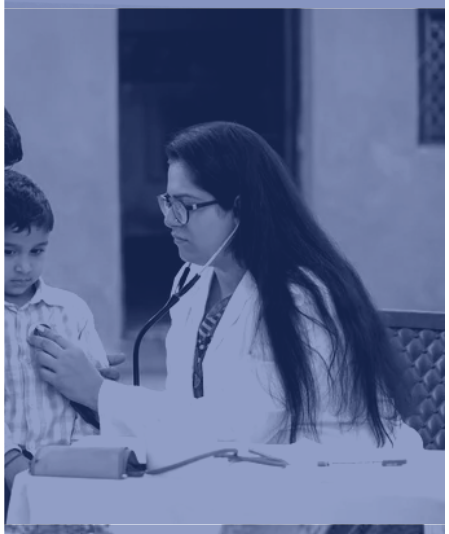

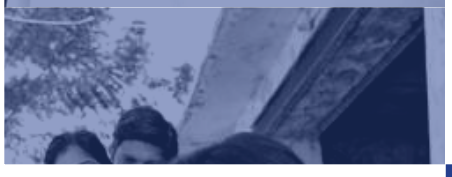

STATE OF HEALTH IN RURAL INDIA

tri Transform Rural India

DIU development intelligence unit

SAMBODHI

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SECTION 01

Introduction

1.1 Prologue

The State of Health in Rural India Survey is an initiative aimed at comprehensively assessing the healthcare landscape in rural India. Conceived and executed by the Development Intelligence Unit (DIU), a collaborative venture between Transforming Rural India Foundation (TRI) and Sambodhi Research and Communications Private Limited, this pan-India survey endeavours to shed light on critical and contemporary aspects of the nation's rural health system in. The survey was done telephonically, covering a total of 6,478 respondents covering 21 states and representing a diverse range of rural communities across India.

The survey seeks to provide evidence-based insights that can inform and guide policymakers, stakeholders, and healthcare professionals toward better healthcare planning and implementation. The primary focus of the study is to gain a comprehensive understanding of the various dimensions of healthcare in rural India, encompassing both traditional and modern practices. One key aspect explored in the survey is the inclination towards traditional medicines and treatment methods, an opportunity for policymakers to mainstream AYUSH practices into the existing healthcare system, leveraging the potential of traditional medicine to enhance overall healthcare outcomes.

The survey also tries to understand the critical issue of social security in healthcare, with a specific focus on the impact of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY). As one of the nation's most ambitious healthcare programs, AB PM-JAY has been effective in providing cashless secondary and tertiary medical treatment and care to vulnerable populations. The survey explores challenges such as out-of-pocket expenditure (OOPE), emphasizing the need to strengthen comprehensive primary health care (CPHC) to ensure equitable access to quality healthcare for all. Another important aspect examined in the survey is the adoption of healthcare technology, particularly the progress of the Ayushman Bharat Digital Mission (ABDM). The survey highlights the creation and awareness of ABHA cards among the surveyed population.

National Tele-consultation Services (E-Sanjeevani) are also touched upon in the survey, with insights into the utilization of telemedicine services. The survey reveals the untapped potential of telehealth and mobile medical units (MMUs) and emphasizes the significance of reducing daily wage loss and out-of-pocket expenses for patients and their families by leveraging telemedicine services effectively. Furthermore, the survey delves into the healthcare technology landscape, including the potential of India as a "Health & Wellness Hub" for medical tourism. The survey identifies opportunities to foster trust and build modern critical healthcare services within each state, encouraging "Domestic Medical Tourism" and reducing the migration of patients to other regions.

Strengthening diagnostic services and palliative care emerges as another crucial aspect explored in the survey. It underscores the importance of doorstep diagnostic services provided by private providers and the desire of individuals to avail health and ancillary services nearest to their homes or villages. The survey's findings have significant implications for the Free Essential Diagnostics Initiative under the National Health Mission (NHM), may encourage policymakers to strengthen hospital and laboratory infrastructure to provide better diagnostic services. Additionally, the survey sheds light on the state of palliative care in rural India, highlighting the need for comprehensive support and services for patients with life-limiting illnesses.

Finally, the survey brings attention to the migration of individuals seeking better healthcare facilities within India. It reveals that a significant proportion of the surveyed population chose to migrate from their locality to other places in quest of quality healthcare services. The survey also highlights the need for mental health and well-being, identifying the increasing burden of mental health issues, particularly in the wake of the COVID-19 pandemic. While India's National Mental Health Programme (NMHP) has been implemented nationwide, the survey aims to explore the availability of comprehensive mental health services.

In conclusion, the State of Health Survey is a pioneering effort that promises to offer valuable insights into India's healthcare landscape. By providing evidence-based recommendations, the survey aims to contribute to the enhancement of healthcare services, address existing challenges, and promote the overall well-being of India's diverse population. Through collaboration and informed decision-making, the findings of this survey have the potential to shape the future of healthcare in rural India, making it more accessible, equitable, and sustainable for all citizens.

1.2 Methodology

The sample of respondents for the telephonic survey was randomly chosen from a pool of empanelled households maintained by Sambodhipanels. Fixed longitudinal panels tend to suffer from the Hawthorne effect, which renders their outputs questionable. Sambodhipanels, on the other hand, maintains several baskets containing sizeable respondent pools of similar profiles (age/gender/occupation/location) and for every survey, randomly choose respondents from each basket basis of a quota for each profile mix. Through this method, they get to minimize the Hawthorne effect since the probability of the same respondent receiving a call multiple times during the year is improbable. At the same time, such a diverse panel ensures more representative coverage. Empanelled callers on the payroll are located across the states to ensure all calls were conducted in the local vernacular.

1.3 Profile of the sample

The study included 6478 respondents, with 75% being adult males and 25% being adult females. The sample is distributed across six regions of the country: North, South, Northeast, East, Central, and West, ranging between 10% contribution in the Northeast to 22% in the East and 20% from the South.[1]

Figure 1: Gender

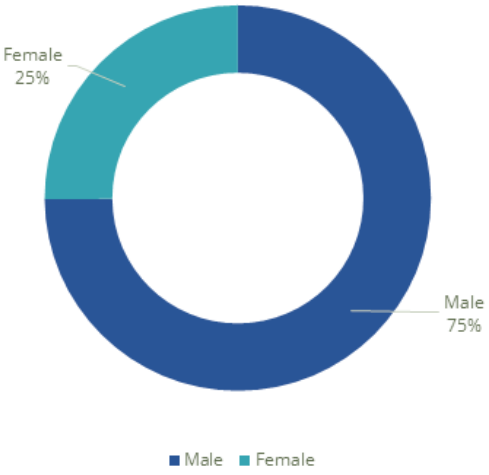
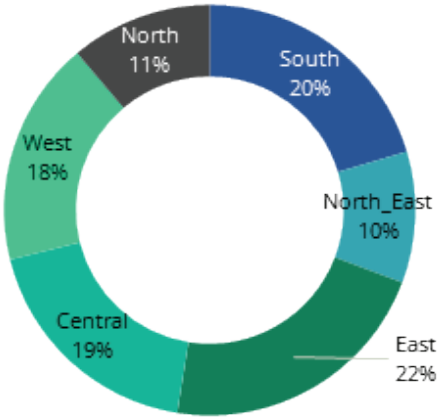
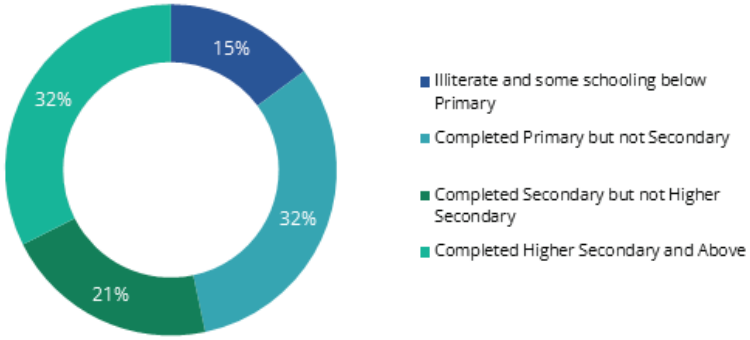


Figure 2: Zone wise distribution of sample



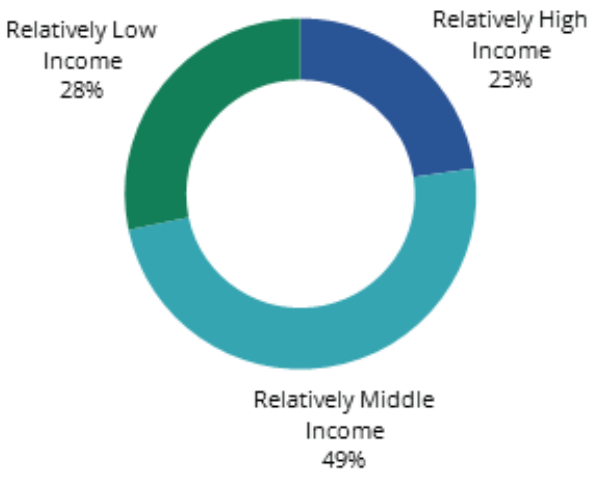
The respondents could be classified into those who were illiterate as well as some schooling below primary (15%), completed primary but not secondary (32%), completed secondary but not higher secondary (21%), and those who have completed higher secondary and above (32%).

Figure 3: Distribution by education levels



[1] *North: Punjab, Haryana, Himachal Pradesh, and Uttarakhand; Central: Uttar Pradesh, Chhattisgarh, and Madhya Pradesh; East: Bihar, Jharkhand, West Bengal, and Odisha; North East: Assam, Nagaland, and Tripura; West: Rajasthan Gujarat, and Maharashtra; South: Andhra Pradesh, Karnataka, Telangana, and Tamil Nadu.*

Figure 4: Income-wise Distribution of Sample



Sixty-three (63%) households had between four and six members. Notably, nearly half of the sampled households had 1-2 members in the age group of 60 years and above. The latter is of importance to this survey as geriatric care or care for the aged who are often chronically ill was also explored as part of this survey.

Finally, the respondents could also be classified in accordance with the proxy income levels of their households (based on the occupation of Chief Wage Earner). Less than a quarter of the sample was from relatively high-income households, while close to half the sample was middle-income households. Around 28% belonged to relatively poor homes.

SECTION 02

Point of accessing healthcare services

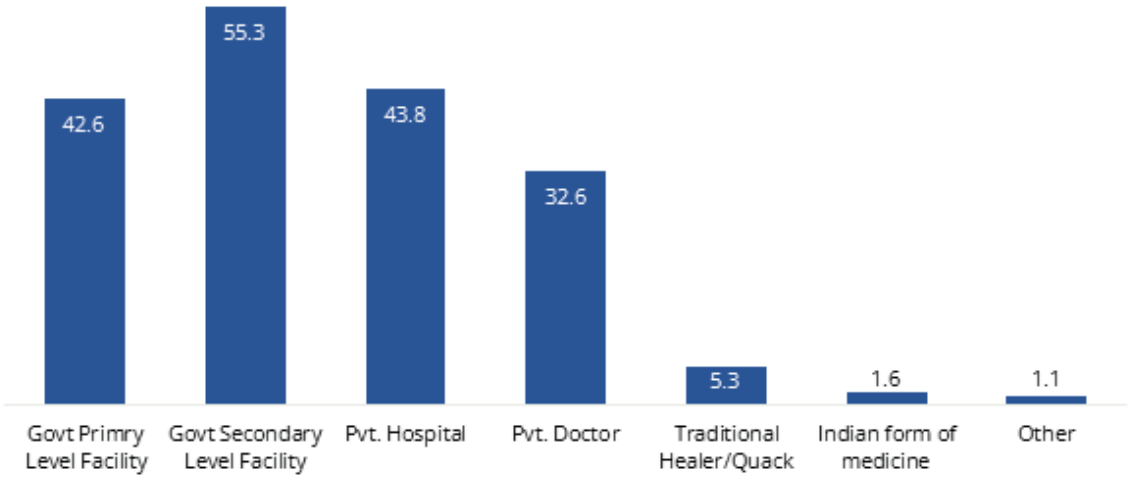
Accessing healthcare is influenced by multidimensional factors socio-cultural and socioeconomic conditions, geographic factors, knowledge, infrastructure, and access. The public and private sectors have been investing in healthcare infrastructure; quality healthcare; digital initiatives like telemedicine health protection schemes and more over the years. There is still a need to enhance the coverage and quality of initiatives to the last mile.

