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Health Schemes Awareness of Rural Households of Schedule Caste and Schedule Tribes in Kodagu

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Abstract: ***Indian economy has been witnessing a higher rate of economic growth for the past two decades and it is also expected to grow at a faster rate in the near future. Ensuring healthy lives and promoting the well-being for all at all ages is indispensable to sustainable development of country. Therefore, the health and healthcare awareness level play a very significant role in sustaining higher growth with justice in the long run and also it helps to achieve inclusive growth. In this context, an attempt was made in this study to examine the level of health schemes awareness with respect to rural households of Schedule Caste and Schedule Tribes in Kodagu District. The study was based on primary and secondary data hence the primary data were collected during 2018-2019 through field survey. Total 60 households belonged to SC and ST communities were randomly selected in this study for review. Out of 60 respondents, 30 sample respondents selected from the SC community and remaining 30 respondents represent the ST community. Results of the study indicated that the SC and ST rural households are socially and economically very backward and more importantly majority of them were illiterate (30%) and they were having only primary education (50%). Further, the level of awareness about health and healthcare facilities was found to be lowest among SC and ST rural households. Therefore, the central and state government should identify the areas where SC and ST people are living and vigorously dissemination of information regarding health and health insurance schemes.***

Keywords: Dissemination, Hadies, Vigorous and Sustainable

1. Background

Indian economy is witnessing a higher rate of economic growth and it is expected to grow at a faster rate in the near future. Ensuring healthy lives and promoting the well-being for all at all ages is essential to sustainable development. Public investment in social infrastructure like education and health is critical in the development of an economy. The expenditure on social services in general and health in particular by the Centre and States as a proportion of GDP has remained in the range of 6 per cent during 2012-13 to 2014. To engineer an inclusive and sustainable growth for India, the social infrastructure like education, health and social protection are being given utmost priority by the Government. Investment in human capital is a pre-requisite for a healthy and productive population for nation building (Economic Survey, 2017-18). In this context, the health is one of the vital indicators reflecting quality of human life. Moreover, the draft of the Twelfth Five Year Plan (2012-2017) lists twelve strategy challenges that continue the focus on inclusive growth. These include enhancing the capacity for growth, generation of employment, development of infrastructure, improved access to quality education, better healthcare, rural transformation and sustained agricultural growth and drinking water. Of these, the health is an important human development indicator and has a great significance for the overall development of the country.

India has a vast healthcare system; however there remain many differences in quality between rural and urban areas, between public and private healthcare and even between Schedule Caste and Schedule Tribes. Healthcare between states and rural and urban areas can be vastly different. Rural areas often suffer from physician shortages and disparities between states mean that residents of the poorest communities, like Schedule Caste and Schedule Tribes, often have less access to adequate healthcare than the upper communities of relatively more affluent people. In this background, this study was undertaken to examine the level of awareness about health Schemes in Kodagu Distirct.

Karnataka is one of the pioneering states in India that provides quality health care to economically backward families. Even before the concept of primary health care and health centers was conceptualized by the Central government, the state Government of Karnataka had already established primary health units in the state. These healthcare units aimed at providing preventive, promotive and rehabilitative care to patients based on quality (Ashish, 2018). Apart from it, Karnataka is a popular destination for medical tourism, given the relatively low costs and high quality of its private hospitals. However, there are large disparities across rural and urban households in terms of real Out Of Pocket (OOP) expenses for Inpatient (IPD) such as doctor's fees, medicines and diagnostics. Compared to a rural household, an urban household spends five times more on diagnostics, 2.6 times more on medicines and 2.4 times more on doctors' fees. It is also important to note that the rural-urban differences were very small in 2004 with absolutely no difference in the average real expenditures on medicine per inpatient case. In addition to this, there are glaring inequalities in Schedule Cast (SC) and Schedule Tribe (ST) with respect to accessible to health care facilities in the country. The SC and ST households are socially and economically vulnerable population subgroups in India. Particularly, the SC households were subjected to historical disadvantages including widespread discrimination associated with their lowest status in the Hindu caste hierarchy. Karnataka has witnessed considerable improvement in health status in last few decades and its overall health indicators are better than all India average (Economic Survey of Karnataka 2015-16).

