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Marketing of Health Care with Affordability for the Poor and Profitability for the Provider

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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 paper suggests an alternative prospective model/a proposition for the provision and disbursement of Health Care to the Rural Poor of the State of Uttar Pradesh (a province in India), which has a population of 166 million out of which 111.5 million is the rural population distributed in 1,12,539 villages. 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. Using examples of few of the successfully implemented models in some other parts of India, the paper 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 for the Provider'. It also raises the prospective issues and constraints associated with the development of such a model/proposition. The paper is also suggestive of a relationship of a society being healthy and a society being harmonious.

Key words: Rural Poor, Health Insurance, Technology, Health Care

Introduction

This paper takes the vital importance of Health Care as the central most aspect of a society's development. The premise of the thought of this paper is well expressed by

----- The Nobel laureate Professor Amartya Sen in one of the interviews (1999); "that,-if one thinks of poverty only as low income, then the health link is indirect: it is easier to earn a living and alleviate poverty when one is in good health. On the other hand, if we think of poverty as basic deprivation of the quality of life and of elementary freedoms, then ill health is an aspect of poverty. Bad health is constitutive of poverty. Premature mortality, escapable morbidity, undernourishment are all manifestations of poverty. I believe that health deprivation is really the most central aspect of poverty." He further adds: "improvement in the public sector health care delivery requires active public discussion on the health care provision; it also requires constant vigilance about the quality of the hospital, medical and the nursing services, etc."

The repercussions of the problem of 'Health Care' are multivariate ranging from reduction in the 'capability' (Sen, 2000) of the poor to reduced social development and subsequently societal harmony. Therefore, this paper proposes for improving the health of the rural and the poor masses through providing better health care services to them because better health may lead to the enhancement of the levels of sustained livelihood (Osmani, 2003). It may also lead to the development in the entrepreneurial activities and the acumen of the nations/societies, thereby, positively effecting social development and finally the 'Societal Harmony'. Better health services are the human right of the masses and should also be seen as a social responsibility of one and all. (See Figure 1)

The paper observes the gaps in the provision and the disbursement of the Health Care to the Rural Poor of the state of Uttar Pradesh (a province in India) and proposes for "Enhancing the reach of the Health-Care with the perspective of Affordability for the Poor & Profitability for the Provider." This proposition is based on the argument that:

Private investment and widespread entrepreneurial activity, assisted by policy reform and extensive usage of technology can support the logic of 'Affordability for the Poor & Profitability for the Provider' thereby supporting overall social development and harmony. This paper is suggestive of a prospective model/proposition (for Health Care provision and disbursement to the Rural Poor) as well as the issues associated with the same with the help of successful examples being implemented in few parts of the country, while supporting the logic of such a proposition with the analysis of the primary data collected in the State of Uttar Pradesh.

The State of Uttar Pradesh

The state of Uttar Pradesh has a population of 166 million out of which 111.5 million is the rural population distributed in 1,12,539 villages. About

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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 and medical supplies to social issues of gender inequality, casteism and political uncertainty the 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.

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,

Appendix

Table 1 : Profile of Uttar Pradesh (Ministry of Health & Family Welfare, 2004)

POPULATION (2001 census)	166197921
MALES	565369
FEMALES	632552
SEX RATIO (females/1000 males)	898
DENSITY OF POPULATION (Persons/ Square Km)	689
URBAN POPULATION %	20.78
LITERACY RATE (census 2001) in %	57.36
MALE LITERACY in %	68.8
MALE LITERATE in numbers	48901413
FEMALE LITERACY in %	42.2
FEMALE LITERATE in numbers	26817871
**BIRTH RATE (PER 1000)	33.5
**DEATH RATE (PER 1000)	10.3
*Population BPL (%)	31.15
*IMR/Per 1000Live Births (1999-SRS)	84
*<5Mort-ality per 1000 (NFHS II)	122.5
*MMR/Lakh (Annual Report 2000)	707
*Leprosy cases per 10000 population	4.3
*Malaria +ve Cases in year 2000 (in thousands)	99
*** Population Bed Ratio for the Rural Population people/bed	4857

Source: *Directorate of Economics & Statistics of respective State Governments (As on March 26, 2004), Ministry of Health and Family Welfare, Govt. of India Economic Activity: Services- Manufacturing- 20%; Services- 37%; Agriculture - 43% Investor Profile: Govt. 49.3%; Foreign 9.9%; Indian 40.8% State Priority Areas: Agriculture-based industries; auto ancillaries; electronics; Infotech Investment Strengths: Adequate coverage of road and railway networks in the state; second largest market amongst all Indian states after Maharashtra; extensive irrigation networks suitable for agri based industries.*