With the study, attempts have been made to understand the diversity in healthcare seeking behaviour across the country based on the severity of the ailment, choice of health facility, dependency on home-based traditional medicine, migration for healthcare, and the expenditure that occurred.

2.1 Source of Treatment

The majority of respondents across the six regions are using government facilities, both primary and secondary levels, for the treatment of small ailments. 55% tend to choose government secondary-level facilities, and 43% tend to choose government-run primary healthcare facilities. Interestingly, 44% even in rural India went to private hospitals for care and 33% went to private doctors.

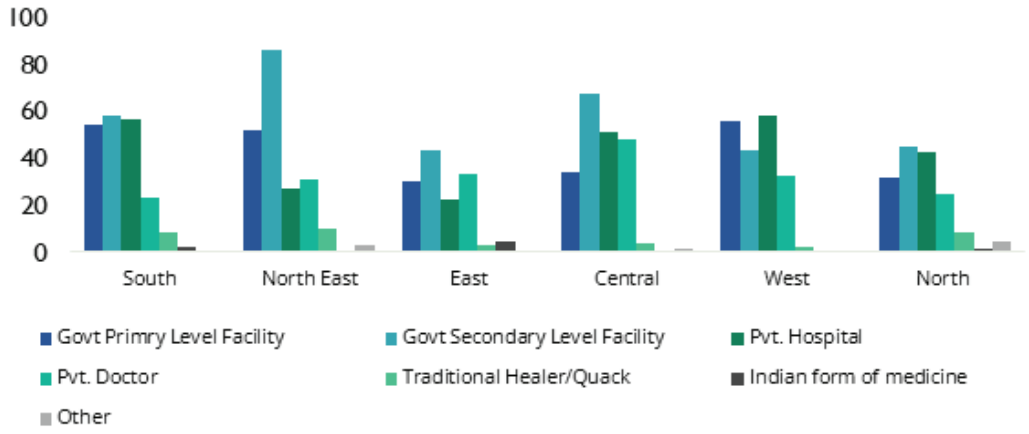
Figure 5: Distribution of Source of Treatment for Small Ailments (%)



Geographically, the consultation with private hospitals even for small ailments was highest in the West and South zones. Dependency on private individual doctors was highest in the Central zone.[2].

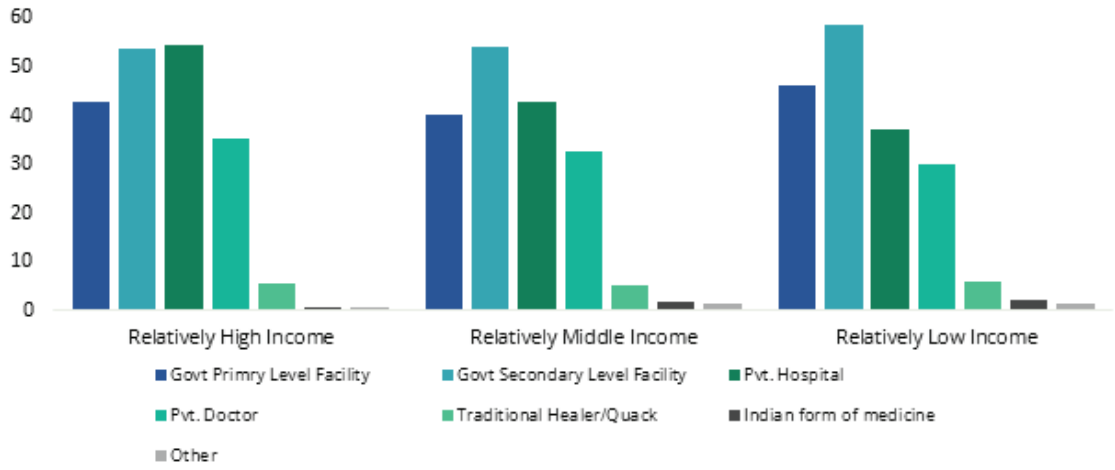
[2] *The achieved sample across zones was as follows: North – 722; Central – 1205; East – 1412; North East – 670; West – 1148; South - 1321*

Figure 6: Source of Treatment-Small Ailment by Geography



Almost the same proportion of respondents across low to high-income groups availed of treatment from public primary-level facilities. The same is the case for public secondary-level facilities. As expected, the proportion of respondents having received treatment in a private hospital is higher in the high-income group at 54.5%, as compared to 37% for the low-income group.

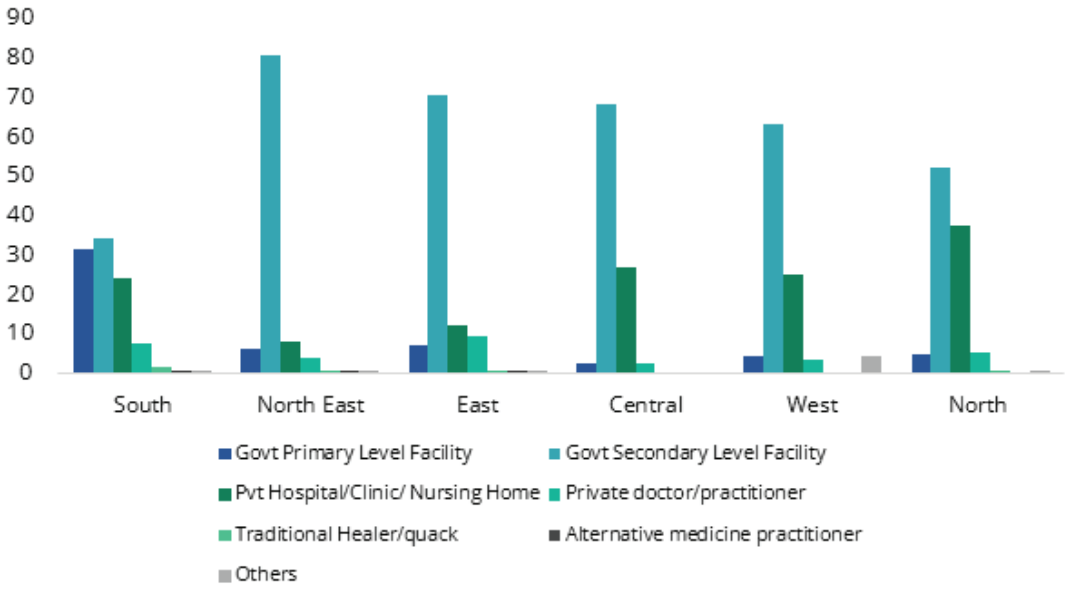
Figure 7: Preference for treatment of small ailments – by income groups



The survey revealed that at an all-India aggregate, a little over 10% of rural India went to a public primary healthcare facility to receive treatment for a serious ailment. The majority would go to a government-run secondary-level facility (60%). About 22% went to a private facility, mostly hospitals, while just over 5% consult a private medical practitioner.

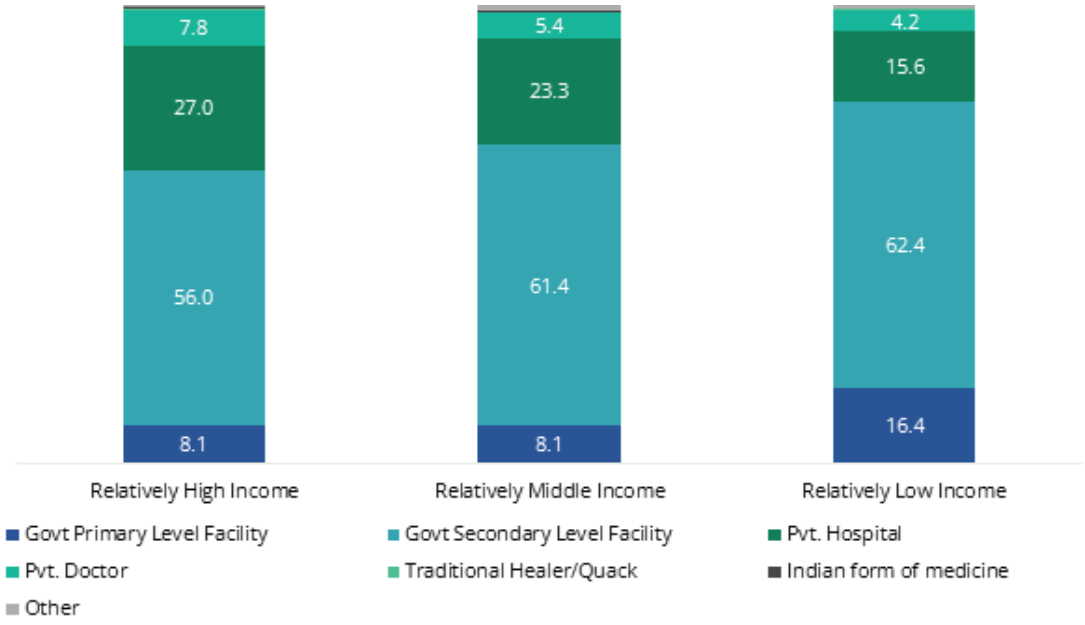
Most respondents in the North, West, Central, East, and Northeastern part of the country prefer public secondary-level facilities as the source of treatment for serious ailments, followed by private hospitals. But in the southern part of the country, the respondents equally prefer public primary-level facilities and public secondary-level facilities, with private hospitals being a distant third for serious ailments. It would seem that the quality of care and reach of public sector primary healthcare facilities is relatively better in the southern states as compared to the rest of the country.

Figure 8: Source of Treatment- Serious Ailment



According to the income categories, nearly two-thirds of the respondents in the lower income group prefer to go to the public secondary level facility as compared to just over 15% who preferred private hospitals. Unlike for small ailments where we had multiple responses on source, here the respondents were asked to specify their first preference for treatment.country.

Figure 9: Preference for treatment of small ailments

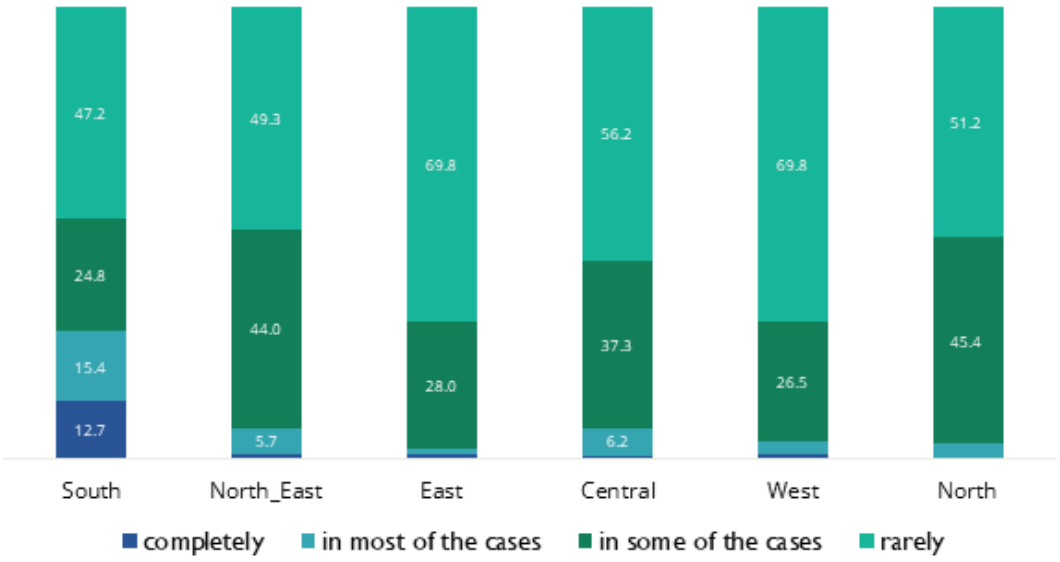


2.2 Dependence on Homebased and Traditional Medicine

India has a rich history of traditional system of medicine based upon six systems, out of which Ayurveda stands to be the most ancient, most widely accepted, practiced and flourishing indigenous system of medicine. The other allied systems of medicine in India are Unani, Siddha, Homeopathy, Yoga, and Naturopathy. Ayurveda is the most dominant system amongst the other Indian systems of medicine and finds its prevalence globally for centuries. In this paper, we have restricted the detailed discussion of various aspects of Indian systems of Medicine (ISM) to Ayurveda alone, and only a comprehensive overview of the other systems is provided in the text. After Ayurveda, the Siddha, Homeopathy, and Unani system of medicine are widely used. Naturopathy is still developing and in future, it may emerge as a flourished system of medicine. Yoga is a system of allied medicine that deals with physical, mental, and spiritual state of an individual.