2. Review of Literature

In this section, the review of research articles was undertaken because which helps to understand the concept, objectives and methodology adopted in previous studies. Therefore, review of past studies was presented below;

Selvam and Pratheepkanth (2019) were examined the awareness and perception of health issues among women in rural area in Vellore district, Tamil Nadu. The study found that the respondents have full awareness and perception about health issues and also they were aware of the various schemes and initiatives taken by the government to uplift the rural women and children to live healthy and better life in rural area. In another study it was indicated that health care utilization increased with age. Healthcare utilization is low in rural areas and more importantly among scheduled castes. As years of schooling and wealth quintile increased, the level of health care utilization also increased; schooling and wealth seem to have a significant effect on healthcare utilization. Exposure to media significantly and positively affects the health care utilization among young mothers (Sachin et.al.,2018).

Bipasha Maity (2016) was compared health outcomes across scheduled tribes and castes in India. The results of the study indicated that STs and SCs are the two most disadvantaged social groups in India. STs consistently perform poorly even relative to the SCs in terms of knowledge and usage of modern contraceptives, antenatal and postnatal healthcare, incidence of anemia and child immunization. Moreover, female infant mortality is significantly higher among SCs than among STs, with no significant difference in male infant mortality between these groups. Further, ST women enjoy high social status and thus are unlikely to face impediments in accessing healthcare due to social norms that restrict women's autonomy. Finally, the health disparity can likely be attributed to the potentially greater marginalization that STs face even relative to SCs when accessing healthcare.

Arifur Zamana (2016) was made an attempt to delineate the continuity and change of the traditional healthcare system of the Deori tribe in two homogenous Villages of upper Assam. The study found that the each tribal community has its own ideas and opinions about health and has got multifarious ways to overcome from the health related problems. The overall health status of the tribal community is the outcome of the several interacting factors. The health of the tribal people has been invariably connected with socio-cultural and magical-religious practices since ancient times. They have developed indigenous way of healing practices to protect their health against various kinds of diseases. There is a popular belief prevalent among them is that some of the diseases are caused by evil spirits and malevolent deities for which they observe pristine parochial rituals to appease them. Further, the traditional method of curing diseases and ailments in general are done by application of varieties of parochial medicines prepared from wild roots, herbs, plant as well as animal parts. However, with the establishment of modern medical facilities within the rural tribal areas, they avail the benefits of the same along with integrally sticking to their pristine Medicare system.

Kusuma et.al., (2018) were examined the awareness, access, and utilization of health insurance by the urban poor in Delhi. The study indicated that though only 19 percent knew about health insurance, 18 percent of respondents had health insurance. Residential area, migration period, possession of ration card, household size and occupation of the head of the household were significantly associated with possession of Rastriya Swasth Bhima Yojana (RSBY). RSBY played a limited role in meeting the healthcare needs of the people however it was not capable of contributing significantly in the efforts of achieving equity in healthcare for the poor. Relatively, Employees State Insurance Scheme (ESIS) and Central Government Health Scheme (CGHS) served the healthcare needs of the beneficiaries better.

Thus the review of research articles related to healthcare awareness of SC and ST rural households revealed that the education is an important component for knowing the various healthcare practices and their utilisation of the state sponsored health schemes. Majority of the studies indicate low level of awareness about health schemes especially among rural households and more importantly SC and ST households which have not accessible to information with respect to different health programmes of State Government in general and Kodagu district in particular. In this context, the present study was undertaken to examine the level of awareness of health Schemes among Rural households of Schedule Caste and Schedule Tribes in Kodagu district with following specific objectives.

3. Objectives of the Study

The present study was based on specific objectives. There are as follows;

1) To examine the socio-economic profile of rural households of Schedule Caste and Schedule Tribe in Kodagu District.
2) To analyze the level of awareness of health schemes among rural households of Schedule Caste and Schedule Tribes in Kodagu District
3) To suggest measure to increase the level of awareness about health schemes.

