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Strengthening Patient Relationship Management and Continuum of Care through Haat Bazar Scheme in Chhattisgarh

Varun Kumar Sahu
Amity Business School Raipur, Chhattisgarh, India varunsahu1992@gmail.com

Sumita Dave
Amity Business School Raipur, Chhattisgarh, India sdave@rpr.amity.edu

Abstract
The Haat Bazar Scheme in Chhattisgarh addresses significant healthcare challenges faced by the state's rural and tribal populations. Initiated to improve healthcare accessibility, the scheme leverages weekly local markets (haat bazars) to provide essential medical services through temporary camps. These markets, integral to rural life, facilitate outreach to populations with limited healthcare access. The initiative integrates patient relationship management (PRM) and continuum of care principles, ensuring consistent and comprehensive healthcare delivery. Services include consultations, medications, diagnostic services, and health education, significantly enhancing healthcare reach and outcomes. The scheme has served 1,519,318 beneficiaries across 3,260 clinics, with 5,873 individuals referred to higher-level healthcare centers. The average patient visits per Haat Bazar Clinic (HBC) increased from 26 to 38 over one fiscal year and further to 63 during the period from April 2022 to June 2022. District-wise performance showed variability, with Bemetara reporting the highest average of 127 visits per HBC and Balrampur the lowest at 16. Digital technology integration, including telemedicine and digital health records, has connected rural patients with specialists, improved diagnostic accuracy, and streamlined patient information management. The success of the Haat Bazar scheme is attributed to its community-centered approach, strategic use of digital technology, and focus on health education, which collectively strengthen PRM and ensure a continuum of care. The comprehensive documentation and continuous evaluation of the scheme provide insights for replicating this innovative healthcare delivery model in other regions facing similar challenges, thereby promoting universal health coverage. (198 words)

Keywords: Haat Bazar Scheme, Patient Relationship Management, Continuum of Care, Rural Healthcare, Digital Health

1. Introduction
Chhattisgarh, carved out of Madhya Pradesh on November 1, 2000, comprises 16 Chhattisgarhi-speaking districts with a tribal population of 30.62% (Government, 2019). The literacy rate among tribals is 59.09%, against the state average of 70.28%. Forest cover spans 65.2% of the land (Report, 2000). Rural healthcare lags, with neonatal mortality at 35.6 per 1,000 live births versus 19.3 in urban areas, and infant mortality at 48.7 versus 26.2 (NFHS-05). Tribal blocks form 58.21% of the state (Governor's Administrative Report, 2018-19).
Patient relationship management (PRM) builds trust and cuts costs through sustained communication. The Haat Bazar scheme sets up temporary camps in weekly markets, offering

consultations, medications, diagnostics, and education. This brings care to remote areas, raises awareness, and has improved outcomes and reduced mortality.

1.1. Integration of Digital Technology

Digital tools enhance the scheme's reach (Sharma et al., 2023). Telemedicine and mobile units link rural patients to urban specialists (Jha et al., 2021). Digital records ensure care continuity and track trends for resource allocation.

1.2. Purpose

- Study the Haat Bazar model for universal health coverage.
- Explore PRM and continuum of care strengthening.
- Discuss success strategies.
- Document features and implementation.

2. Literature Review

Chhattisgarh's tribal population and forest cover create barriers to healthcare, evidenced by low tribal literacy and high rural mortality (Government, 2019; Governor's Administrative Report, 2018-19). The Haat Bazar scheme integrates services into weekly markets to reach remote areas.

2.1. Patient Relationship Management (PRM) and Continuum of Care

PRM improves satisfaction and reduces costs via sustained communication (Hummel et al., 2014). In rural settings with limited resources, PRM builds trust. Continuum of care provides coordinated services from prevention to follow-up (McDonald et al., 2007). The scheme delivers care in local markets, enhancing both.

2.2. Community-Based Healthcare Models

Market-integrated services increase access and awareness, as seen in Bangladesh (Ahmed et al., 2013). Chhattisgarh's scheme, launched in Bastar in 2020, offers diagnosis, treatment, referrals, and education in haat bazars (HatBazarClinicYojna.Pdf, n.d.; Sharma et al., 2023).

2.3. Digital Health Innovations

Telemedicine enables remote consultations in underserved areas (Wootton, 2012; Jha et al., 2021). Digital records support continuity and epidemiology (Brennan and Bakken, 2015). The scheme uses these to link rural patients to specialists.

2.4. Success Factors

Community engagement tailors services and boosts uptake (Rifkin, 2009). Digital tools expand reach (Bashshur et al., 2016). Health education promotes prevention (Glanz and Bishop, 2010). Provider training sustains technology (WHO, 2016).