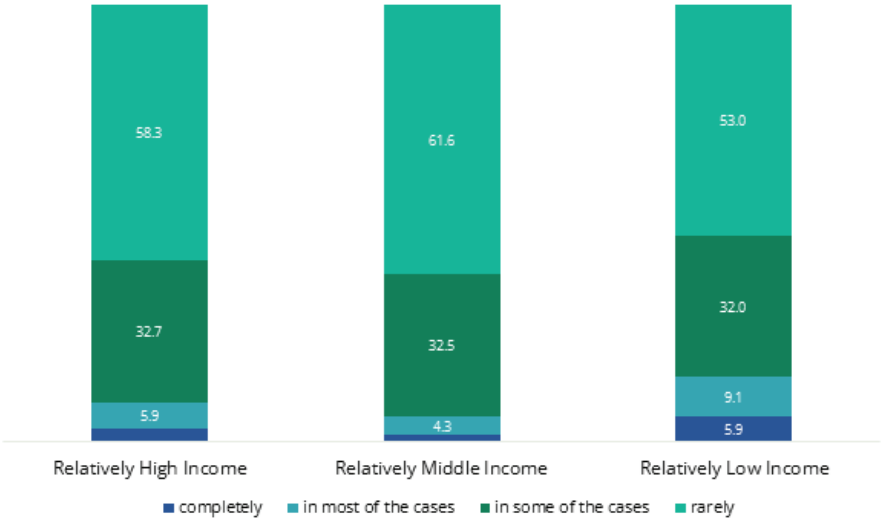
The study found that 58% of rural India rarely depend on home-based traditional medicine. Nearly one in three persons use home-based care/traditional medicine in selective and specific cases, while just over 9% do so with some degree of regularity. Dependency was least among the Eastern and Western parts of the country with 70% of respondents in the Eastern and Western states are rarely dependent on home-based traditional medicine, followed by Central and North India. 45% of the respondent in North India and 44% from the North-East rely on home-based traditional medicine for treatment mostly in some specific cases or ailments. On the other hand, nearly 28% of the respondents from the Southern states reported that they are mostly or even completely dependent on home-based-traditional medicine. From the survey, it is evident that there is a significant inclination towards traditional medicines/treatment methodologies among the populations from the south. However, across all the other zones, there is usage of traditional forms of medicine, albeit in a more selective manner. The growing popularity could be attributed to AYUSH and naturopathy interventions, including the usage of ayurvedic medicines. Also, this is an avenue for policymakers to integrate AYUSH into mainstream health programmes.

Figure 10: Dependance on Home-based/ Traditional Medicine- Zone



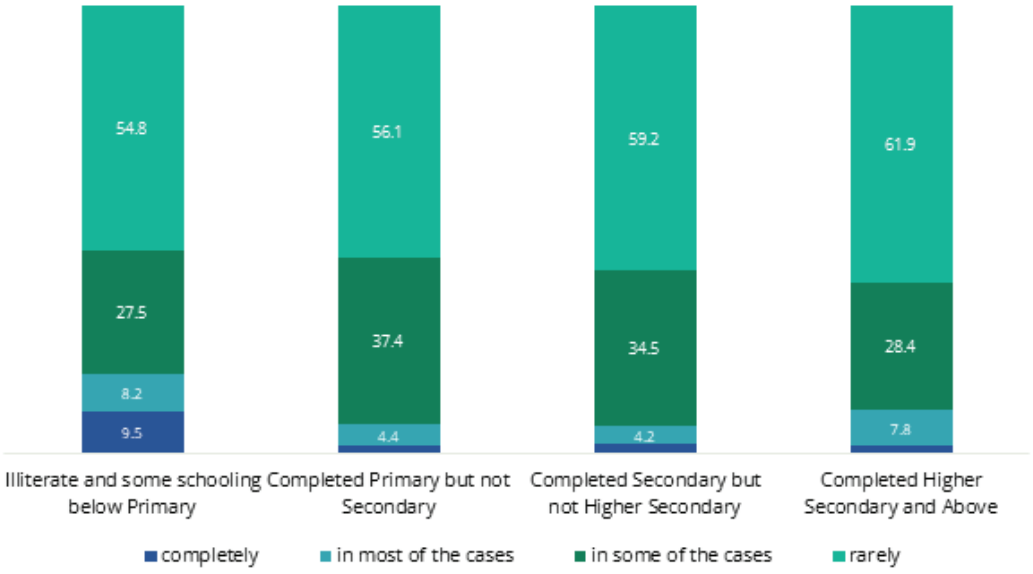
Depending on their occupation, nearly 6% of respondents were from relatively low-income groups who relied entirely on traditional home medicine, compared with 1.5% from relatively middle-income groups and 3.1% from high-income group. Similarly, 9% were from lower-income groups that rely on traditional family medicine for most cases, compared with 4.3% from the middle-income group and just below 6% from the higher-income group. Interestingly, the data shows that the proportion of respondents who rarely or occasionally rely on home-based traditional medicine is roughly equal among high, middle, and low-income groups.

Figure 11: Extent of Dependence on Home-based/ Traditional Medicine



According to their educational background, just under one in 10 respondents who were illiterate or had primary education or less reported having full dependency on home-based traditional medicine. On the other hand, this dependency was less than 2% among those who had completed higher secondary education or above.

Figure 12: Dependence on Home-based/ Traditional medicine- Education background

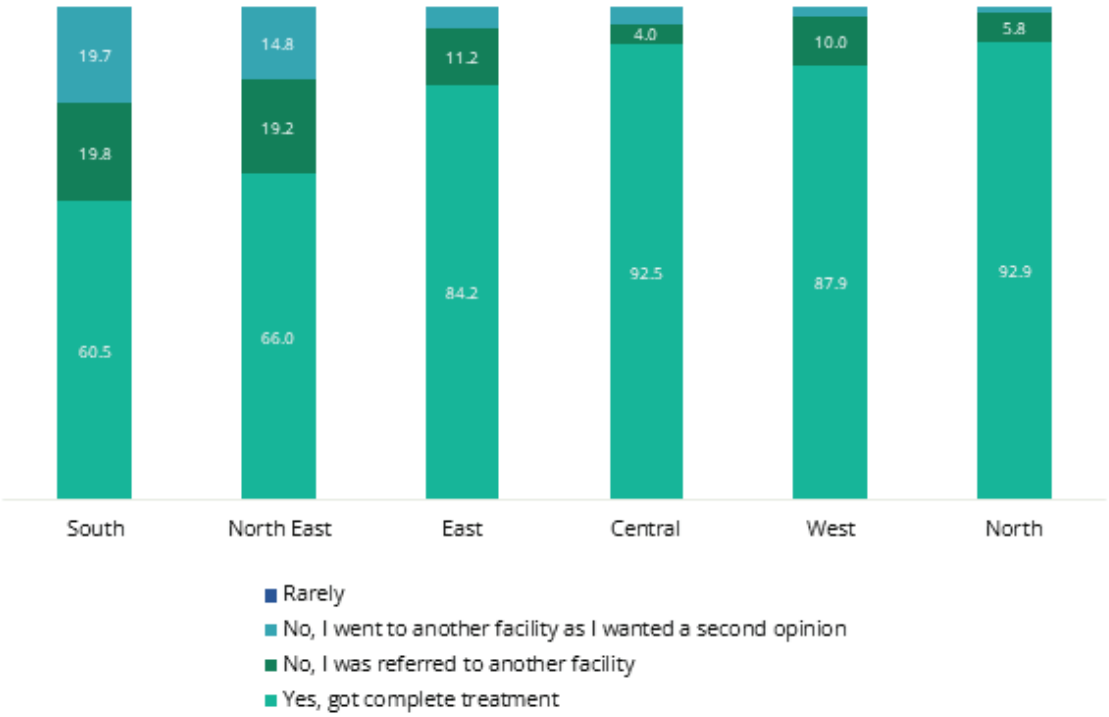


2.3 Receiving Complete Treatment in First Facility Availed

The majority of the respondents in these six regions mentioned that during the last serious ailment of the patients in the household, they received complete treatment in the first facility they visited. More than 92% of the households from North and Central states had received complete treatment in the first facility visited; this was followed by Western and Eastern states. On the other hand, only 20% of the respondents from the South and 19% from the North East had reported having been referred to another facility for treatment[3].

[3] *Respondent base: North – 551; Central – 643; East – 1111; North East – 568; West – 718; South - 1255*

Figure 13: Zone wise pattern of treatment in first facility accessed



SECTION 03

Migration from locality in quest of quality care

When quality health services are not available in the nearby health facilities, the patients are bound to migrate to other locations for seeking better healthcare. In India, temporary migration within or outside the state to avail better healthcare services has been a normal phenomenon for decades, mainly due to structural deficits in healthcare facilities, especially in cases of serious or critical illness. The need as well as the availability of health services is not uniform across the states. In the primary and secondary health centres, the availability of human resources and essential requirements such as hospital beds, physical infrastructure, drugs, and diagnostics, sometimes do not match the local demand or disease burden. These circumstances compel patients to relocate to tertiary healthcare centres within or outside the state in order to seek improved medical care.

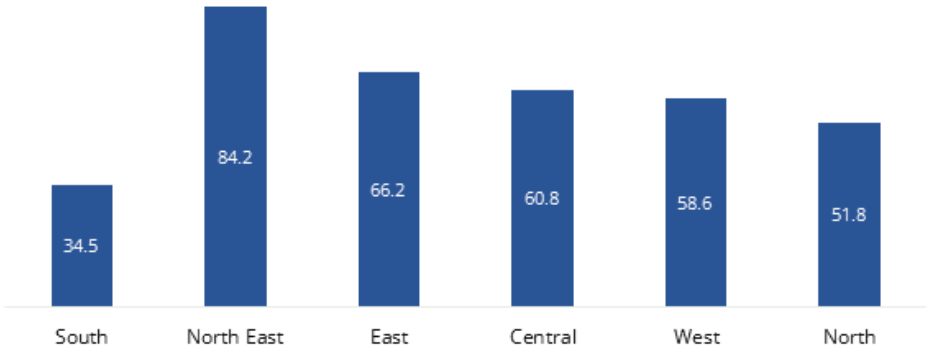
Over the past decade, India has gained a reputation for providing high-quality medical services at low costs to medical tourists travelling from across the globe. The potential for the 'Health & Wellness Hub' developed through centuries of wisdom of this ancient civilization needs to be fully tapped. While International Medical Tourism has gained momentum, 'Domestic Medical Tourism' has been overlooked.

The findings of this study indicate that a large proportion of the participants opt to relocate from their current area in order to receive improved medical care for severe illnesses and surgical procedures. According to a survey, nearly 58% of the respondents had said that it is a general trend for people in their neighbourhood to migrate for seeking better health facilities for the treatment of critical illness.