4. Methodology of the Study

Present study was undertaken to examine the level of health schemes awareness of the rural households belonged to SC and ST community and hence the data required for this study collected from both primary and secondary sources. Secondary data collected from research articles published in refereed journals, Central and State government reports, research projects, published theses etc., whereas primary data collected from the field survey which was conducted during 2018-2019. Simple Random Sampling technique was adopted for the selection of rural households and simple averages were used for data analysis. In this process, 30 Schedule Caste (SC) and 30 Schedule Tribe (ST) respondents were selected randomly from the two legislative constituencies of Kodagu district namely Madikeri and Virajpet. This study was confined to examine the awareness about healthcare with respect to rural households of SC and ST.

5. Results of the Study

In this section, the results of the study were presented in accordance of the specific objective set for the review. Therefore, the results are discussed and presented in the following sub headings;

5.1. Socio economic profile of the Sample Respondents

The respondent is one who was given a response to the questionnaire is considered as respondent and thus the respondent may be the head of the family or decision maker. Socio economic conditions of the households are very important for determining the nature and pattern of healthcare practices of the family. Therefore, the respondent's age, education, size of family, occupation, size of land holdings, nature of housing conditions and use of cocking fuel are collected for the study. Information related to the socio economic profile of the respondents were collected and presented in the table 1. Age of the respondent influences on the kind of healthcare practices were followed in the family. Mean values of the age of the respondents was summarized in the table separately for both sample respondent households of Schedule Caste and Schedule Tribes. The average age of the both the category was found to be similar.

Education is one of the important demographic features which determine the nature and level of awareness about healthcare practices of the family. Information regarding the level of respondents' education was collected and presented in the table. Person who is not known to read and write is termed as illiterate whereas a person who studied up to Seventh standard are categorized as primary education and the person who has studied till tenth standard is considered as secondary education. Those who studied till the Eleventh year and above are in college education. Though the percentage of literates were found to be more than the illiterates, still the 30 percent of the respondents were found to be illiterate. In disaggregate data indicated that the higher percentage of illiterates were found to be belonged to the ST (33.3%) community than the SC (26.7%) community. It was very interesting to note that the percentage of respondents' were having primary education was found to be very high for both the categories. It was also observed the percentage of respondents having college education was found to be lowest with respect to the SC and ST households. Hence it could be inferred that the people belong to Schedule Caste and Schedule Tribe prefer to engage in work for taking care of their parents on the one hand on the other they have responsibility to feed their families and hence they prefer work to education.

Size of family is another socio economic feature of the sample respondents and hence the size of family influence on the decision making with regard to take the patients to public or private hospitals. The size of the family were categorized into small (<6) and big family (>7). Overall category includes both SC and ST rural households and in the overall category the percentage of big families (51.7%) were found to be more than the small families (48.3%). However, it was also observed from the table that Schedule tribe people were more inclination towards the large families and prefer to live together whereas people belonged to SC community showed more interest in small families. Occupation pattern determines the economic status of the family and therefore the information about occupation of the respondents was collected and presented in the table. Majority of the respondents belonged to ST community (26) were found to be engaged in daily wage work especially in coffee plantations and other agricultural related works when compared to SC community(22). Though the higher percentage of the respondents of SC and ST households were working for daily wages, their dependency on agriculture was negligible. Any other work includes autoriksh, construction, petty business etc in rural areas. Therefore, it could be inferred that the people belonged to Schedule Caste and Schedule Tribe are resource poor so that majority of them are daily wage worker. Land is an important asset in the rural area and it indicates social prestige of the family in the society. It was observed from the table that the majority of the respondents are landless labour irrespective of their caste. Out of 60 sample respondents, only 4 respondents belonged to SC and ST community households were having marginal and small land holdings.

House state and type of cocking fuel was using for preparing food determining the socio economic conditions of the family in the society. Data related to housing conditions and type of fuel used for cocking was collected and summarized in the table. It was observed from the table that majority of the respondents belonged to SC and ST community were found to be resided in the pachha house. However, the higher percentage of ST households (53.3%) were found to living in kachha houses compared to the respondents belonged to SC community (43.3%). Similar results were found with respect to the fuel use for cocking the food.

