*Many sociologists, spiritual and the political leaders like Mahatma Gandhi, A.H.Maslow and others have studied these facts and widely acknowledged the strength of human mind and the limitations of the human behavior, attitude and especially the limitations of humans in maintaining the spontaneity of their actions.(Specifically for the benefit of others).*
*One more important factor is that this paper strongly recommends the role of women in all the steps beginning from the execution and workers level to the levels of strategic management, as time and again females have proven themselves and their roles in the social development. They have also proved to be the binding forces in the development of such models of social values and importance. This fact is duly endorsed by the organizations like UNICEF with the perspective that the financial independence of the mother is directly proportional to the development of the child.*

**(The paper tries to present this concept pictorially in the pictorial demonstration no.3.**

**(Pictorial demonstration No. 3**

**CREATING BUYING POWER**

**(The groups which are referred to are constituted of the Females who are referred to as the MOTHERS)**




ONCE A MOTHER IS CAPABLE OF GENERATING REVENUES OR BECOMING ECONOMICALLY INDEPENDENT its BENEFITS IN THE FORMS OF HEALTH AND EDUCATION PASS ON TO THE CHILDREN & subsequently to THE FAMILY.
HERE, THE AWARENESS COMES IN, INCREASING THE INTEREST LEVELS GOING ON TO THE BIGGER EFFORTS FOR HEALTH MAINTENANCE hence INCREASING THE SPENDING ON HEALTHCARE AND FURHTER GOING ONTO THE BIGGER EFFORTS FOR INCREASING THE BUYING POWER FURTHER, WHICH, IS AN INDICATION OF ECONOMIC DEVELOPMENT.

**The expected issues and constraints those may emerge:**

i) Legalities and constitutional guidelines.
ii) Difference in the Objectives and Missions and also the Visions of the government and the private organizations.
iii) Cultural and perceptual barriers relating to the acceptability of the beneficiaries towards private institutions and social changes accompanying the same.
iv) Social structure, as the politically and the socially powerful people would be required to be adaptive of the changes so that they may be instrumental in replicating the process once the association are implemented.

**Some of the issues that would emerge would be in relation to the facilitators of the process. These issues may come up in the form of:**

i) The adaptability levels of the manpower i.e. if they perceive the process to be beneficial for them and adapt the change in the working environment after the public institutions get associated with private organizations having sea change in the working philosophy and environment as compared to theirs.
ii) The prevalent problems of corruption in the state.

One of the major concerns would emerge is in the form of the integration factor (Osmani, 2003) "which is the extent to which the rural and the poor (the prospective beneficiaries and the agents) are able to integrate into the economic processes so that, when growth occurs and the employment potential expands, they can take advantage of the greater scope for improving the quality and the quantity of employment". But experience and proven methodologies of

organizations like ITC due to their integrative, promotive and interactive capabilities may face this, once the perceived levels of the implementation of such partnerships are achieved.
Further, as far as other constraints such as question of literacy, cultural and perceptual barriers, social structure, caste discrimination, role and position of women in the society (especially with regards to Uttar Pradesh), manpower availability, their adaptability and learning levels, their work culture, electricity, the huge problem of corruption in the State and the likes are concerned, they definitely may pose restriction to the process but in due course of time some measures will come up as a solution to them and some have to be implemented at the policy-levels. Few measures, which might occur and are emerging presently, are:

> i) Edusat (a dedicated satellite for education based link ups), which is facilitating the span of delivery of education and thus the awareness and hence the acceptability of the process,
> ii) Organizations like Tata literacy (http://www.tata.com/0_beyond_business/community/tcci_news/20010502.htm) and many other foundations are working towards the enhancement of rate of literacy,
> iii) Partnership of Public Administration and Private Enterprise may enhance the levels of transparency so as to support reduction of corruption levels and finally
> iv) These partnerships as a mode also may emerge as a solution in themselves to many of the issues, but definitely after a particular stage.

**Conclusion**

This paper along with emphasizing on the urgency of Health Care needs of the 'Rural Poor' of Uttar Pradesh, the most populous state of India has expressed their willingness and wish for an improved Health Care system having the strong support of an Health Insurance system and an organized Private Health Care Service industry. The paper demonstrates the rural and the poor consumer's behaviour and decision making process towards acquiring the Health Care Services along with a comprehensive five-stage model and wishes that the fruits of Globalization should also trickle down to the lowest levels of the populace and the social strata especially in case of countries like India where more than two-third of the population still lives in the rural areas and this being a great market opportunity for a savvy marketer is also his responsibility for not only looking at such markets with the perspective of Business Opportunity but also with reasonable responsibility. The paper strongly supports the logic of better Health of the society leading towards Societal Harmony. The paper considers Better Health as a form of 'Freedom' (Sen, 2000).