3.1 Migration for different degrees of illness

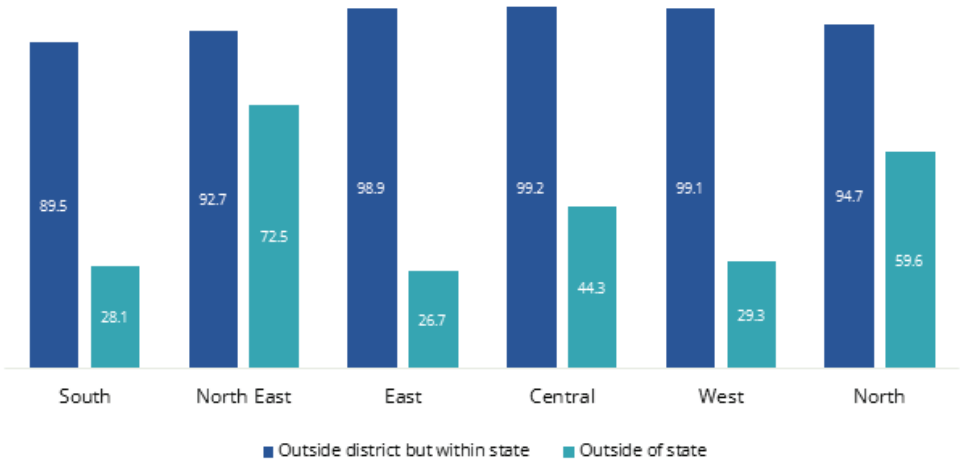
In the study, an attempt was made to understand the reason and pattern of such migrations along with the expenses in treatment received outside. The findings of this study indicate that a large proportion of the participants opt to relocate from their current area in order to receive improved medical care for severe illnesses and surgical procedures. According to the survey, the Northeastern states have the highest preference for migration (84% of respondents) in search of better medical treatment. This is closely followed by Eastern India with 66%, and Central India with 61% expressing similar intentions. More than half of the respondents from the North and West prefer to migrate for better treatment. On the contrary, more than two-thirds of the respondents from the South felt no need to migrate out for treatment.
According to the study, a large majority of the participants, accounting for over 90%, had expressed a preference for moving to a different district within their state rather than to a different state when faced with a serious illness.

Figure 14: People choosing to Migrate from Locality for Serious Ailments/Surgeries – Zone wise



The majority of respondents from the Northeast, accounting for nearly 73%, expressed a preference for migrating outside their state, while the figure stood at 60% for respondents from the North region. This indicates a higher inclination towards migration outside the state in Northeast and North and Central India compared to other regions[4].

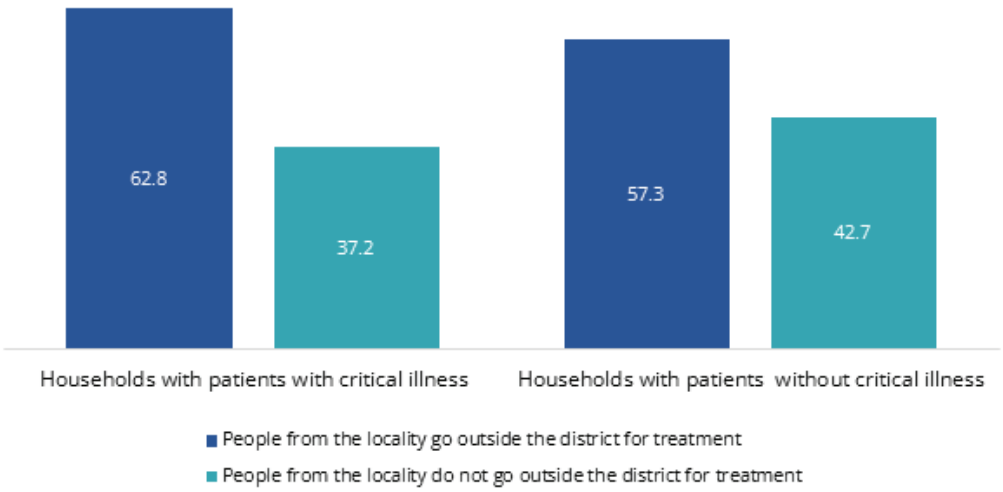
Figure 15: Inter/Intra-State Migration for Serious Ailments



The survey also looked at the distribution of people choosing to migrate for treatment for serious ailments/surgeries among households having patients with chronic illnesses. About 63% of the surveyed populations (family members suffering from NCD) chose to migrate to other states to avail of better healthcare services. 73% of such people (or families) in northeastern states 60% in northern states prefer to avail treatment outside the state[5].

based-traditional medicine. From the survey, it is evident that there is a significant inclination towards traditional medicines/treatment methodologies among the populations from the south. However, across all the other zones, there is usage of traditional forms of medicine, albeit in a more selective manner. The growing popularity could be attributed to AYUSH and naturopathy interventions, including the usage of ayurvedic medicines. Also, this is an avenue for policymakers to integrate AYUSH into mainstream health programmes.

Figure 16: Migration in Households with/without chronic illness

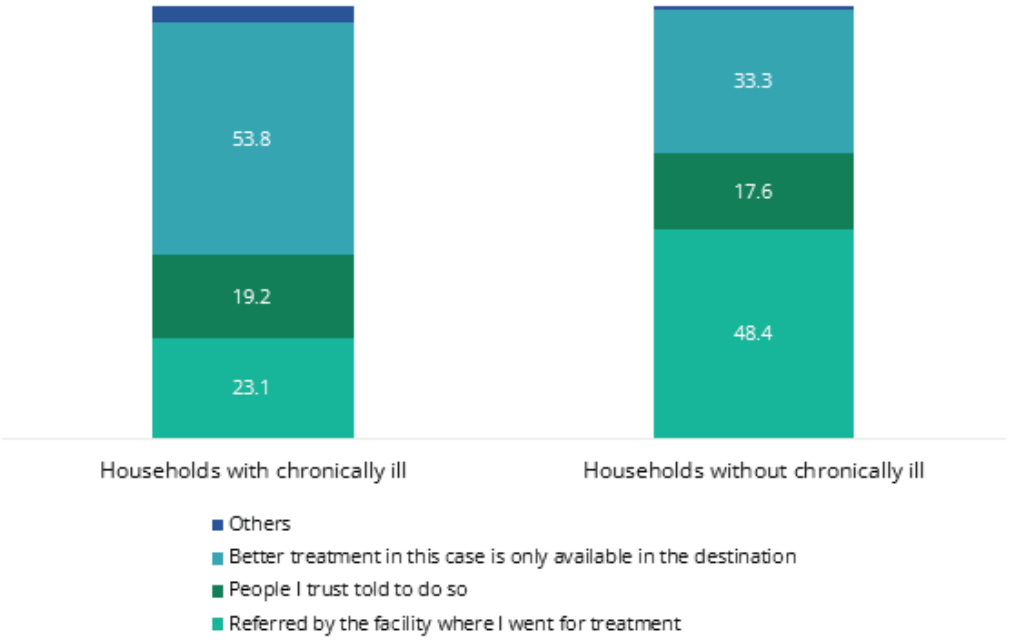


[4] Respondent base: North – 374; Central – 733; East – 935; North East – 564; West – 673; South - 456
[5] *Households has member/s suffering from chronic illness = 427; household does not have any member suffering from any chronic illness = 6051*

3.2 Reason for going out of State for Medical Treatment within State

Among those with chronically ill household members, the driving factor for going out of state for treatment was the destination having better treatment facilities. For those without any chronically ill members at home, the majority did so because of a referral given from the place they were receiving treatment.

Figure 17: Reason for going out of state for medical treatment



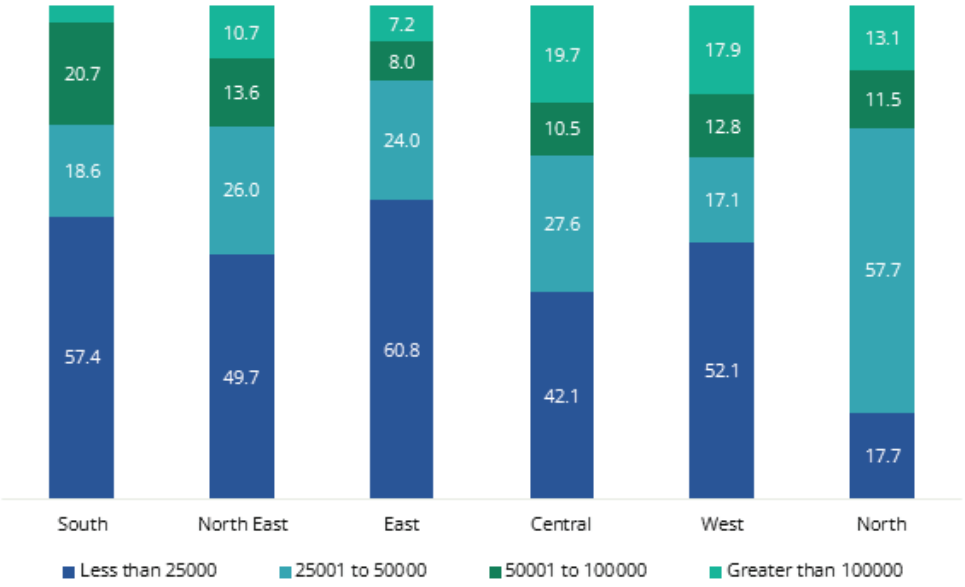
3.3 Expenditure on Medical Migration

The survey indicates that among the households that migrated out of their home district for treatment, 51.6% of the households spent less than INR 25000 and about 25% spent between INR 25001 and 50000[6]. The analysis of survey data on medical treatment expenses incurred outside the district, categorized by geographic zones and states, reveals varying spending patterns.

The South zone had the highest proportion of respondents (57.4%) spending less than 25,000, while the East zone showed the most significant percentage (60.8%) in this category. In contrast, the North zone had the highest percentage (57.7%) of respondents spending between 25,001 and 50,000. The Central zone displayed a relatively even distribution of spending across all categories. The West zone had 17.9% of respondents with expenses exceeding 100,000, while the North-East zone had 10.7%. These findings provide valuable insights for policymakers and healthcare providers to address the varying financial challenges faced by individuals seeking medical treatment outside their district and design targeted interventions to ensure equitable access to healthcare services.[7]

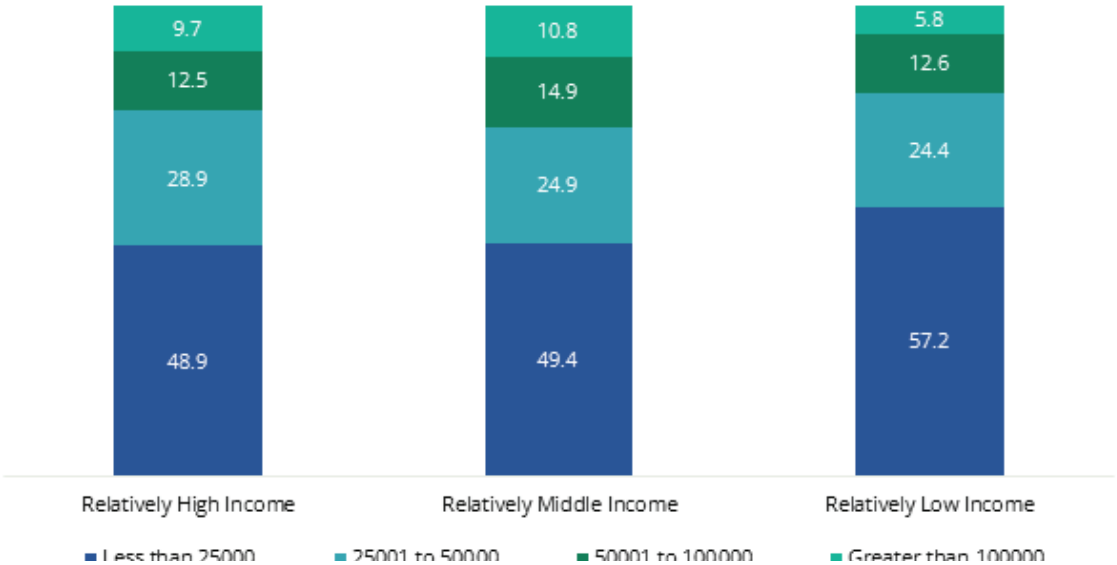
[6] *Respondent base: 1393 (households that migrate)*
[7] *Respondent base: North – 130; Central – 76; East –375; North East – 308 West – 117; South - 387*

Figure 18: Expenditure incured by household for medical migration by zone



The survey reveals distinct spending patterns based on income groups. Individuals from the Relatively High Income group exhibited a relatively higher proportion (48.9%) of spending less than 25,000 on treatment. Moreover, a substantial number (9.7%) from this category had medical expenses exceeding 100,000.8 Respondents from the Relatively Middle Income group also had a significant portion (49.4%) with expenses less than 25,000. However, the percentage of respondents with expenses exceeding 100,000 (10.8%) was comparable to the Relatively High Income group. In contrast, individuals from the Relatively Low Income group had the highest percentage (57.2%) spending less than 25,000. Furthermore, only a small fraction (5.8%) faced treatment expenses exceeding 100,000.