Table 1: Socio Economic Profile of Sample Respondent Households

Sl. No.	Particulars	Schedule Caste Households	Schedule Tribes Households	Overall
1	Age of the Respondent	45.3	44.5	45.0
2	Level of Education			
	i) Illiterate	08 (26.7)	10 (33.3)	18 (30.0)
	ii) Primary	16 (53.3)	17 (56.7)	33 (55.0)
	iii) Secondary	04 (13.3)	02 (06.7)	06 (10.0)
	iv) College	02 (06.7)	01 (03.3)	03 (05.0)
	Total	30 (100.0)	30 (100.0)	60(100.0)
3	Size of Family			
	i) Small Family	18 (60.0)	11 (36.7)	29 (48.3)
	ii) Large Family	12 (40.0)	19 (63.3)	31 (51.7)
	Total	30 (100.0)	30 (100.0)	60 (100.0)

4	Occupational Pattern			
	i) Daily wages	22 (73.3)	26 (86.7)	48 (80.0)
	ii) Agriculture	03 (10.0)	01 (03.3)	04 (06.7)
	iii) Any Other	05 (16.7)	03 (10.0)	08 (13.3)
	Total	30 (100.0)	30 (100.0)	60 (100.0)
5	Size of Land Holdings			
	i) Landless Households	27 (90.0)	29 (96.7)	56 (93.3)
	ii) Marginal Holdings	02 (06.7)	01(03.3)	03 (05.0)
	iii) Small Holdings	01 (03.3)	00(00.0)	01 (01.7)
	Total	30 (100.0)	30 (100.0)	60 (100.0)
6	Type of House			
	i) Pacca House	17 (56.7)	14 (46.7)	31 (51.7)
	ii) Kachha House	13 (43.3)	16 (53.3)	29 (48.3)
	Total	30 (100.0)	30 (100.0)	60 (100.0)
7	Cocking Fuel			
	i) LPG	07 (23.3)	06 (20.0)	13 (21.7)
	ii) Wood	23 (76.7)	24 (80.0)	47 (78.3)
	Total	30 (100.0)	30 (100.0)	60 (100.0)

Source: Field Survey 2018-2019
Note: Figures in parentheses are percentages to total

Both SC and ST households mainly depend upon the wood rather than Liquefied Petroleum Gas (LPG). Hence, it was inferred that the housing conditions of the people belonged to SC and ST community are not suitable to live and even it was very worst conditions in case of the Schedule Tribe households.

5.3 Awareness about Health Schemes

In this section, awareness about various healthcare schemes implemented by the Government of Karnataka over the past one and half decade has been presented;

Arogya Karnataka is one of the important health schemes introduced in 2004. The objective of the scheme is to extend 'Universal Health Coverage' to all residents in Karnataka State. Under this new scheme, primary healthcare specified secondary and tertiary health care benefits are provided. The current ongoing health schemes like Vajpayee Arogyashree, Yeshaswini Scheme, Rajiv Arogya Bhagya Scheme, Rashtriya Swasthaya Bima Yojana (RSBY) including RSBY for senior citizens, Rashtriya Bala Swasthaya Karyakram (RBSK), Mukhyamantri Santwana Harish Scheme, Indira Suraksha Yojane and Cochlear Implant Scheme. Any other category includes, Jyoti Sanjeevini, Universal Health Scheme and Indradhanush. Information of various health schemes are being implemented in Karnataka collected and presented in the table 3.

Overall category includes both SC and ST rural households and thus 71.7 percent of households aware of the Vijpayee Arogyashree scheme. In the disaggregate data, SC households (80%) were well aware of the scheme than the ST rural households (63.3%). It was fact that the scheme was very popular among SC households compared to the ST households. In fact, the level of awareness about various State and Central Government sponsored health schemes were found to be more among the households of SC than the households belonged to ST community. Yeshasvini Co-Operative Farmers Health Care Scheme offers health insurance coverage to tenant farmers and peasants who are the members of co-operative societies in Karnataka. It was observed from the table that only 53 percent of respondents in the overall category were found to be aware of the scheme whereas 47 percent of the respondents unaware about the scheme. It was because; the majority of the respondents are landless labourers and also not the members of cooperative society. Rajiv Arogya Bhagya Scheme (RAB) is a Health Assurance Scheme of Government of Karnataka to make super specialty quality tertiary healthcare treatment accessible and affordable to Above Poverty Line (APL) population of Karnataka. About 33.3 percent of overall sample respondents were aware of the scheme besides 36.7 percent of SC community households and 30 percent ST community households aware of the scheme. Therefore, it could be inferred that the level of awareness was very meager among SC and ST households.