**NATIONAL HEALTH POLICY DRAFT OF INDIA-2001*

*** A survey report of U.P. Health Systems Development Project of Government of Uttar PradeshJanuary 2004.*

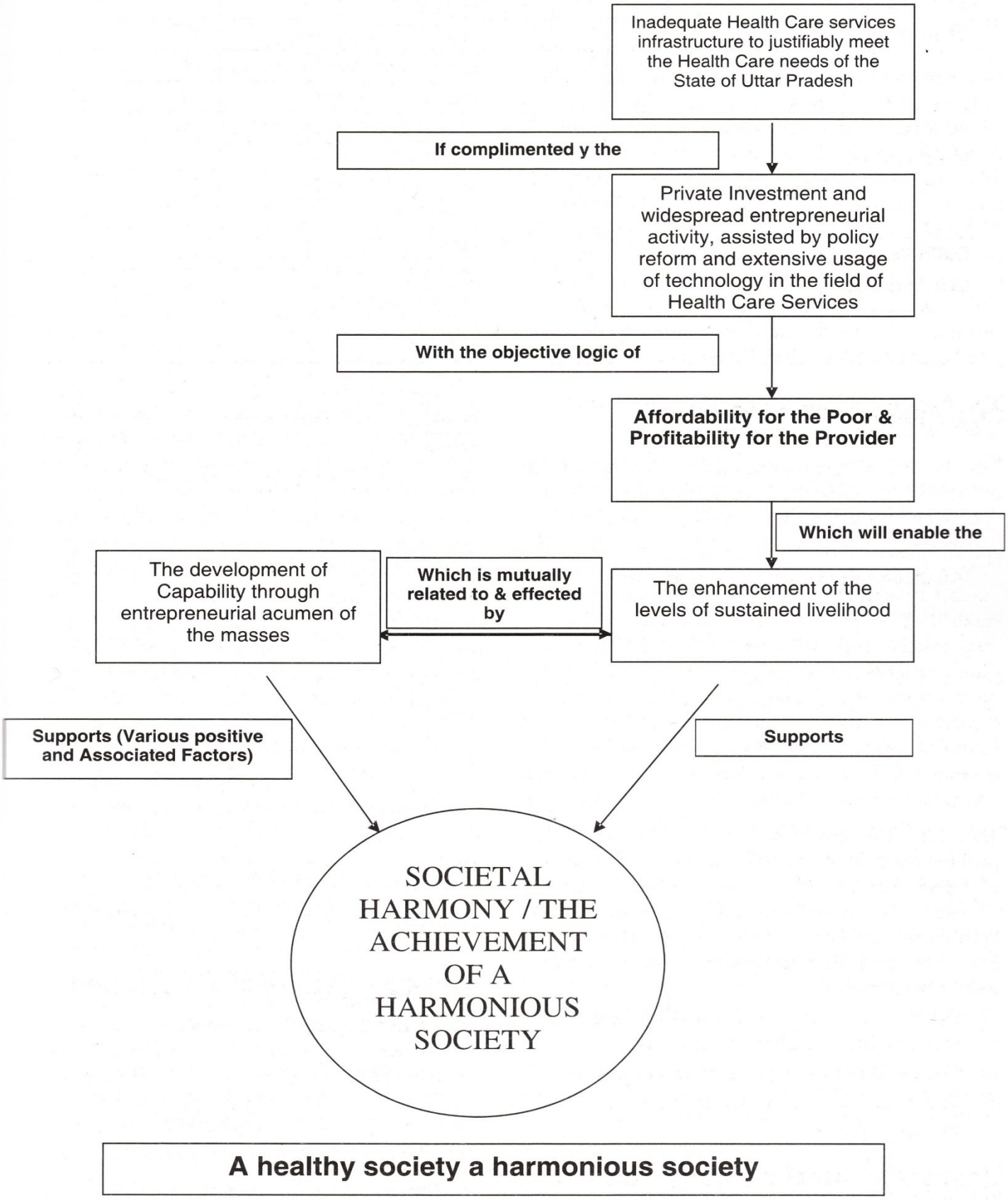
****Annual Performance Report of the Directorate of Health and Family Welfare working under the Ministry of Health and Family welfare of the State of Uttar Pradesh.-----2004-05*

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.

a) Survey Area & Sample Size taken: Rural population of the districts of Saharanpur, Bijnor, Lucknow, Barabanki, Allahabad and Faizabad in the State of Uttar Pradesh.

Figure: 1


Inadequate Health Care services infrastructure to justifiably meet the Health Care needs of the State of Uttar Pradesh
If complimented y the
Private Investment and widespread entrepreneurial activity, assisted by policy reform and extensive usage of technology in the field of Health Care Services
With the objective logic of
Affordability for the Poor & Profitability for the Provider
Which will enable the
The development of Capability through entrepreneurial acumen of the masses
Which is mutually related to & effected by
The enhancement of the levels of sustained livelihood
Supports (Various positive and Associated Factors)
Supports
SOCIETAL HARMONY / THE ACHIEVEMENT OF A HARMONIOUS SOCIETY
A healthy society a harmonious society

TABLE—2 (Focused Groups and Number of Respondents per Group)

REGION	DISTRICTS	SUB-DISTRICTS	VILLAGES	FOCUSED GROUPS EMERGED	AVERAGE NUMBER OF RESPONDENTS PER FOCUSED GROUP
WESTERN UTTAR PRADESH	SAHARANPUR	BEHAT	BEHAT DEHAT	08	06
			TODARPUR	05	07
	BIJNOR	NAJIBABAD	ALAMPUR GANGA	09	06
			BARAMPUR	06	04
CENTRAL UTTAR PRADESH	LUCKNOW	BAKSHI KA TALAB	JAMKHANVA	08	07
			BAGAHA	03	05
	BARABANKI	NAWABGANJ	CHETNAGARHI	05	05
			CHHULAHA	05	06
EASTERN UTTAR PRADESH	ALLAHABAD	ALLAHABAD RURAL	BHARETHA	07	06
			DAIWGHAT	05	04
	FAIZABAD	RUDAULI	BANGAUNA	06	06
			VAJIDPUR	07	07

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.