Figure 19: Expenditure Incurred by Household for Medical Migration



8 *Respondent base: Relatively high income: 329, Relatively middle income:650, Relatively low income:414*

SECTION 04

Digital Health Telemedicine

With the recent technological advancements, healthcare has gained a multi-disciplinary approach which comes through the intersection of technology and healthcare. With improvements like healthcare informatics, electronic records, mobile applications, etc., digital health has provided access to remote and advanced care. Digital health innovations are designed to help save time, boost accuracy and efficiency, and combine technologies in ways that are new to healthcare.

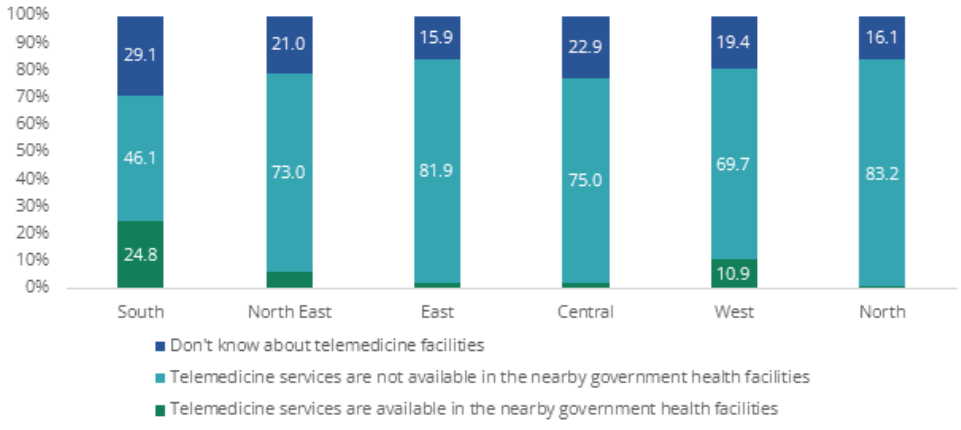
The Ayushman Bharat Digital Mission (ABDM) aims to develop the backbone necessary to support the integrated digital health infrastructure of the country. It will bridge the existing gap among different stakeholders of the healthcare ecosystem through digital highways. Ayushman Bharat Digital Mission (ABDM) will provide choice to individuals to access both public and private health services, facilitate compliance with laid down guidelines and protocols, and ensure transparency in pricing of services and accountability for the health services being rendered. One of the biggest benefits of digital healthcare is telemedicine. It is the provision of remote clinical service in which a patient can connect with a remotely placed doctor via virtual means and through audio-visual communication, and in the process, completing the treatment process. This can be a boon to the remote areas where the reach of specialist doctors can be ensured where otherwise no doctors are present. This can have a significant impact on saving time and money. eSanjeevani is Govt. of India's free telemedicine service integrated with NHA's Ayushman Bharat Digital Mission (ABDM). With its linkage through Ayushman Bharat Health Account (ABHA) it is possible to link and manage the existing health records like prescriptions, lab reports etc. which doctors can access for better clinical decision-making and ensuring the continuum of care.

While there are many benefits of the digital health mission, several concerns have been raised by experts. Like in most online services, privacy is a major threat. Another major issue dealt with by many digital services is the exclusion of certain people. This could be due to a number of factors, one of which being digital illiteracy.

In the study, attempts were made to understand the level of reach of digital health interventions in rural India. According to the study, a mere 9% of the respondents have utilized telemedicine services while in the case of patients suffering from critical illnesses, the utilization of telemedicine services was found to be in 12% of households.

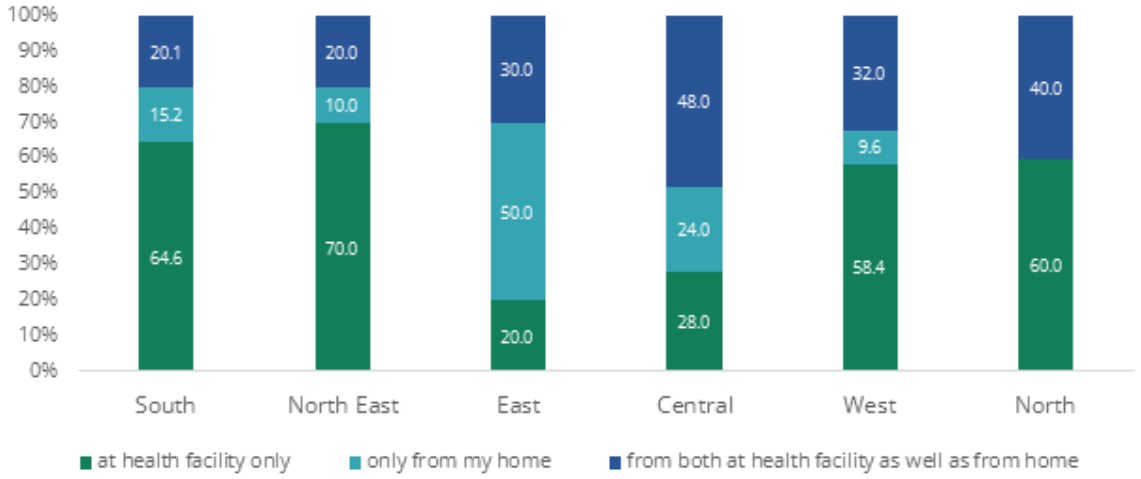
According to the research findings, it is revealed that the majority of the nearest government health facilities in different regions of India lack telemedicine services. Specifically, the North region has the highest percentage of facilities without telemedicine services at 83%, followed by the East region at 81%, Central India at 75%, the Northeast at 71%, the West at 70%, and the South at 46%. In the southern region, 25% of the nearby facilities offer telemedicine services, while 29% of the population is unaware of any telemedicine facility available.

Figure 20: Information on availability of telemedicine facilities in the nearest government health facility



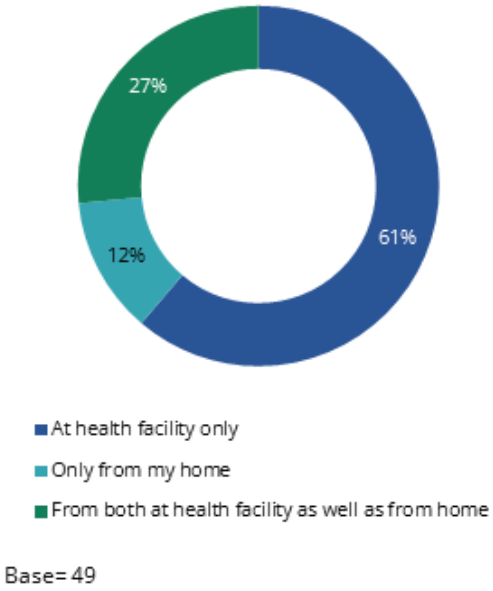
The majority of people who have used telemedicine services accessed them mainly from healthcare facilities in the North East region, accounting for 70%. This is followed by the South with 65%, the North with 60%, and the West with 58%. Around 50% of the participants from the Eastern region utilized telemedicine services from their residences, while in the Central region, 48% of the respondents accessed such services both from health facilities and their homes.

Figure 21:Access of telemedicine services by Zone



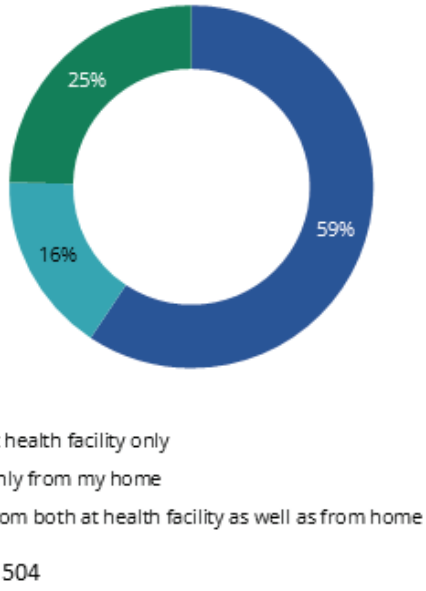
A majority of families, about 61%, utilized telemedicine services provided at health facilities when dealing with critical illnesses in their patients, while a significantly smaller proportion of only 12% accessed these services from their own homes. The same trend applies to households with non-critical patients.

Figure 22: Households with family members Suffering with chronic illness



Base= 49

Figure 23: Households with no family members Suffering WITH chronic illness



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SECTION 05

Access to Diagnostic services

Diagnostic examinations play a vital role in the stages of disease management. It can help in the accurate diagnosis of diseases or medical conditions and with the help of data, doctors can make apt interpretations and opt for a specific treatment route. Diagnostic services are important for screening purpose and it also aids in the monitoring of patients who have an incurable disease. While some diagnostic tests can be done very cheaply, there are several tests that can burn a hole in a patient's pocket. For poor rural people, the affordability, as well as availability of diagnostic services, becomes very critical.

One of the National Health Mission priorities is to provide free diagnostic service under "Health for All". The objective of the free diagnostics services is to ensure availability and access to diagnostic tests at public health facilities so as to reduce the out-of-pocket expenditure incurred by patients on diagnostics. The study tries to find out the reach of diagnostics services availed or provided to the beneficiaries.

5.1 Usage of diagnostic services

As per the survey conducted, 63% of the respondents availed the diagnostic services from Government Secondary level facilities and only 19% of respondents availed the diagnostic service from Government Primary level facilities.

Figure 24: Proportion of survey participants who had gone in for diagnostic services

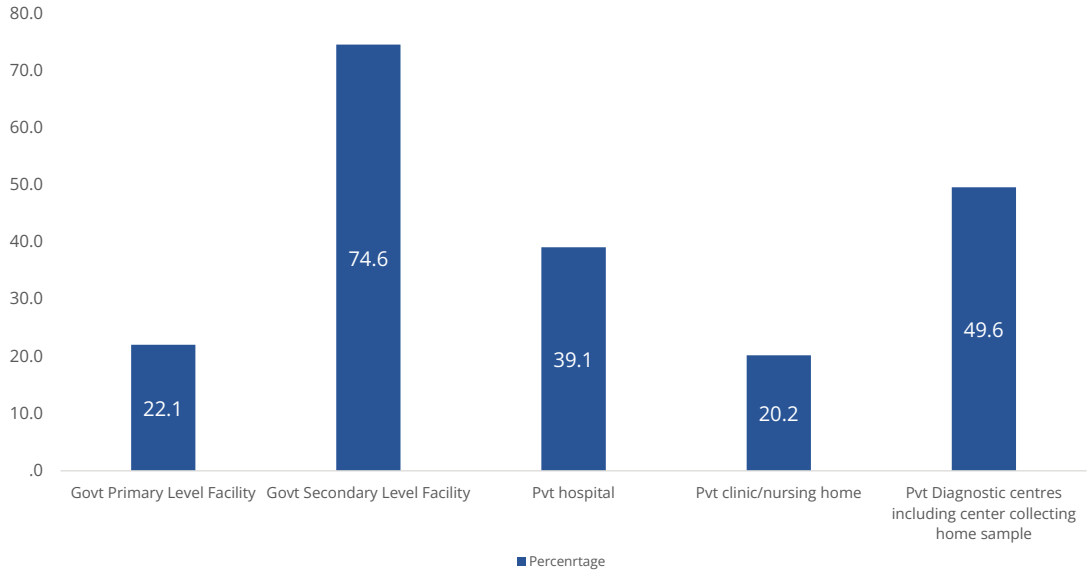
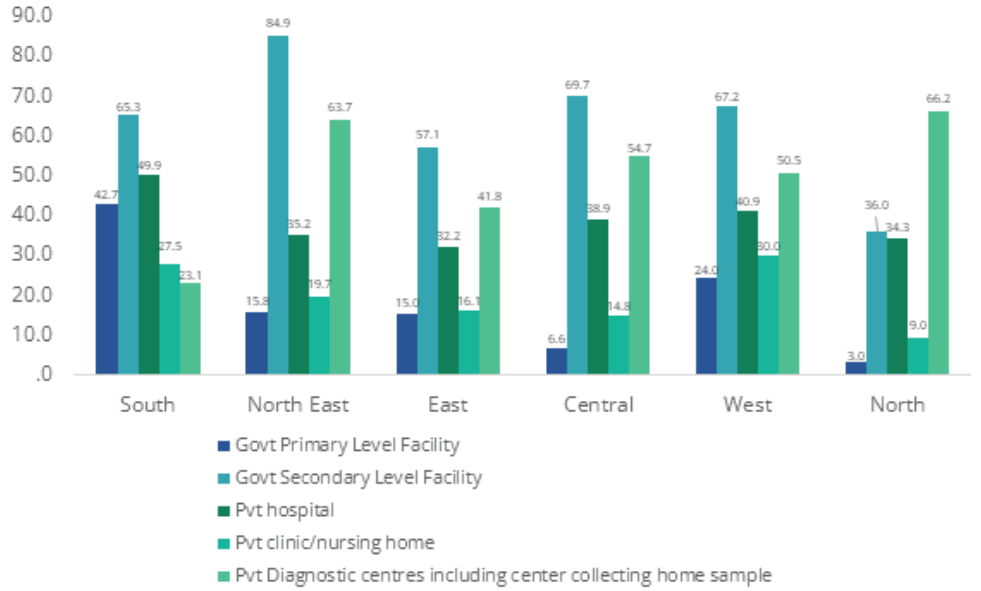


