Introduction
The Indian sub-continent has diversified landmass and huge population. Currently the country has crossed over 1.2 billion population. India is one of the fastest developing countries in Asian region. The development is also included in better quality and standard life style of the people. It has understood through the status of Human Development Index [HDI]. It has indicated from the infant mortality, maternal mortality ratio, life expectancy, birth-rate, and malnutrition level etc. In the HDI, India’s position is 136th out of 187 countries (2013), it is ranked in medium rate, and malnutrition level etc. In the HDI, India’s position.
Sub-Centre is maintained by one Auxiliary Nurse Midwife (ANM) and one Male Health Worker/ MPW(M). One Lady Health Worker (LHV) is assigned to supervise six Sub-Centres. The Sub-centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhea control and control of communicable diseases. Also the Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of the rural people. The Ministry of Health & Family Welfare is providing 100% Central assistance to all the Sub-Centres in the country, since April 2002 in the form of salary of ANMs and LHV’s, rent at the rate of Rs. 3000/- per annum and contingency at the rate of Rs. 3200/- per annum, in addition to drugs and equipment kits. There are 148366 Sub Centres functioning in the country as on March 2012.

Primary Health Centres (PHCs)

The PHCs are the first contact spots between village community and the Medical Officer. The PHCs are provided curative and preventive health care and Family Welfare Services to the rural population. The PHCs are established and maintained by the State Governments under the Minimum Needs Programme (MNP)/ Basic Minimum Services Programme (BMS). Currently a PHC is managed by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 Sub Centres. It has 4 - 6 beds for patients. There are 24049 PHCs are functioning as on March 2012 in the country.

Community Health Centres (CHCs)

The CHCs are being set-up and maintained by the State Government under MNP/BMS programme. It is operated by four medical specialists i.e. Surgeon, Physician, Gynecologist and Pediatrician and supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray unit, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. As on March, 2012, there are 4833 CHCs functioning in the country.

Challenges in Providing Health care Facilities

India is a geographically divided and diversified populated country. Therefore to provide equal and better medical care to every citizen of India is a major-challenging task. However the government have succeeded in controlling and eradicated some of the major diseases like Polio, Leprosy, small box, etc., Nevertheless, these are not an indicators for the success level of the health care facilities in India. The majority population of the country are facing many of the challenges and struggles such as infrastructure facilities including the manpower in the hospitals, approach road and transportation facilities, the people's own cultural and traditional way of medical practices, economic imbalance of the people, not affordable treatment cost of poor people and lack of awareness on diseases and treatment and absenteeism of medical practitioners and supportive staff in the hospitals. In India there is only one doctor per 1,700 citizens. India has 387 medical colleges (181 in government and 206 in private) and it has produced 30,000 doctors, 18,000 specialists, 30,000 AYUSH graduates, 54,000 nurses, 15,000 ANMs and 36,000 pharmacists per year. But this strength of medical personnel is not enough to provide better treatment for the huge population. While the Union Health Ministry figures claim that there are about 6-6.5 lakh doctors available, India would need about 4 lakhs doctors more by 2020 to 50,000 doctors for PHCs; 0.8 lakh for community health centres (CHC); 1.1 lakh for 5,642 sub-centres and another 0.5 lakh for medical college hospitals. According to Medical Council of India survey the 75% of doctors’ practise in urban areas and 23% in semi-urban areas. The government takes efforts to place the Doctors in the rural areas but it has not fully implemented and the doctors are refused to work in the rural areas. But India is one of the rural area based countries, its majority of the population living rural areas.

Telemedicine Programme in India

The term telemedicine coined in the 1970s, which literally means “healing at a distance”. The telemedicine method of treatment system has introduced in the mid to late 19th century, but its modern form was started in the 1960s in the military and space technology sectors, as well as a few individuals using with available commercial equipment. The major focused areas of telemedicine services are on diagnosis and clinical management. It has offered in the industrialized countries such as the United Kingdom of Great Britain and Northern Ireland, Scandinavia, North America, and Australia. The biometric devices in the telemedicine system have used for measuring and monitoring heart beat rate, blood pressure and blood glucose levels. The telemedicine system has overcame the geographical barriers, and increase access to health care services, particularly for the rural and un-deserved communities in developing countries, those who are traditionally suffering from lack of access to quality health care.