A brief about the villages selected

All the 12 villages (Please refer to TABLE-2 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 is as follows:

a) House Holds: A 'household' is usually a group of persons who normally live together and take their meals from a common kitchen unless the exigencies of work prevent any of them from doing so. Persons in a household may be related or unrelated or a mix of both. However, if a group of unrelated persons live in a census house but do not take their meals from a common kitchen, then they are not constituent of a common household. Each such person was to be treated as a separate household. The important link in finding out whether it was a household or not is a common kitchen. There may be one-member households or multi-member households.

b) Illiteracy: A person aged 7 years or above who cannot read and write or can only read but cannot write is treated as illiterate. All children of age 6 years or less, even, if going to school and have picked up reading and writing are treated as illiterates.

c) Worker: A worker is defined as a person who participates in any economically productive activity with or without compensation, wages, or profits. Such participation may be physical and/or mental in nature. Work involves not only actual work but also includes effective supervision and direction of work. It includes part time work or unpaid work on a farm, family enterprise or in any other economic activity. Persons who are engaged in cultivation or milk production even solely for domestic consumption are also treated as workers.--- Reference period for determining a person as worker and non-worker is one year preceding the date of enumeration.

d) Main Workers: Those workers who had worked for the major part of the reference period (i.e. 6 months or more) are termed as main workers.

e) Marginal Workers: Those workers who had not worked for the major point of the reference period (i.e. less than 6 months) are termed as marginal workers.

f) Sex Ratio: Sex Ratio has been defined as the number of females per 1000 males in the population.

The major reasons for including these indicators in the analysis are that the proponent wished to check that if there is much of a deviation in the proportions of indicators in accordance with the population of each village and if that may affect the analysis.

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

TABLE 3: 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
WESTERN UTTAR PRADESH	SAHARANPUR	BEHAT	BEHAT DEHAT	3292	496	6.6	2264	912	867	779	88
			TODARPUR	3061	541	5.7	1805	791	948	825	123
	BIJNOR	NAJIBABAD	ALAMPUR GANGA	1110	148	7.5	575	904	301	297	4
			BARAMPUR	2368	409	5.8	976	916	585	409	176
CENTRAL UTTAR PRADESH	LUCKNOW	BAKSHI KA	JAMKHANVA TALAB	1759	358	4.9	1065	863	624	601	23
			BAGAHA	2546	472	5.4	1620	883	906	859	47
	BARABANKI	NAWABGANJ	CHETNAGARHI	1445	227	6.4	699	953	497	348	149
			CHHULAHA	1724	267	6.5	983	937	622	585	37
EASTERN UTTAR PRADESH	ALLAHABAD	ALLAHABAD RURAL	BHARETHA	1898	298	6.4	1298	802	570	498	72
			DAIWGHAT	804	140	5.7	692	896	379	319	60
	FAIZABAD	RUDAULI	BANGAUNA	1605	294	5.5	1099	924	592	533	59
			VAJIDPUR	2191	342	6.4	1227	1014	694	573	121

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.

Summary analysis of the questions asked and the discussions held:

- The initial round of the discussion and the questions put forward were directed to test the awareness levels of the respondents i.e. if at all the respondents understand the basic reason of Health and a healthy life and the levels of reasons they attributed to the same. The first question or round of dialogue tried to get an insight on the perspective of the respondents with respect to the awareness they have in correlation of a healthy life and nutritious food along with cleanliness and other hygiene related factors.
- The second set of questions was directed to gain an understanding towards the mediums through which the respondents are getting the information in relation to the health care and disease prevention programmes and the activities i.e. are they getting information through the electronic media, through individuals or through any other medium? And if at all they are getting the information.
- The next set of questions tried and tested their levels of information in relation to the immunization and other disease prevention programmes run by the Government, like that of AIDS, PULSE POLIO (the polio prevention initiative taken by the government of India), programmes with regards to the Antenatal care and others to have an understanding in relation to the difference (frequency and reach of the information and the media involved) levels in relation the information reaching them with regards to various programmes.
- And, further the proponent tried to develop an understanding that if the respondents are getting the information, then, are they acting upon it?
- The next phase of the discussion, which was on more intense lines was constitutive of the questions and extraction of opinions on the:

a) Kinds of Health Care Services available.

b) The qualifications and the credentials of the service providers (including doctors, the medical, and the non-medical staff of the Government organizations).

c) The levels of infrastructural support and the facilities and the supplies in terms of medicines and other facilities.

d) The dedication with which these services are offered.

e) The kinds of costs the respondents have to pay. (The costs being financial, in kinds or cash, the emotional costs and other types of costs involved even in relation to the time which is consumed)

f) Then a comparison of these factors with that of similar factors involved in getting the similar services from the Private health Care Services providers or even by the Government Health Care Service providers privately.

g) Further, the questions were directed towards measuring their satisfaction levels by adding attributes to the parameters of the services and by providing comparisons to them, which they themselves suggested as the parameters of the quality and the standards of the services they perceive.

h) Finally, a discussion which could lead to an understanding in relation to their concept of satisfaction levels in relation to the costs they are paying for the services was done and this round of discussion concluded on generating a consensus if their thought process has coincidence with at least five families or groups of their likes, which actually were not present there but the present groups through their experiences and observations in such cases could affirmatively suggest that.