Figure 25: Place of accessing diagnostic services by location

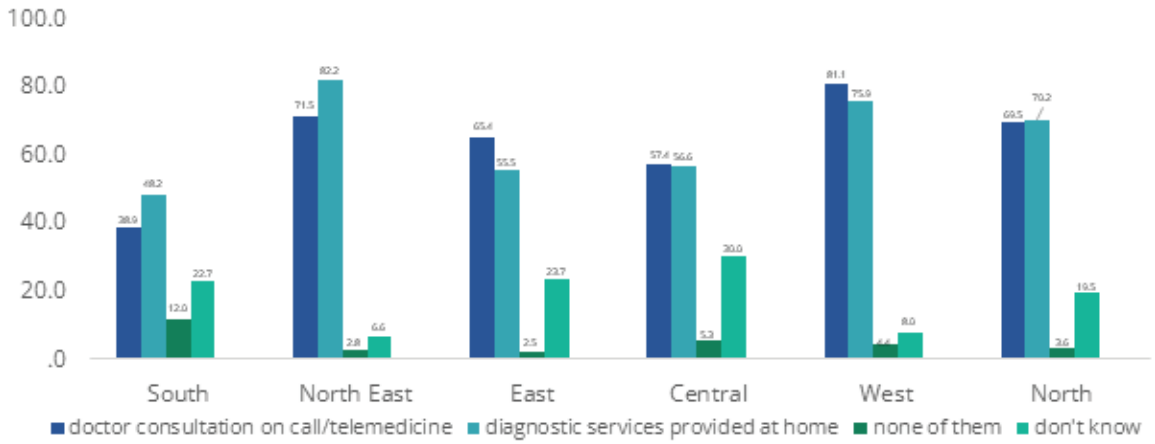


People's health concern for taking care of their own health and the demand for diagnostic tests has increased rapidly in the past years. The study tried to look at the diagnostic service availed in public health facilities and private diagnostics centres in India. The survey findings show that 63% of the respondents availed diagnostic services in the Government Secondary level facility and 19% respondents availed this service from Primary level health facility. 47% of the respondents availed the doorstep Private diagnostics services, which is 66% in the North region and 23% in the south region states. 52% of the respondent's family members with chronic illness availed services for doorstep delivery for diagnostic services.

The survey further shows that 33% of the respondents had availed of direct delivery of diagnostic services, out of which 14% of doorstep delivery diagnoses were done by government health facilities and 14% of doorstep delivery diagnoses were done by private agencies. When it comes to the diagnostic services for patients with chronic illness, the findings show that 52% of the patients have availed the doorstep delivery of diagnostic services, of those who opted for diagnostics services.

The survey also looked at the health care services expectation of the respondents; 62% of the respondent expressed that if "on-call doctor consultation" and "diagnostic services" are provided, that will be very helpful for the families. More than 50% of the respondents from all the regions showed expectation for the services "on-call doctor consultation" and "diagnostic services" except the South region.

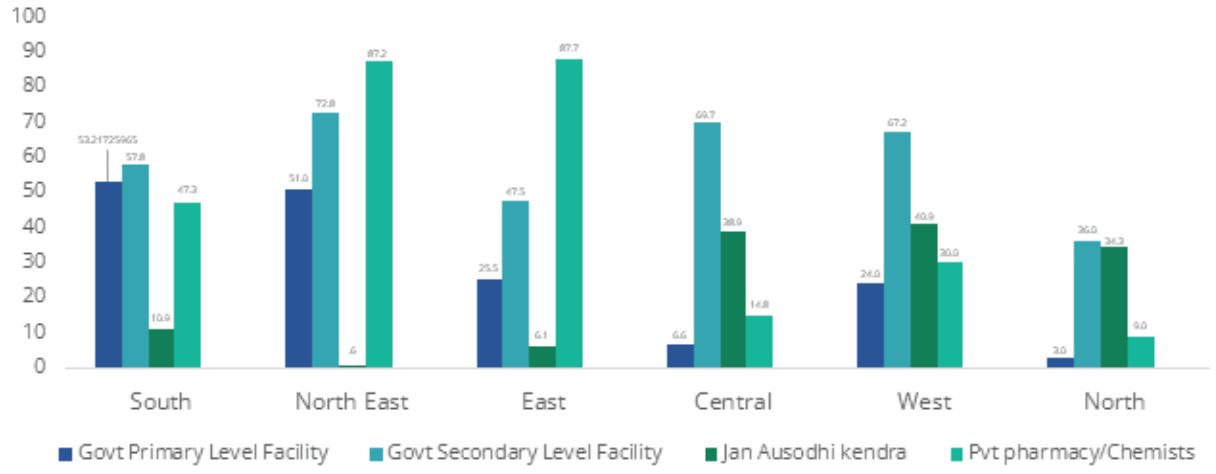
Figure 26: Preference / Expectations of people for diagnostic services and tele-medicine services



5.2 Jan Aushadhi Kendra

To bring down the healthcare budget of every Indian citizen, the Ministry of Health and Family Welfare introduced Jan Aushadhi Kendra, which provides quality generic medicine at an affordable price and provides free medicines from health facilities. The study shows that 37% of respondents availed of free medicine from Government Primary level health facilities and 55% availed of medicine from Government Secondary level health facilities. 10% of the respondents purchased medicines from the Jan Aushadhi Kendra and 75 % of respondents purchased medicines from Private Pharmacy.

Figure 27: Region-wise medicine purchasing/procuring of medicine



More than 50% of the respondents had said that they availed free medicine from the Government Secondary level health facility. The study also shows that 75% of the respondents have purchased medicine from private facilities. Except for the South, purchasing of medicine from private pharmacies/ chemists is more than 70% in all the other regions of India.

SECTION 06

Ayushman Bharat Health Account (ABHA) Card and other Government Services

The Ayushman Bharat Digital Mission (ABDM) aims to develop the backbone necessary to support the integrated digital health infrastructure of the country. ABDM bridges the existing gap amongst different stakeholders of healthcare ecosystem through digital highway. One of the important components of this Mission is that each beneficiary should have an Ayushman Bharat Health Account (ABHA) card and avail health care services using this card, which will help to reduce the health expenses burden. ABHA card is a health insurance card issued by the government of India which provides health insurance coverage to Indian citizens who are below the poverty line. The cardholders can use their ABHA card to avail of free medical treatment at any government hospital or health center across India. The ABHA card also entitles the holder to get discounts on medicines and other medical expenses.

6.1 Penetration and usage of ABHA cards

The study tries to find out the few key features of this program like awareness, availability, and status of getting benefits of the ABHA card, etc. The findings from the study show that 23% of the respondents have an ABHA card and among them, 30% have availed the health services through the ABHA card. The region-wise coverage of a few indicators shows that 48% of the respondents from the southern region have availed of the ABHA health card services and it is low in North and Central region states. The awareness level among the respondents is promising, as around 85% of the interviewed respondents were aware of the ABHA health card.

Figure 28: Awareness and penetration of ABHA card by zone

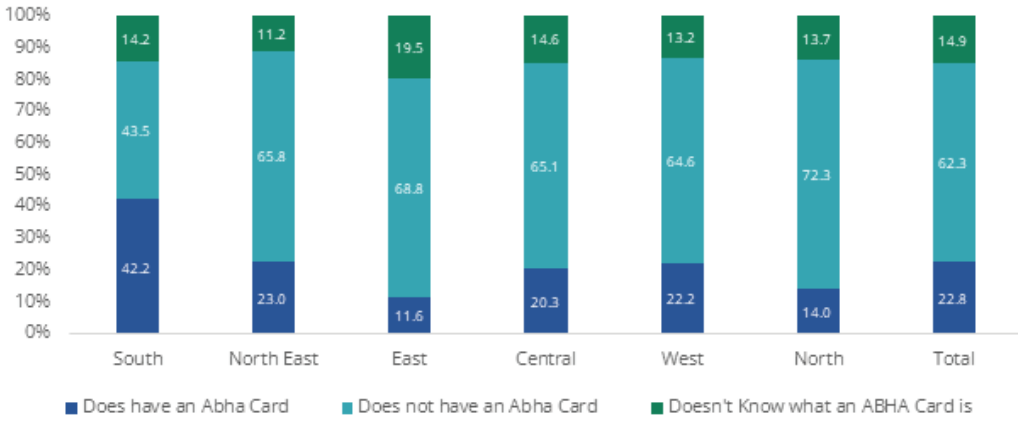
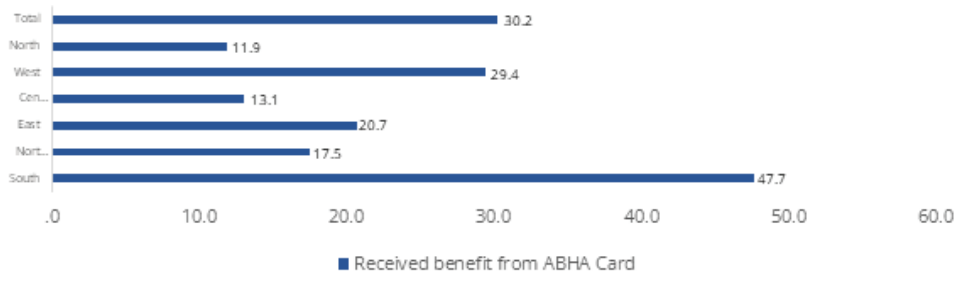
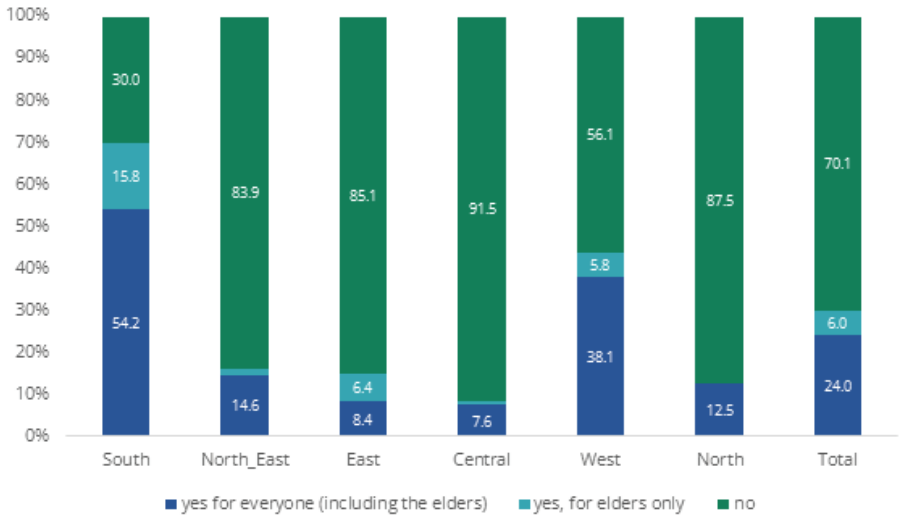


Figure 29: Received benefit from ABHA card



6.2 Health tracking of elderly and chronically ill

Figure 30: Perception on health record keeping at facility



The above diagram indicates that at an all-India aggregate, 24% of the respondents had reported that there is a system in place where frontline health workers in their village maintain a registry for all those who are chronically ill in the village (including elderly) so that their health can be tracked by doctors. 6% said this facility was only available for the elderly in the village. As far as tracking is concerned, the South and West zones are far in advance of the rest of the country.