> **In the words of Prof. Amartya Sen "Freedom are not only the primary ends of development they are also among its principal means. In addition to acknowledging foundationally, the evaluative importance of freedom, we also have to understand the remarkable empirical connection that links freedoms of different kinds with each other. Political freedoms (in the form of free speech and elections) help to promote economic security. Social opportunities (in the form of education and health facilities) facilitate economic participation. Economic facilities (in the form of opportunities for participation in trade and production) can help to generate personal abundance as well as public resources for social facilities. Freedoms of different kinds can strengthen one another. This freedom-centered understanding of economics and of the process of development is very much an agent-oriented view" (Sen, 2000).**

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**Table 1: Survey Area and Sample Size**
**(Focused Groups and Number of Respondents per Group)**

| REGION | DISTRICTS | SUB-DISTRICTS (TEHSIL) | VILLAGES | FOCUSED GROUPS EMERGED | AVERAGE NUMBER OF RESPOND-ENTS PER FOCUSED GROUP | TOTAL NUMBER OF RESPONDENTS |
|---|---|---|---|---|---|---|
| WESTERN UTTAR PRADESH | SAHARANPUR | BEHAT | BEHAT DEHAT | 08 | 06 | 48 |
| | | | TODARPUR | 05 | 07 | 35 |
| | BIJNOR | NAJIBABAD | ALAMPUR GANGA | 09 | 06 | 54 |
| | | | BARAMPUR | 06 | 04 | 24 |
| CENTRAL UTTAR PRADESH | LUCKNOW | BAKSHI KA TALAB | JAMKHANVA | 08 | 07 | 56 |
| | | | BAGAHA | 03 | 05 | 15 |
| | BARABANKI | NAWABGANJ | CHETNAGARHI | 05 | 05 | 25 |
| | | | CHHULAHA | 05 | 06 | 30 |
| EASTERN UTTAR PRADESH | ALLAHABAD | ALLAHABAD RURAL | BHARETHA | 07 | 06 | 42 |
| | | | DAIWGHAT | 05 | 04 | 20 |
| | FAIZABAD | RUDAULI | BANGAUNA | 06 | 06 | 36 |
| | | | VAJIDPUR | 07 | 07 | 49 |
| TOTAL | 06 | 06 | 12 | 68 | | 434 |

**Table 2. Details of Villages Selected for FGDs**

| Region | Districts | Sub-districts | Villages | Population | Total number of house-holds | Average house-hold size | Total number of illiterates | Sex ratio | Total number of workers | Main Workers | Marginal Workers | Nearest govt. Facility (Surrounding the sample Villages) | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | Number of primary health center | Community health center |
| Western Uttar Pradesh | SAHARANPUR | BEHAT | BEHAT DEHAT | 3292 | 496 | 6.6 | 2264 (68.8%) | 912 | 867 | 779 | 88 | 2 | RANDOL |
| | | | TODARPUR | 3061 | 541 | 5.7 | 1805 (59%) | 791 | 948 | 825 | 123 | 1 | |
| | BIJNOR | NAJIBABAD | ALAMPUR GANGA | 1110 | 148 | 7.5 | 575 (52.3%) | 904 | 301 | 297 | 4 | 1 | DHAMPUR,NAJIBABADSYAU, SYOHRA |
| | | | BARAMPUR | 2368 | 409 | 5.8 | 976 (41.2%) | 916 | 585 | 409 | 176 | 1 | |
| Central Uttar Pradesh | LUCKNOW | BAKSHI KA TALAB | JAMKHANVA | 1759 | 358 | 4.9 | 1065 (60.5%) | 863 | 624 | 601 | 23 | 1 | BAKSHI KA TALAB, ITAUNJA |
| | | | BAGAHA | 2546 | 472 | 5.4 | 1620 (63.6%) | 883 | 906 | 859 | 47 | 1 | |
| | BARABANKI | NAWABGANJ | CHETNAGARHI | 1445 | 227 | 6.4 | 699 (48.4%) | 953 | 497 | 348 | 149 | 2 | TIKAITNAGAR, JAIDPUR |
| | | | CHHULAHA | 1724 | 267 | 6.5 | 983 (57%) | 937 | 622 | 585 | 37 | 1 | |
| Eastern Uttar Pradesh | ALLAHABAD | ALLAHABAD RURAL | BHARETHA | 1898 | 298 | 6.4 | 1298 (68.4%) | 802 | 570 | 498 | 72 | 2 | JASRA, KARCHANA, KAUNDHIARA, SANKARGARH, SORAON |
| | | | DAIWGHAT | 804 | 140 | 5.7 | 692 (86%) | 896 | 379 | 319 | 60 | 2 | |
| | FAIZABAD | RUDAULI | BANGAUNA | 1605 | 294 | 5.5 | 1099 (68.5%) | 924 | 592 | 533 | 59 | 1 | RUDAULI |
| | | | VAJIDPUR | 2191 | 342 | 6.4 | 1227 (56%) | 1014 | 694 | 573 | 121 | 1 | |