- The next phase of the discussion was led towards the questions in relation to the diseases and the Health related problems, the

respondents faced or the reasons for the need of the respondents to approach a Doctor or Health Services Setup or a Health Care Services provider (even in the case of Obstetrics and Gynecological problems) during the past two years. This round of discussion also included the costs incurred, the duration of illnesses faced, the provisions made for the costs those were incurred, the demographics and other related factors to bring in association of the income, savings and health.

- 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.

Detailed Analysis of the discussions held: (This section actually produces the Intention of the Questions asked and Discussions held along with the Responses)

Question 1 The initial question intended to ask about the concept of Healthy life, offering clues to the respondents with reference to nutritious food, cleanliness habits, healthy environment being the reasons for a healthy life. This question had an intention of developing an understanding of respondents' criterion of parameters responsible for a healthy life.

Answer 1 The answer to this question was highly satisfying and all the respondents were crystal clear of the correlation of Nutrition, Healthy life style, be it food habits, be it cleanliness, healthy and clean surroundings good cooking with Healthy life. But, the factor of 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.

Question 2 This question targeted the reach of various efforts being made by several Government and Non-Government agencies to generate Health Care awareness through different media. The intention of the question was also to understand about the types of media reaching the targeted population effectively especially with regards to the health care, which was Para metered in terms of Healthy life, disease prevention and immunization in this question.

Answer 2 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.

Question 3 This question further complimented Q2. And focused on the modes of disease prevention and immunization about which the concerned population gets to learn through several media. Here, it was tried to judge the respondents' seriousness and priority of disease prevention for e.g. In terms of immunization practices, Antenatal care or maintaining Healthy life through cleanliness and drinking clean water etc.

Answer 3 PULSE POLIO (The Anti Polio Drive of the Government) has done quite a 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.

Question 4 Now it was asked that if they are aware and at least have a point of view in terms of Health Care, do they at all go for it? Do they try to follow immunization? Do they try to take the benefits of whatever are facilities available?

Answer 4 Though valid percent of affirmative answers is 88% but this answer has an amalgamation of actions being taken by the respondents in response to many-many types of messages and that too not very regularly. Anti polio drive is highly supported thorough 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. Females are not involved in the decision making and have to render all the duties related to House management and rearing of the children.

Question 5 This question was floated in the form of sequentially associated smaller questions. The intention was to generate an objective view of the respondents' feelings and now formed belief about the Health Care facilities and services in the vicinity.

Answer 5 As already mentioned, this discussion was being held in the form of focused groups, this question broken in the several parts and asked in YES & NO form wanted to judge the universality of the views of the respondents if any, as they were divided in small/various opinion groups by now. (And though they were having similar conclusions on various aspects but had different point of views for e.g. Q5(e) where few had an experience that Doctors and Medical staff wish to provide services/(are ready to) but once correlatively asked with Q5(b) 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 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. Therefore; Q5 asked about the respondents feeling and beliefs developed on the basis of their experiences in past 2 to 3 years.

Question 5(a) This question tried to learn about if the Government doctors and medical staff in the nearby facilities or else are felt to be competent by the respondent. The indicators of the competence as emerged during the discussions and as preferred by the respondents were with regards to the successful treatment they, their family members or someone known to them received if any.

Answer 5(a) Doctors enjoy a very high reputation among the respondents. None of the respondents at first ever wished to put a negative aspect about the doctors and medical staff especially the doctors. In addition to that, being associated to the Government machinery, their image is still superior and qualification, skills and abilities are not a matter of questioning. But, once this question was asked in the context of the individual and associated experiences in reference to them or in reference to those known to them (though all the respondents were treated by these doctors at one or the other point of time) with regards to the treatment especially in comparison to the treatment they got somewhere else like in cities for the same illness or with regards to the factor that they did not get expectedly well within the time frame they thought they should have. (Due to their understanding or information). Only around 50% of the respondents suggested that the doctors and the medical staff are competent.

Question 5(b) This question asked/wanted to see that if the availability of the doctors matched with the requirements of the respondents' especially emergency requirements.

Answer 5(b) Availability of doctors though a very clear aspect but, emerged as a relative question, because of the reasons that doctors and medical staff on the one hand was not available in the Out Patients Department's timings except for some resident staff who was compulsively using premises as his residence. Even in the cases of places and Primary Health Centers very near to main cities like in the case of CHETANA GARHI in Barabanki and Jamkhanva in Lucknow doctors and staff did not attend the hospitals for many-many days at a stretch and the concept of night stay was out of question. On the other hand a fact, which further reduced the contact was that, the respondents move towards medical care/for any treatment at very advanced stages and in emergency .Now a general image about the availability of doctors and medical staff that has been formed in general is that they are never available. The respondents though were not very aggressive in exclaiming this and they have actually very complacently accepted this fact. (Affirmative answer only 14%)

Question 5(c) Here the proponent seeked to judge the criterion of the respondents' understanding of the facilities and equipment that they feel were/are essential on the one hand and by prompting about the equipment and facilities those should be actually there as per norms, the proponent wished to learn that if those are there on the other hand.