6.3 Health expenses of chronically ill

Health expenses impact each individual and family a lot, and to address this, the National Health Mission aims to provide free health services. The study tried to know on an average how much amount has been spent and how much free medicine each chronic ill patient gets from the health facilities. The average expenditure on a patient under critical illness was found to be close to Rs.5000 while they received Rs. 1600 worth of medicine free of cost.

Figure 31: Monthly medical expenses of patients with chronic illness

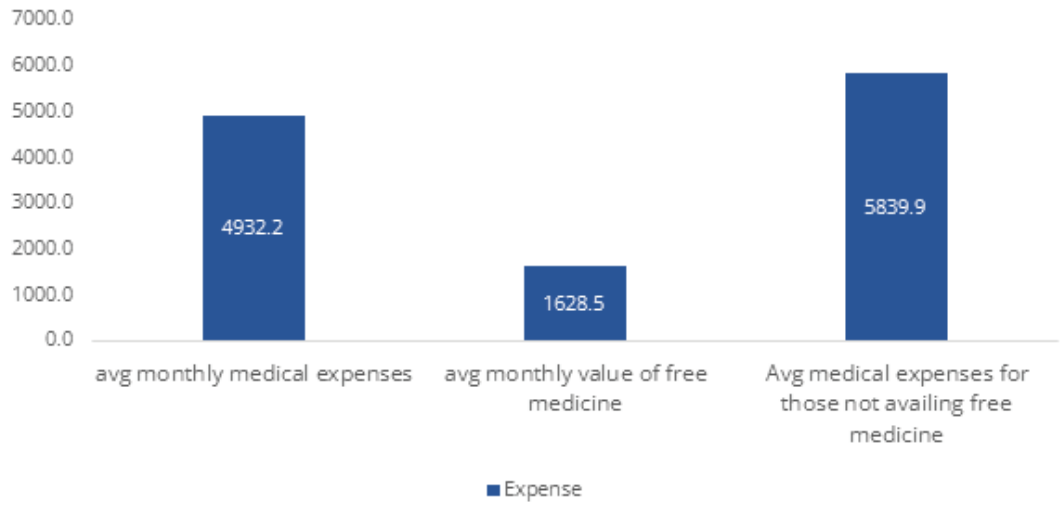
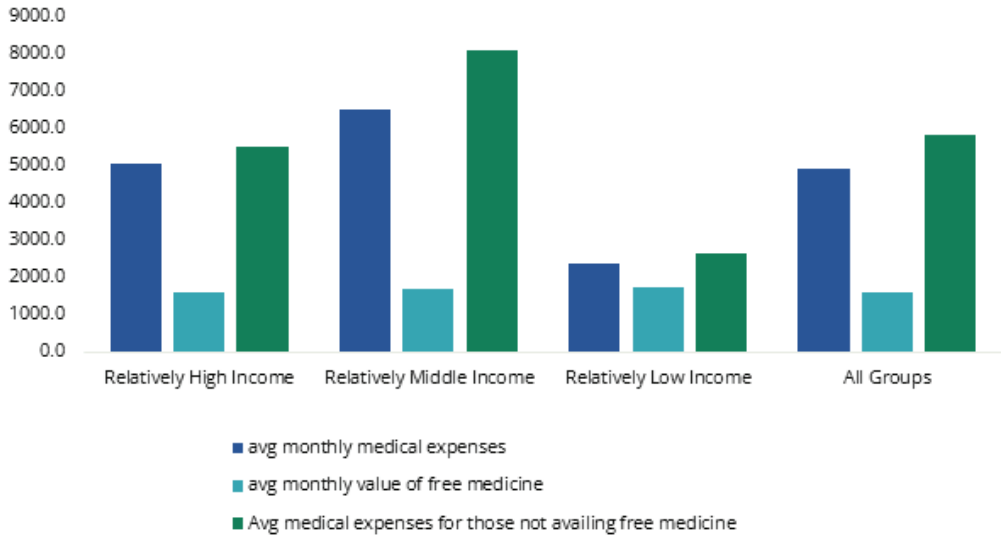


Figure 32: Monthly medical expenses in households with chronically ill



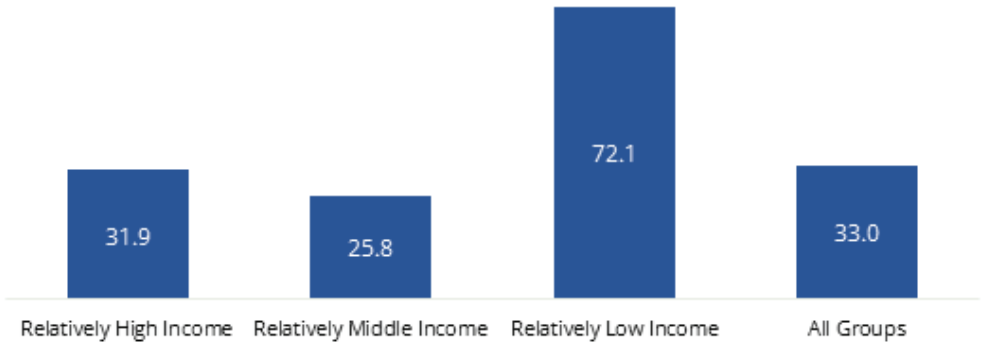
In India, most patients seeking treatment for acute or chronic diseases were facing a silent crisis in access to essential drugs. India has some of the highest Out of Pocket Expenses (OOPE) when it comes to healthcare, drugs constitute over 67% of out-of-pocket expense on healthcare (NSSO 68th round).

If quality essential drugs are provided free of cost to all patients visiting public health facilities, it would bring significant saving to the patients. Hence, the provision of free drugs has one of the most important intervention towards mitigating the burden of healthcare cost. Sustainable Development Goals to achieve universal health coverage can be attained via. safe, effective, quality and affordable essential generic medicines.

Ministry of Health & Family Welfare, Govt. of India has recognized the importance of essential drugs being available and accessible at public healthcare facilities. So, in 2015, the "Free Drugs Service Initiative" (FDSI) was launched under the National Health Mission (NHM). The guidelines emphasise on procurement of generic essential medicines at low prices, eliminating irrational medicines and unscientific fixed-dose combinations.

The survey revealed the true extend of impact of this free medicine scheme. To the relatively low income household with at least one chronically ill patient, the subsidy is to the tune of 72% of the total monthly health expenses.

Figure 33: Value of free medicine as percentage of monthly expense



SECTION 07

Support for Mental Health and facing physical abuse

Mental health issues have become more concerning now in India. In 2017, 197·3 million (95% UI 178·4–216·4) people had mental disorders in India, including 45·7 million (42·4–49·8) with depressive disorders and 44·9 million (41·2–48·9) with anxiety disorder s. To address this the Government of India has launched the National Mental Health Program in 1982. Domestic violence and psychological/ emotional violence with women in India has been a problem for long which has evolved as a social, community, criminal justice, and public health issue. Section 498A covers mental cruelty done to a wife by husband and relatives in relation to demand of dowry, child procreation or for any other purpose. Such an offence can attract punishment up to 3 years with heavy fines and it is non- bailable. On top of this, nearly one-third of women in India have experienced physical or sexual violence, finds the National Family Health Survey-5 report. While domestic violence against women has declined from 31.2% to 29.3% in the country, 30% of women between the age of 18 and 49 have experienced physical violence since the age of 15 years, while 6% have experienced sexual violence in their lifetime. Only 14% of women who have experienced physical or sexual violence by anyone have brought up the issue.

In the study, attempts were made to know the status of the availability of treatment for women subject to physical/ mental abuse and treatment availability for mental health issues in rural India. The study findings show that 28% of the interviewed respondents knew that their nearest PHC had a provision for the treatment of women subjected to physical and/or mental abuse in India. The region-wise findings show that 48% of the respondents from the western region states said that the nearest PHC they visit for ailments had the provision for treatment subject to physical and mental abuse, which is highest among the other regions. The lowest occurrence is in the North region (14%). 11% of the respondents also said that there is an alternative provision available for treatment where the PHC doesn't have the provision for treatment of mental/physical abuse.

7.1 Information regarding availability of services for women facing mental health issues and physical abuse

Figure 34: Whether the nearest PHC/HWC has provision for services for of physical or/and mental abuse for women

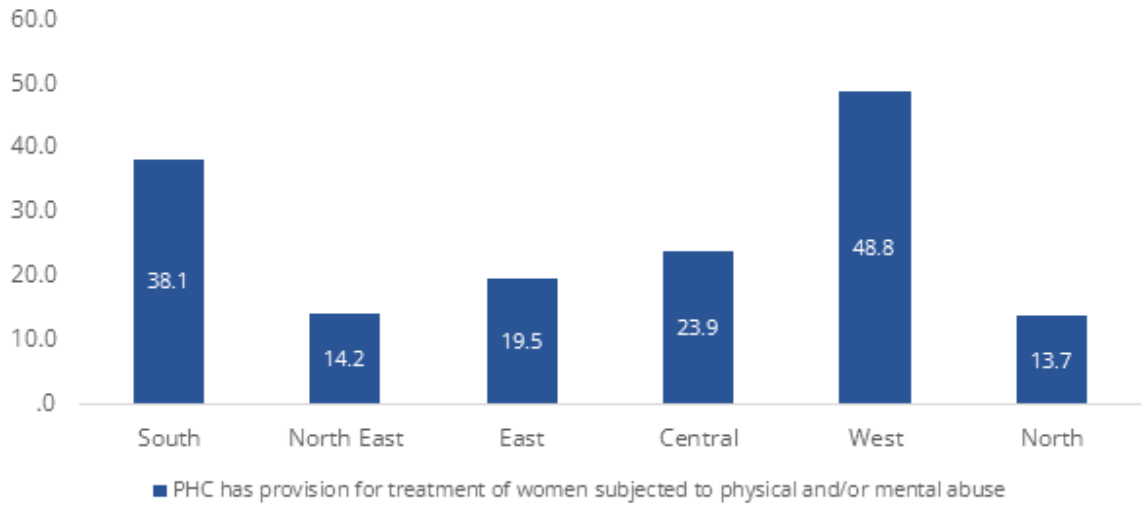
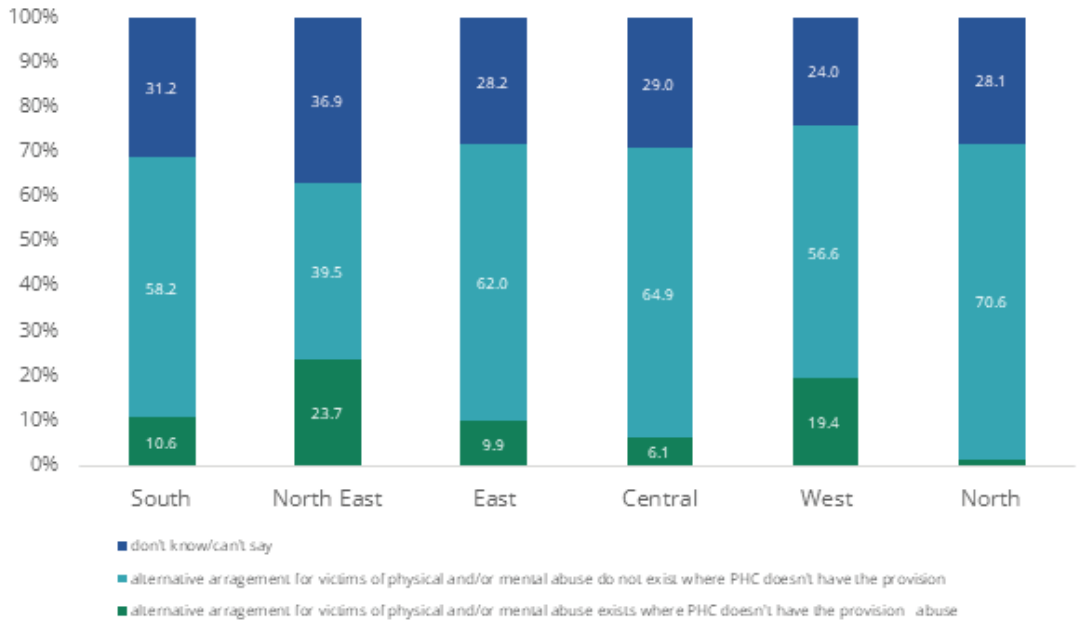