India is one of the vast geographical landscape countries spread over an area of 3 million square kilometres. The population strength is more than 1.2 billion across 29 states and six union territories. Almost 70% of the population resides in rural areas lacking access to medical expertise and infrastructure. The healthcare delivery is difficult in its geographical terrain such as mountain regions in the northeast, deserts of the northwest, and the off-shore islands of Andaman and Lakshadweep. In this background, India is one of the appropriate countries for implementing the telemedicine based healthcare facilities to its rural populations. In this circumstance Government of India such as the Ministry of Information Technology, Science & Technology and Space have been experimented the telemedicine as pilot projects since early 2000, and the successful outcome of these pilot projects, the Ministry of Health and Family Welfare has adopted the telemedicine programme into the National Rural Health Mission an initiative focused on improvement of the rural healthcare delivery system. There are various telemedicine initiatives have been taken up by both government and private sector organizations with central and state funding. The following are some of the examples for such major telemedicine initiatives in rural areas of India: Indian Space Research Organization (ISRO) GRAMSAT, the Apollo Telemedicine Networking Foundation, Village Resource Center (VRC)
The Challenges ahead in the Telemedicine programme

The traditional method of treatment gives an emotional relationship between the patient and the doctors. The patients wanted to touch their body by doctors and speak with them personally during the treatment for their illness. Therefore the implementation of telemedicine in the rural is difficult task for the service providers of the telemedicine programme. In addition it has closely associated with attitude and behavior of the rural people.

The basic literacy and ICT based literacy are other setbacks for the implementation of the telemedicine programme in the rural community.

The legal issues related to problems of the telemedicine is not properly taken care by the government as well as the private service providers. The governments are not implemented the appropriate policies for the telemedicine programmes.

The privacy of the patient and maintaining confidentiality on the diseases are major significant process in the method of treatment, but in the telemedicine programme following two are unable to sustain properly.

Lack of emotional and moral support from the doctors during the process of treatment.

Lack of infrastructural facilities like electric power backup, quality instruments, internet connectivity and location of the places

Lack of availability of the man power such as Doctors and the services providers and the relationship between the local kiosk/ information centers/ common services centers operators and rural people.

Practice of the traditional knowledge in health care by the rural community

A shortage of studies and documentations work on economic benefits and cost-effectiveness of telemedicine applications.

Lack of effective support from government such as policy for implementation of the telemedicine programme.

Suggestions:
The followings are some significant suggestions for the effective implementation and further functions of the telemedicine programme in the rural areas in India

Taping traditional health care practices of the rural community with telemedicine programme.

Create connectivity between the rural kiosks, sub centers, primary health centres, community health centers and district level hospitals. This system should also include with nearby medical college hospitals and eminent doctors in the local areas.

Create better professional and personal relationship between the people, grassroots service providers and technocrats. It will help understand the real ground status.

The public and private stakeholders of the telemedicine programme should be ensure the infrastructural facilities of the telemedicine centers

• To create separate policy for implementing the telemedicine programme. It should give legal support to this programme
• To create awareness on telemedicine programme to the rural people. It will help to reduce the unnecessary emotional and ethical doubts of this programme
• To motivate the scientific and academic community to do the research studies on the telemedicine programme

Conclusion

The invention of technologies and implementation in the community and further obtaining the benefits of technologies by the grassroots beneficiaries are interlinked process in the community development process. This process has to perform appropriately, otherwise there will a major setback in the real and fundamental concept of the technologies. This could be applicable to the telemedicine programme also, this is because it has closely associated with health related sentiment of the people. Therefore before implementation of this kind of programme in the community the technocrats and the service providers create awareness and solved the technological related doubts to the people. It would be a success formula for people oriented technological programme implementation in the community.

References
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