The essentiality of the facilities and equipments those should be there emerged on the basis of the need encountered by the respondents and their peers and as expressed by the doctors and medical staff from time to time to quote that a particular treatment could not be done because of the lack of such a facility.

Answer 5(c) Again the answers were based on the factors related especially to the gaps the respondents felt in case of unavailability of equipment. The gaps only appeared when the need was felt and expressed by the doctors and medical staff or whenever the patients were suggested that they were being referred because of the same. None

of the patients were aware of the norms, but the general conclusion (almost 95%) (Except for the cases who some how did not require all or major equipments or passed on special favors) was that the local facilities, doctors and medical staff was deprived of equipment and this image has taken an intensely prevalent shape so much so that the usage of equipment is not there where ever/and even if they are present. The technicians and the support staff have started rendering their services or their skills to or are now and as a resultant being used by private Medical and Health Care Service providers in the vicinity.

Question 5(d) This question tried to learn two things i.e. one if doctors have prescribed medicines from outside in general and two if the level of medicine disbursement is decreasing vice versa or requirement is increasing-implying two things again that if doctors are writing frequent prescriptions and if this is developing a trade/an underlying trade.

Answer 5(d) Availability of medicines was felt only in the cases of very general purpose medicines (30%) and with the context of these medicines not being effective but were still availed whenever disbursed with or without the prescription of qualified doctor or with/due to the advice of the staff whosoever was available only because of the free availability factor and due to the reason that if some money could be saved. Comparatively it was a general experience of the respondents that medicines bought from the market were more effective (98%) (Though their credibility was by no means under question and could be judged). Further to add to this problem doctors and medical staff (when corroboratively asked) themselves denounced the medicines available with them. This also came up as one of the reasons of for patients to be moving away.

Question 5(e) Now, after bringing the discussions to a situation where criticality emerged by itself and prejudice reduced- this question intended to learn that despite of all the ins and outs do the respondents feel that the doctors and medical staff has a willingness to deliver or not? Meaning thereby, that things may change if infrastructural support is excelled or things may slightly vary and may not change at all even if continuous up gradation in the infrastructural support is done (here it is to be mentioned that patient dissatisfaction does not decreases even if infra support is enhanced (UPHSDP report, 2004) and infrastructure only does not motivate doctors to stay in the rural areas (as interviews with some doctors suggested).

Answer 5(e) This question had a relative answer, it was felt by the respondents that the doctors and medical staff had a willingness to serve (whenever there was a substantive interaction level) and this was corroborated by the statements of the doctors when interviewed subsequently that they had willingness but could not do much because of lack of infrastructure. But, the conclusion (87% negative) which emerged after a detailed debate amongst the respondents and discussion that if they would be willing then things would be different and would not be moving towards a negative direction (The direction was defined negative because of the past experience as well as because of the awareness generated by the Government that larger budget allocations are being done and more programmes are being launched But the respondents could not feel that effect).

Question 5(f) This question had a dual motive one that if the respondents at all knew about their fundamental rights and if they did consider Health Care (services) as their fundamental right and if in some cases an opinion emerged that yes then did they have been rendered these services as their fundamental rights. The question intended to learn that do the respondents ever try to or would be able to extract the services. (Things may change if they could).

Answer 5(f) They could tell that they have fundamental rights but health could be seen with the same perspective was not there and the matter of extraction of services was completely absent (no question of execution of rights) though it was a usual practice to use influence of the affluent in the area to use / avail the services.

Question 5(g) Now, comes the question which wants to learn that even if the answers to the preceding questions is positive then to get the services or to get them quickly or to get them better. Do the respondents pay? And are they being asked to pay? (Again is there any underlying trade going on) or is there any possibility of the same?

NOTE: (Though preliminarily the situation pertains to demand and supply but remedial measures at policy levels could be taken if thing are turning that way) and it also indicates market otherwise.

Answer 5(g) Yes in most of the cases (in around 60%) the respondents had to pay, were motivated to pay

and of course used private services and hence paid for the services they availed. The respondents who did not pay used contacts in some cases and could not pay in other cases. The patients who paid for (especially Government services felt responsible themselves also rather helpless that to avail favour and services (basically) offered money themselves on the other hand no one is offering services for free at large, and Government machinery has partially taken the shape of private machinery itself, where as the private Medical and health care services providers are developing because of demand & supply gaps which are there and practically have been widening in rural areas because of the Government machinery's inability to yield (primarily because of their unwillingness).

Question 5(h) The intention of this question was to initiate a discussion on the availability of privately owned alternative means and modes of Health Care Services and what are the proportions of their growth.

Answer 5(h) Private Health Care Services are present everywhere and growing, promoted by Government Health Care providers in some cases and otherwise. These services are provided by moderately qualified i.e. not proper degree holders, not having allopathic knowledge for example a board in Todarpur village under Saharanpur read that "One may get Dental, Gynecological, orthopedics and other emergency Services" while the doctor was BAMS (Bachelor degree Holder in Ayurvedic Medicine, and alternative medical science practiced in India) from a nearby district. 20-30% cases were found that the male doctors were having diplomas and degrees from unconfirmed sources where as females in most of the cases were not doctors at all and were technically attached to some gynecologist attending part time clinics in the near by towns.