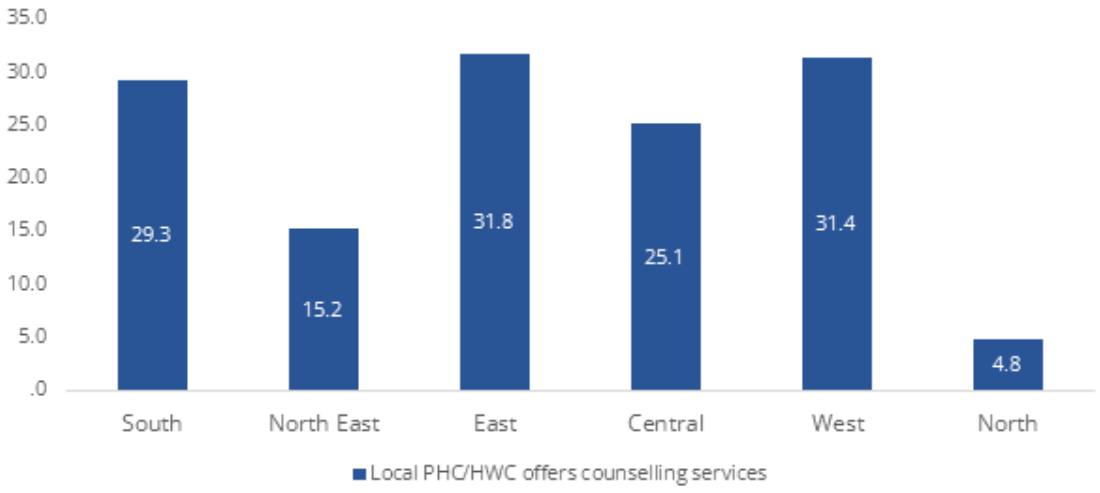
Figure 35: Availability of alternate arrangement for people in need of support in case of mental health issues and physical abuse



7.2 Availability of counselling services for people in need of mental health support

Counselling can provide a wide range of benefits for those who have experienced intimate partner abuse. It can improve self-esteem and help with mental health difficulties like depression, anxiety, and PTSD. Therapy can also help survivors of domestic abuse process their traumatic experiences and let go of anxiety and depression. It may

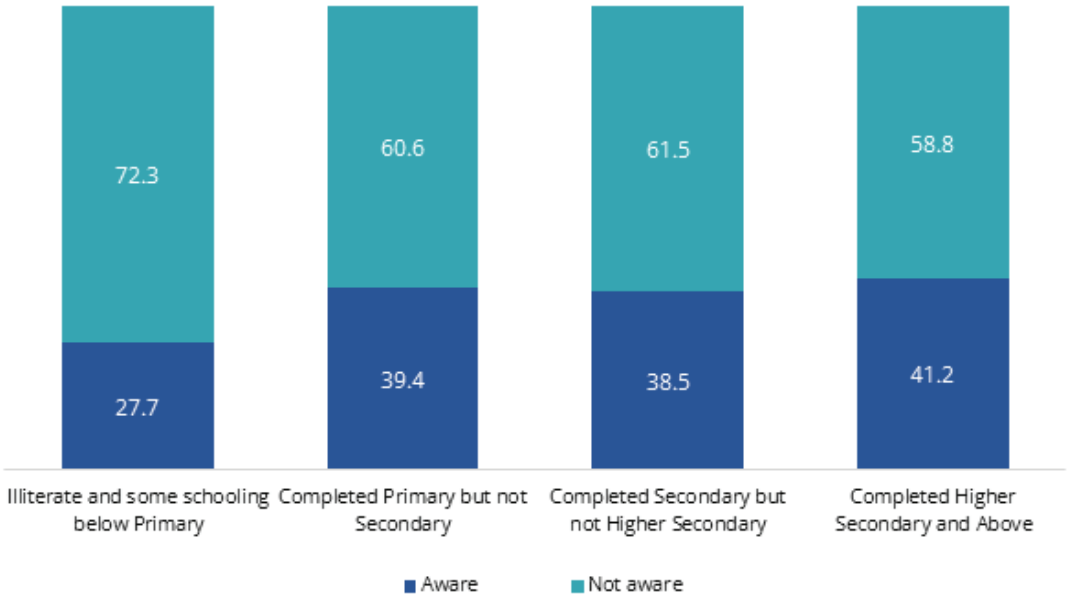
Figure 36: Availability of counselling services for mental health at local PHC/HWC by zone



also assist with rebuilding self-esteem and letting go of unhealthy relationship patterns. The survey also looked at the availability of such counselling facility at the local PHC/HWC.
As the above figure depicts, both in East and West zones, close to a third of the respondents could confirm that their nearest PHC/HWC has such provisions. This was 3 in 10 in the South zone and about one in four in the Central zone. The North zone states have very limited availability of counselling facilities for mental health in their PHCs/HWCs.

Over 60% of the respondents who had reported that their nearest PHC/HWC did not have mental health counselling

Figure 37: Awareness of where to go to avail of counselling service when not vailable in local PHC/HWC



facilities were unaware of where to go to get that service. As expected, awareness was also influenced to some extent by education of the respondent.

In this context, it may be mentioned that over two in three respondents who had reported not having such a service in their local PHC/HWC had expressed the need to have it made available.

SECTION 08

Way Forward

Sixty-three percent of the people availed the diagnostic services from Government secondary level health facilities with patients not having any critical illness, which is a good indication. Under XV-FC Health Grant and Pradhan Mantri Ayushman Bharat Health Infrastructure Mission, Free Essential Diagnostics Initiative under NHM efforts have been made to improve the Dianoetic services, which brings hope for the common rural families towards access to health diagnostic services.

- Experience from COVID and technological innovations in diagnostic services as well as the entrance of entrepreneurs in delivering services at the doorstep has opened a new arena for innovation and transformation of diagnostic services. As many people have received diagnostic services also demographic transition and increasing burden of NCDs may have contributed to it. Therefore, innovation in decentralised Home-Based Diagnostic Services (HBDS) has immense potential to be explored. Additionally, it has scope to generate employment and entrepreneurship opportunities for local youths in Rural India.
- Additionally, leveraging the technological innovations and tapping the opportunity of digital transformation decentralised diagnostics services on outreach camps and Village Health and Nutrition Days (VHSNDs) can be strengthened.

As Out-of-Pocket expenditure is a big concern for the patients, an average of Rs1628 worth of free medicine is provided by the State to patients with chronic illnesses. That has proved extremely helpful for patients from poor background.

- The policy-level interventions and actions have been taken by the Government to promote generic medicine and established Jan Aushadhi Kendras to be strengthened at the grassroots level to provide more benefits for the people. While there is a scope to accelerate the services provided at public health facilities and outreach services, new paths to expand the provisions under Jan Aushodhi Kendras are to be explored. For example, JAKs at Panchayat Level can be explored which will increase the penetration of free/ low-cost medicines to the people and will also ease the financial burden.

Over the past decade, India has gained a reputation for providing high-quality medical service at reasonable costs to medical tourists traveling from across the globe. However, while international medical tourism has gained momentum, 'Domestic Medical Tourism' has been overlooked.

- It can be explored in two ways- a) a huge potential to bring modern and critical services along with trust-building efforts within states themselves, and b) creating National Level Facilitation Networks to nurture 'Domestic Medical Tourism'. It may be recalled that 6% of the families having household members suffering from chronic illness were already availing of doorstep diagnostic services.
- The Domestic Medical Migration requires urgent attention to "Close the Care Gap". The disparities affect every step of medical care, i.e., from screening to treatment and the quality of life after treatment. To reduce the regional disparities, an urgent 'Whole of System-Whole of Society' approach is required involving all the stakeholders, from private to public, to demonstrate a Decentralised Healthcare Model'.
- Ensuring basic services at Health & Wellness Centre: Augmenting the frontline primary healthcare system, leveraging special funds allocated under PM-ABHIM and XV-FC Health Sector grant. In the absence of critical services, the conversion to Health & Wellness remains physical infrastructure driven only; dedicated resources are needed to immediately fill the equipment and service gaps in already converted facilities.
- Special fund for supporting Private Nursing Homes and Clinics: In the absence of public health infrastructure rural poor depend on the neighbourhood's mushrooming nursing homes. Most lack basic infrastructure, are run by entrepreneurial medical practitioners, with an average of less than 10 beds. These facilities are not covered under Ayushman Bharat Insurance Schemes. A special fund. administered through banking infrastructure as interest subvention to pilot transiting the small nursing homes to upgrade their facilities for empanelled under Ayushman Bharat Insurance will support bringing quality tertiary care closer to communities. Private investments in underdeveloped regions are required.

The vision to build India's digital health infrastructure is taking momentum, 23% of the respondents have the ABHA Card, and out of which 30% have availed the benefits from the same. This draws attention to the increase in the availability of ABHA cards and availing benefits from this card.

- Implementation and ongoing operation of the program need to be monitored to ensure that it is meeting the aim in a sustainable manner. With more additional interventions the program can prove to be a potential platform to reform India's health care system and to accelerate India's journey towards Digital Health coverage.

Last few years, Mental Health Issues has been emerged as a concern, and in the last Union Budget National Mental Health Programme was launched. 38% (South), 14% (Northeast), 20% (East), 24% (Central), 49% (West), and 14% (North) states have availability of treatment for women subjected to physical/ mental abuse at the local PHC/HWC.

- Universal health coverage will not be achieved without strengthening of "health services for disabilities" and "mental illness". It should be considered a public good and need more to be invested in a timely manner. This momentum and the unprecedented juncture where India finds itself on the issue of mental health should be utilized to take concrete actions on mental health and disability and to advance Universal Health Coverage in India.

Government of India's vision to remove barriers to accessing healthcare is getting momentum on the ground. 9% of the respondents from the survey had expressed that they have availed of telemedicine services for their household members. This has significantly helped in reducing the travel time of the patient as well as the accompanied person. In another way, it has also impacted Out-of-Pocket expenses.

- The telemedicine services are being implemented across the country, but still there is a scope to improve awareness level and use of this service. Monitoring patients in their homes can lead to better healthcare at lower cost which implies an increased demand for new healthcare strategies like telemedicine.

About the Development Intelligence Unit (DIU)

The Development Intelligence Unit (DIU) brings data and expert analysis to the intersection of opportunity and deprivation in rural India. The DIU supports stakeholders who navigate the increasingly opaque, complex and uncertain world of data to analyse social and economic developments, forecast trends and better understand development programmes and practices. Doing so provides actional insight to improve the efficacy and effectiveness of development initiatives.

The DIU platform is a clearing-house of rural information presented in a user-friendly format, addressing the needs of diverse stakeholders in public, private and civil society. It brings rural India into focus and furthers the field of rural analytics for understanding, positioning and informing stakeholders and decision makers.

DIU specialises in evidence-based insights that will create an impact for governments and non-profits. It has expertise to develop data-driven solutions to public policy challenges based on robust evidence, expert insights and data analysis. It is providing data, research and tools to amplify issues in order to help rural India gain a voice, spark deeper conversation and help shape the future of India.

STATE OF HEALTH IN RURAL INDIA

Transform Rural India

development intelligence unit

SAMBODHI