Table 3: Awareness about Health Scheme among Sample Respondent Households

Sl. No.	Particulars	Awareness-Wise Distribution of Rural Households		
		Schedule Caste Households (30)	Schedule Caste Households (30)	Overall (60)
1	Vajpayee Arogyashree	24(80.0)	19(63.3)	43(71.7)
2	Yeshaswini Scheme	18(60.0)	14(46.7)	32(53.3)
3	Rajiv Arogya Bhagya Scheme	11(36.7)	09(30.0)	20(33.3)
4	Rashtriya Swasthaya Bima Yojana	09(30.0)	07(23.3)	16(26.7)
5	Rashtriya Bala Swasthaya Karyakram	08(26.7)	05(16.7)	13(21.7)
6	Mukhyamantri Santwana Harish Scheme	14(46.7)	13(43.3)	27(45.0)
7	Indira Suraksha Yojane	20(66.7)	15(50.0)	35(58.3)
8	Cochlear Implant Scheme	07(23.3)	03(10.0)	10(16.7)
9	Any Other	06(20.0)	02(6.7)	08(13.3)

Source: Field Survey 2018-19
Note: Figures in parentheses are percentages to total

Rashtriya Swasthya Bima Yojana is a government-run health insurance programme for the Indian poor. The scheme aims to provide health insurance coverage to the unorganized sector workers belonging to the Below Poverty Line (BPL) category and their family members shall be beneficiaries under this scheme. Awareness level about this scheme was found to be very low even in the overall category (26.7%) compared to other schemes. Another scheme, Rashtriya Bal Swasthya Karyakram (RBSK) which was introduced by the Ministry of Health and Family Welfare, Government of India, under the National Health Mission. It was innovative and ambitious initiative which envisages Child Health Screening and Early Intervention Services, a systemic approach of early identification and link to care, support and treatment. The level of awareness of this programme was found to be lowest among the ST households (16.7%) compared to the SC community households (26.7%). In the overall category out of 60 sample respondents only 13 respondents were aware of the scheme whereas the majority of the respondents were unknown.

Mukhyamantri Santwana Harish Scheme which was implemented in 2016 for providing free medical help without any eligibility criteria like poor, rich, APL and BPL. In the overall category 27 respondents were found to be aware of this scheme. In the disaggregate data indicates that more than 40 percent of respondents belonged to SC and ST households knew about it. Indira Suraksha Yojane implemented through Suvarna Arogya Suraksha Trust (SAST).The beneficiaries under the scheme are the dependent family members of the farmers who have committed suicide in Karnataka. Therefore this scheme intended to provide free and quality healthcare for the treatment of secondary and tertiary illnesses involving hospitalization, surgery and other therapies through an identified network of specialty and super specialty hospitals. In the overall category, it was observed that more than 58 percent of respondents were aware of the scheme. The higher percentage of SC (66.7%) and ST (50%) respondents were found to be aware than the other schemes. Karnataka Government was introduced the Cochlear Implant Scheme for providing free treatment to children with severe deafness. Out of 60 respondents, 10 respondents were found to be aware about the scheme and remaining 50 respondents were not at all heard the scheme. It was similar in case of households belonged to SC and ST community. Any other category was also indicated that the awareness about Jyoti Sanjeevini, Universal Health Scheme and Indradhanush was not satisfactory.

6. Findings of the Study

Findings and suggestions of the study were presented as follows;

Socio economic conditions of the rural households of Schedule Caste and Schedule Tribes revealed indicated that still there were socially and economically very backward in the district. Though the illiteracy was prevailing in SC and ST, the majority of them were having only primary education whereas very few of the respondents were having secondary and college education. However, the merely one respondent who belonged to ST community was having college education and hence SC and ST respondents were educationally very backward in the study area. Therefore, the massive expansion of education is required for inclusion of excluded SC and ST community people, especially those who are living in Hadies of the district. Hadies are the places where only tribes are living.