Question 5(i) Now the discussion moved towards the orientation of the respondents towards the private Health Care Services and they were asked the very basic question that do they avail those services at all? The intention was to learn when do they move towards availing those services

- At the time of being dejected by the Government hospitals, doctors, medical staff i.e. Health Care Services?
- At the time of their non- availability and the respondents emergency.
- At the time when the respondent does not feel satisfied (due to 'n' number of reasons (reasons also emerged later)).

Answer 5(i) Whether it be the case of being dejection from the government system, whether it be experiences, whether emergency or any other reason almost all have used and are using private health services though are being referred by these private health care providers to bigger government hospitals in many-many cases. Practically, the Government medical and health care machinery is virtually moving towards death, felt as alive whenever few initiatives and drives on the front of family planning and welfare, immunization etc. are made by the district based agencies. Otherwise medical care is dying and is complacently accepted at the most basic/lowest levels.

Question 5(j) This question very specifically intended to understand that if the Private Health Care services are being supported or virtually developed by the government doctors and medical work force themselves? Here an underlying thought of the question was that if the answers to the questions 5c and 5d were affirmative (which actually was) and including other job satisfaction and environmental factors- the question wanted to peep in that if all this was negatively effecting the Health Care providers' motivation and they were resorting to the practices for /towards their individual interests.

-The answer to this question was later corroborated with the answers provided by the doctors and medical staff in their interviews.

Answer 5(j) Yes, was the answer in most of the cases (82%) though the reasons were differentiated, in few cases because of unavailability of equipment and assistance but in most cases if the respondents were being referred by themselves (Government doctors and staff) then either because they didn't want to serve and take care or because they wished to attend them privately, but the basic reason was that they had to attend their own interests.

Question 5(k) This question by letting the parameters of satisfaction (especially with regards to what best the respondents could expect from Private Health Care providers) emerge, wanted to know the levels of satisfaction of the respondents.

Answer 5(k) Whatever levels of satisfaction (in around 25%cases) emerged was because of the attention they got from the private Health Care providers after being dejected by the Government

health care providers otherwise the desired levels of cure especially in emergency and specialized cases was not there and many (more than 65%) had to resort to the bigger hospitals later.

Question 5(l) This question actually intended to match the parameters of satisfaction between Private and Government Health Care Services and then wanted the respondent to express the level of satisfaction comparatively between the two systems.

Answer 5(l) Yes comparatively they were more satisfied with the private services (more than 90%), even if they were being provided the services by the Government doctors privately and that is due to the level of attention and immediate treatment but, the bitterness of knowingly restoring to a compromise and shifting from services (Government) which they feel (should be) superior and credible is deeply rooted there.

Question 5(m) Now taking it as an emerged and deemed fact that the cost of Private Medical & Health Care Services are higher as compared to the Government's services, the question asked that if the satisfaction level if Higher in case of private Services (which actually emerged to be higher) was considered to be higher and more even after looking at/taking comparatively higher cost as a prime parameter for the same.

Answer 5(m) The affirmative answer (to the tune of 50%) had reasoning and logical support of getting respite and relief whenever required and cost subsided as a reason for generating high level of dissatisfaction.

Question 5(n) The question tried to look at that:

(i) If many people from same family are participating in the discussion

(ii) If their opinion is divided or same (if two or more members are present)

(iii) That if the difference of opinion can give the discussion a different lead-emphasizing on the need of scanning individual opinion rather than representative opinion

(iv) That if this part of discussion could give birth to individual consumer behavioral analysis and suggest that a patient as an individual consumer bases his analysis on his own experiences.

Answer 5(n) In most of the cases the answer is affirmative (around 98%)and was found that the females did not have much of the say and their congruence with opinion suggested by the males present and participating in the discussion was deemed taken for granted and as same. Opinion also did not differ substantially with age and other factors because bearing illness by one always effects partially to all in the family.

Question 5(o) This question asked about How many other related people might suggest the same views as the participants are suggesting and if at least 5 people related to them would opine similar views. This qs. on the one hand tried to expand the sample size through representative mode and on the other hand tried to judge (after a detailed discussion) the level of influence the respondents had taken or given with regards to the generation of opinion, which emerged after this sequence.

Answer 5(o) The answer to this question was affirmative and the proportion of people saying yes was at the increased levels because at this stage of discussion the expression was more or less suggested an intense need of change and the sentiments backed up with recall generated this answer which actually solved the purpose of this question.

Question 5(p) Now finally this question which was the last one in the series (which discussed about various aspects based on their experiences during past 2-3 years) wished to conclude on the aspect of the justification of amount of expenditure the respondents &relatives would have incurred on the services (private health care services).

Answer 5(p) Almost everyone concluded the expenditure on private services was unjustified (i) because they had in mind when they themselves or as told did not incur any expense for these earlier (ii)they feel that they usually are being motivated to shelve down money as if they are purchasing consumer goods in Haats(local markets) as in the case (many cases) it was reported that as soon as they reach any private doctor and hospital they are asked about their buying capacity either through asking their profession or else and then treatment and charges are suggested. In addition to this except for the respondents who are blessed by babies and feel happy about it, it was reported in most of the cases (more than 85%) that they felt, they were charged (exorbitantly according to them) when they were vulnerable and in dire need.