3. Haat Bazar Scheme: Innovative Healthcare Delivery Model

The scheme uses weekly markets for camps, starting in Bastar in 2020 (HatBazarClinicYojna.Pdf, n.d.). Services include primary diagnosis, treatment, referrals, and education, reducing out-of-pocket costs toward universal health coverage. Similar models succeed in Bangladesh (Ahmed et al., 2013).

3.1. Digital Technology Integration

Telemedicine improves access and quality (Wootton, 2012; Jha et al., 2021). Digital records streamline management and monitoring (Brennan and Bakken, 2015).

3.2. Strategies for Enhancing Success

Community tailoring boosts acceptance (Rifkin, 2009). Digital tools expand services (Bashshur et al., 2016). Education improves literacy (Glanz and Bishop, 2010). Training sustains initiatives (WHO, 2016).

3.3. Comprehensive Documentation and Implementation

Detailed records aid replication, covering objectives, strategies, and outcomes (WHO, 2016).

4. Methodology

A descriptive study used secondary data from state reports to March 2022.

4.1. Data Collection

Metrics included beneficiaries, services, referrals, and visits from government, WHO, and NGO reports.

4.2. Participants

1,519,318 beneficiaries across 3,260 clinics, staffed by medical officers, assistants, and community workers; 5,873 referrals.

4.3. Data Analysis

Descriptive statistics compared visits over FY 2020-2021 and 2021-2022.

4.4. Ethical Considerations

Secondary public data ensured anonymity; no approval needed.

5. Analysis and Key Findings

1,519,318 beneficiaries received services; 1,419,226 directly benefited; 5,873 referred.

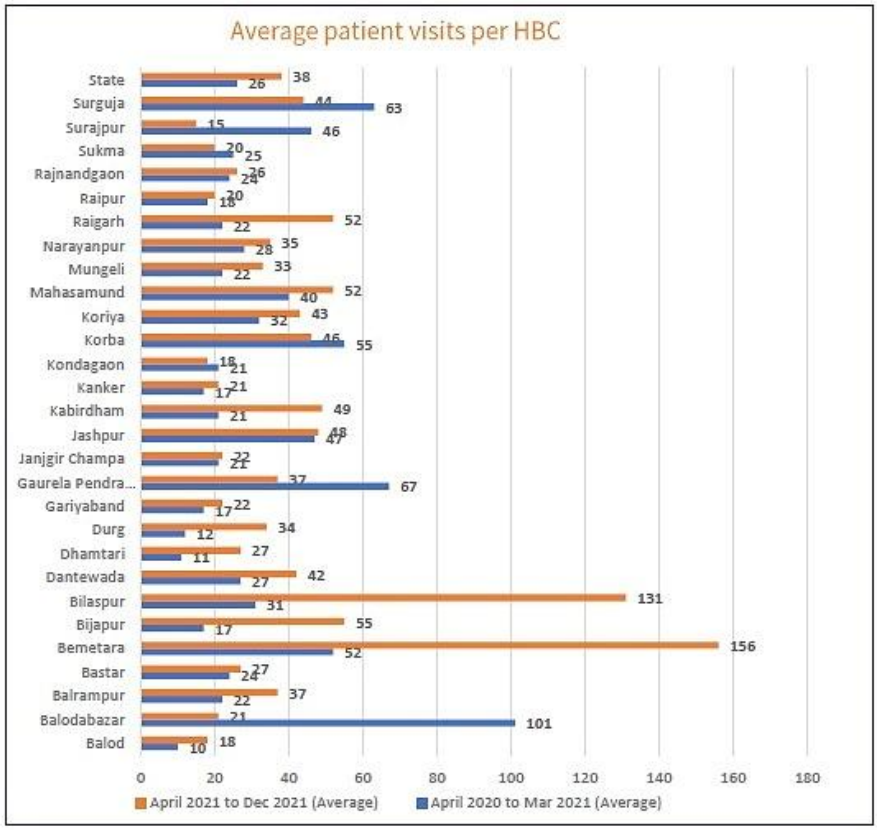

Figure 1. Average patient visits per HBC
(source: Evam and Sansthan, 2023)

5.1. Average Patient Visits per HBC

WHO average: 32; Bemetara 127, Balrampur 16. Visits rose from 26 to 38, then 63 (April-June 2022).

5.2. District-wise Performance

Narayanpur: 637 clinics; Balod: 5,692. Twenty-one districts improved.

5.3. Impact of Socio-economic Factors

Higher literacy and infrastructure correlated with more visits.