Another interesting result was observed in the study that the SC households prefer to live in small families whereas the ST households were found to be lived in big family. Still rural households of ST community practice the joint family system and SC households are moving towards the small family. Further, the majority of the respondents belonged to SC and ST were landless labours and worked as daily wage laboures. A few were having tiny agricultural land. Hence, it is necessary to extend the social security and comprehensive health insurance schemes which cover all the families whether they live in revenue villages or in habitat.

The nature of housing facilities influence on the health status of the households and thus it was observed in the study that the houses of SC and ST community are completely dilapidated and even they were not suitable for living. Majority of the households were using the wood as a source of cocking the food and also many of the households have not accessible to economic and social infrastructure. In fact, it was true in case of ST households where they were still living in hadies. Therefore, the district administration should extend the central government sponsored schemes such as Pradhan Manthri Avas Yojana and Pradhan Manthri Ujwala Yojana by changing the conditions were laid in the programmes.

Awareness of health schemes ensure the people to get the available medical facilities from several hospitals before falls in sick on the one hand and utilizing the benefits under different health schemes for the treatment of diseases on the other. In fact, it was observed in the study the rural households of SC and ST categories were unaware of the various health schemes implemented by the State and Central Governments. Awareness of health schemes through the mass media and display of various health schemes information on the walls of hospitals and medical centres is not enough because majority of the people belong to SC and ST community are illiterate and residing in rural areas. Further, organizing training and health awareness programmes in Grama Panchayath level is not enough to educate them. Instead of it, the state and central governments must organize the health awareness programmes in remote areas where the majority of SC and ST community people are residing.

7. Conclusion

Health and health awareness are the two faces of a coin because absence of any one will make no value for human life. Therefore, health and health awareness are very important social infrastructure in the society and hence health is not merely free from diseases and injuries but also sustain happiness and wellness throughout life. Recently, the primary, secondary and tertiary healthcare facilities are made available at reasonable charges, irrespective of the

income level, for all sections of the community in the country. In addition to it, the Central and State governments initiated the universal health programmes which ensure not only health but also health insurance for protecting all the people who are living in the destitute conditions. However, the marginalized sections of the society, still they have not yet accessible to basic health facilities due to lack of awareness. In fact, the majority of the rural households were not connected to urban areas for utilizing the health facilities. Especially it is true, in case of schedule tribe people who are living in places where there are no adequate social and economic overheads. Thus, the state must take appropriate steps to transmission of information regarding health and health insurance schemes. It would help to prevent the causalities.

References

[1] Arifur Zaman (2016), "Traditional Medicine and Health Care Practices: A Study among the Deori Tribe of Assam", World Congress on Health and Medical Sociology, September 19-20, 2016 Las Vegas, USA conferenceseries.com
[2] Ashish Roy (2018), "Karnataka Government Health Schemes and Insurance", November 26.
[3] Bipasha Maity (2016), "Comparing Health Outcomes Across Scheduled Tribes and Castes in India", December 11, 2016. WWW. Google.Com.
[4] Economic Survey (2013-2014), Government of Karnataka, Bangalore
[5] Economic Survey (2017-2018), Government of India, New Delhi.
[6] International Student Insurance, WWW. Google.com
[7] Sachin B. Kamble, Neha Seth, Nitesh K. Adichwal, Mritunjay P. Singh and Rahul Sarwade (2018), "A Study on Health Awareness Among Young Mothers in India", Journal of Statistics Applications & Probability An International Journal, **7**, No. 1, 161-182 (2018)
[8] V. Selvam, D. Ashok, P. Pratheepkanth (2019), "Awareness and Perception of Health Issues Among Rural Women", International Journal of Recent Technology and Engineering (IJRTE) ISSN: 2278-3075, Volume-7 Issue-5S, January.
[9] Yadlapalli S. Kusuma, Manisha Pal and Bontha V, Babu, (2018), "Health Insurance Awareness, Utilization and Its Determinants among the Urban Poor", Journal of Epidemiology and Global Health Volume 8, Issue 1-2 December 2018 Page 69-76.