Subsequently, the second round of discussion included questions with regards to the prevalence proportion of various Health Care problems encountered by them and the family at various parts of time with in past 2 to 3 years and a correlation of the same the parameters(as emerged) of referred cases prolonged diseases, emergency situation expenses and definitely frequency of occurrence.

- This discussion suggested that the Gynecological and Pediatrics especially in terms of Antenatal Care and Neo-Natal Care (for around 98%) is the cause of worry for not only the population targeted but whole of the country for that matter, so much so that a new market segment and an entirely separate Medical and Health Care Services strategy can be carved out for the same and this is what this study tried to find out that what was the occurrence level of the need of such services and what kind of assistance was required in such cases (This problem as emerged creates biggest levels of anxiety and worries amongst respondents).

- Orthopedics problems (for about 37%) especially in coherence with accidents as the same are caused by many factors such as due to heavy tools and equipment, proximity to Highways and roads(and this indeed) is a major factor. Other ailments, which have a low reported rate of occurrence but just because of not being, diagnosed for example immunological problems, cardio problems, mental and brain/neurological ailments etc. need attention and were found the cause of worry.

- Commonly addressable diseases requiring Out Patients Department care and disbursement of medicines(qs 5d) plus ailments which after a stage sometimes take the shape of epidemic and urological problems which especially are the result of eating habits for example high incidence of kidney stone operations are reported by city hospitals and the patients most of the times are rural people (affirmative response around 79%).

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 excessive expenditure but also the trauma faced) along with other factors like awareness about the usage of technology and imagination about its prospective effectiveness in the Health Care discussed conclusively;

Suggested the following facts (presented below), which became the logical basis for the proposition of an alternative model(s) based on the premise of 'Affordability for the Poor & Profitability for the Provider'.

The Conclusion that emerged in the interpretive form:

- The rural and the poor population of the State of Uttar Pradesh is needs and is asking for a change.
- They wish for radical changes, though still have high regard and trust for the Government Machinery.
- They do not save for Health Care expenses and it is a matter of generating habit (which actually has large constraints due to priorities).
- 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.
- They are willing to pay for the better Health Care Services though definitely in consideration to their buying capacity limitations.
- They are aware of the name of 'computer' as a proverb though do not exactly 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.

Examples in relation to the role of insurance and the technology supporting the provision of better Health Care Services to the rural poor:

This paper prominently puts forward three examples here:

a) Narayan Hrudayalaya: An integrative

approach to bring low cost health care to the farmers through the usage of technology and insurance cover. (See: http://www.hrudayalaya.com)

b) **Video Doctors of Asha Sanjay in Tamil Nadu India (A Southern state in India):** A project set up by one of India's leading technology institutes has put women in charge of forging the way across the digital divide as the proprietors of a fast-growing number of internet cafes or kiosks around the sub-continent.(See: http://news.bbc.co.uk/go/pr/fr/-/1/hi/world/south_asia/3871529.stm)

c) **SGPGI MS(Sanjay Gandhi Post Graduate Institute of Medical Sciences) Lucknow, Uttar Pradesh:** Government takes first step to telemedicine for poor [Saturday, October 11, 2003 03:15:33 pm TIMES NEWS NETWORK] LUCKNOW: The state government has taken an initiative to provide the benefits of telemedicine to the rural poor. (See: http://timesofindia.indiatimes.com/cms.dll/html/uncomp/articleshow?msid=228239)

The preceding models and examples justifiably emphasize on three major factors:

1) There is a bright prospect for the Health Insurance for the rural poor.
2) Technology can play a definite and a highly supportive role especially in the form of telemedicine.
3) It does make Business sense and a prospect.
4) And above all the rural poor are readily adapting such a positively oriented change.

A Proposition/Alternate 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) We should be looking at the 'Size' of the market and not at the buying capacity 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, we can compliment the same with strategic generation of buying power i.e. by 'creating buying power'. So as to

'Provide a stable solution for the health care problems to poor and the rural population at their doorsteps through commercial health care providers, without sacrificing the commercial feasibility or viability of the resources invested by them'.

The core concept of this objective asks for the solution of the following problems:

a) How to motivate the commercial (large or small) health care providers (organizations) to spread over into seemingly less lucrative rural & poor markets?

b) How to develop a universally acceptable and financially viable business proposition for such a situation and the people involved?

The basic need is for a model to be generated in this regard mainly involving commercial organizations because of the reasons such as:

a) Being the commercial motive involved positive results can be expected.

b) The major issue is of replicating the model and this definitely is expected when commercial organizations are involved, as it is a major characteristic of money to replicate.

But why would commercial healthcare providers provide their services (which involve substantial costs) to the people who cannot afford the same? OR why they would enter into a MARKET, which at least seemingly, does not assure financial feasibility?

And the answer is that this market is associated with the huge population however poor, but has access to the most basic and huge resources of agriculture and other rural produce and labor, therefore the basic logic of marketing and sales support the huge 'size' of this market.

Therefore, this paper stand with the basically logical marketing asset here and that is 'the size' of the MARKET.

As emphasized earlier, the paper looks forward to generate and establish a model so that the same may be replicated for wider and the far reaching results.

Hence forth, it recommends a strategic model, which broadly is based primarily on the development of human will through the support of clear vision and precise objectives. (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).