5.4. Comparison with Other Schemes

Haat Bazar excels in market-based access and digital continuity (Sharma et al., 2023; Jha et al., 2021). Mukhyamantri Haat Bazar targets maternal health (Chhattisgarh Health Department, 2019). Hamar Clinic builds permanent centers (Government of Chhattisgarh, 2020). Mobile units reach inaccessible areas (National Health Mission, 2020).

6. Conclusion

The scheme enhances PRM and continuum of care via community focus and digital tools. Upward visit trends and beneficiary numbers show effectiveness. Monitoring and equity efforts are vital for scaling.

7. Discussion

The Haat Bazar scheme addresses healthcare access barriers in Chhattisgarh's tribal and forested regions by integrating services into weekly markets (Sharma et al., 2023). Over 1.5 million beneficiaries across 3,260 clinics reflect substantial reach (Evam and Sansthan, 2023). Telemedicine connects rural patients to urban specialists, improving diagnostic accuracy (Jha et al., 2021), while digital records ensure care continuity and epidemiological tracking (Brennan and Bakken, 2015). Patient visits per HBC rose from 26 to 63, indicating growing acceptance (Evam and Sansthan, 2023).

Community engagement, digital integration, and health education drive success (Rifkin, 2009; Bashshur et al., 2016; Glanz and Bishop, 2010). Compared to permanent clinics (Hamar Clinic) or scheduled units (MMUs), the scheme's market-based temporality reduces access costs (Government of Chhattisgarh, 2020; National Health Mission, 2020).

Limitations include reliance on secondary data and district variability (e.g., Balrampur's 16 visits). Future research should assess long-term mortality impacts and cost-effectiveness via primary surveys.

8. Data Availability

The data used in this study are secondary and sourced from publicly available Government of Chhattisgarh health reports and WHO publications up to March 2022. Full datasets and performance dashboards are accessible via the National Health Mission Chhattisgarh portal and state health department annual reports.

9. **Acknowledgments**
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References

1. Ahmed, S.M., Evans, T.G., Standing, H., Mahmud, S., 2013. Harnessing pluralism for better health in Bangladesh. Lancet 382, 1746-1755.
2. Bashshur, R.L., Shannon, G.W., Smith, B.R., Alverson, D.C., 2016. Telemedicine/telehealth: an international perspective. Telemed. e-Health 22, 373-382.
3. Brennan, P.F., Bakken, S., 2015. Nursing needs big data and big data needs nursing. J. Nurs. Scholarsh. 47, 477-484.
4. Chhattisgarh Health Department, 2019. Mukhyamantri Haat Bazar Clinic Yojana. Annual Report.
5. Evam, P., Sansthan, S., 2023. Chaupal Gramin Vikas Strengthening the Haat Bazaar Clinic Yojana in Chhattisgarh. http://apps.who.int/bookorders.
6. Glanz, K., Bishop, D.B., 2010. The role of behavioral science theory in development and implementation of public health interventions. Annu. Rev. Public Health 31, 399-418.
7. Government of Chhattisgarh, 2019. Census of India 2011. http://censusindia.gov.in/.
8. Government of Chhattisgarh, 2020. Hamar Clinic Initiative. Official Document.
9. Governor's Administrative Report, 2018-19. Chhattisgarh: Tribal and Rural Health Statistics.
10. Hummel, J., Evans, P., Lee, H., Serra, J., 2014. Patient Relationship Management: CRM for Healthcare Providers. HIMSS Analytics.
11. Jha, A.K., Prasanna, A., Raghavan, A., 2021. The potential of telemedicine in India. J. Fam. Med. Prim. Care 10, 1841-1846.
12. McDonald, K.M., Sundaram, V., Bravata, D.M., Lewis, R., Lin, N., Kraft, S.A., Owens, D.K., 2007. Closing the quality gap: a critical analysis of quality improvement strategies (Vol. 7: Care Coordination).
13. National Health Mission, 2020. Mobile Medical Units: Reaching the Unreached. Ministry of Health and Family Welfare.
14. Report of the National Health Survey, 2000. India: Rural Health and Healthcare Disparities.
15. Rifkin, S.B., 2009. Lessons from community participation in health programmes. Health Policy Plan. 24, 1-3.
16. Sharma, R., Singh, S., Verma, P., 2023. Digital health innovations in India's rural healthcare: The Haat Bazar scheme. Int. J. Health Serv. 53, 123-135.
17. WHO, 2016. Global diffusion of eHealth: making universal health coverage achievable. World Health Organization, Geneva.
18. Wootton, R., 2012. Twenty years of telemedicine in chronic disease management–an evidence synthesis. J. Telemed. Telecare 18, 211-220.