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.

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 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.

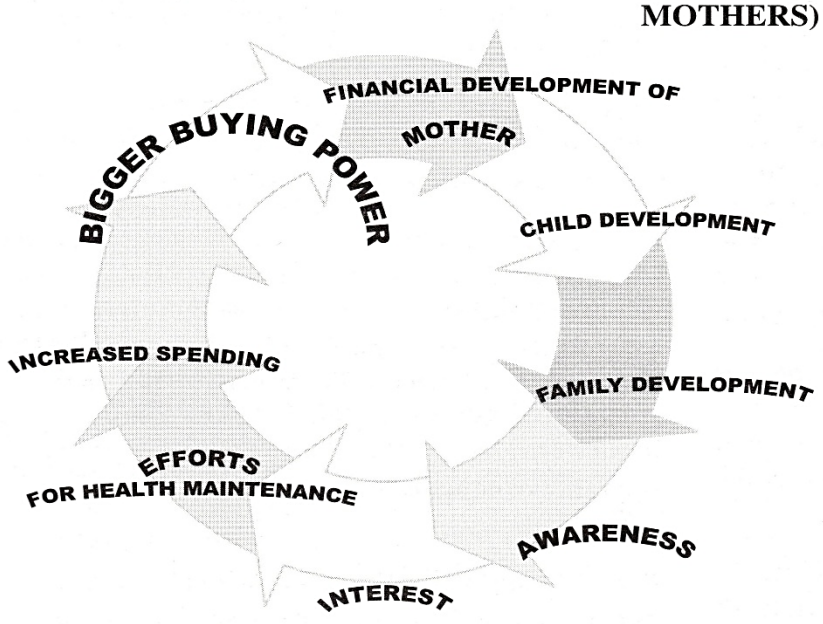
Now, looking at the five major aspects on which this paper is trying to argue, the objective comes out to

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 (pictorial demonstration no.2) 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 See Figure No.2).

(Figure No. 2)
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 to the bigger efforts for health maintenance hence increasing the spending on Healthcare and further going on to the bigger efforts for increasing, the buying power further, which is an indication of economic development

A clue about the practical implementation of the Proposition:

A Prospective Association of ITC's e-Choupal) with the Department of Health and Family welfare of the State of Uttar Pradesh: Here, comes the role of Information Technology based organization like ITC's e-Choupal. ITC is one of India's foremost private sector companies with a market capitalization of over US $ 7.5 billion and a turnover of US $ 2.6 billion. The Company's 'e-Choupal' initiative is enabling Indian agriculture significantly enhance its competitiveness by empowering Indian farmers through the power of the Internet. This transformational strategy, which has already become the subject matter of a case study at Harvard Business School, is expected to progressively create for ITC a huge rural distribution infrastructure, significantly enhancing the Company's marketing reach. Presently Around 4500 Choupals are serving over 3 million farmers and villagers across 30000 villages (adding 6 a day) out of which Uttar Pradesh has 1700 kiosks installed in its villages.

ITC is also exploring partnering with banks to offer farmers access to credit, insurance, and other services that are not currently offered or are prohibitively expensive. Moreover, farmers are beginning to suggestand in some cases, demandthat ITC supply new products or services or expand into additional crops, such as onions and potatoes. Thus farmers are becoming a source of product and service innovation for ITC. Now, the basic factor and requirement is to fill up the gaps in the Health Care Services which on the one hand may be achieved through the enlargement of the infrastructure and human resource requiring lot of fixed and recurring costs and redundancy of resource base of the state. While on the other hand a partnership of the department of health and Family Welfare with ITC may give a reasonable raise in the profitability of the company also fulfilling its new found objective of co- creation of value through multiplication of the usage of their network and systems and will effectively enhance the dispersion of services of the department of health through increasing its reach and the contact and the communication levels with the beneficiaries. The only thing required to initialize the process is association of the two organizations and the added offer of the health services through e-Choupal network.

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)".

The expected issues and constraints those may emerge in such partnerships:

Foreseen issues with, which the proposed partnerships may expectedly be confronted with, would emerge in terms of:

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. This is also supported by the proposition that this partnership initially is proposed to develop markets which are supposed to trigger a sequence of achievement of substantive freedoms supportive of reduction in the levels of the constraints.

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) The launch of edusat (a dedicated satellite for education based link ups), which will facilitate the span of delivery of education and thus the awareness and hence the acceptability of the process,

ii) Organizations like Tata literacy 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 has also supported the proposition it gives for the same through some successfully implemented examples and has given a clue to the practical implementation of its proposition through the support of a prospective association of organization like ITC with the states Health Care system. 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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Narayana Hrudayalaya may well be one of the biggest hospitals in the world, but the fact that it?s one of the biggest hospitals, with a heart, is becoming legendary access on 4th June 2010 and available at :http://www.hrudayalaya.com/

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Affordability for the Poor & Profitability for the Provider" is the strategic proposition of this work encompassing Market Development through Business Opportunity Development with a concentric effort focusing on Provision of Health Care to All. access on 4th June 2010 http:// www.amazon . co.uk / AFFORDABILITY - POOR-PROFITABILITY - PROVIDER Population / dp/3639 161823 / ref=sr_1_6? ie=UTF8&s=books&qid=1278314561&sr=1-6