The National Rural Health Mission: A Stocktaking

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The failure of decentralisation, the lack of inter-sectoral coordination, and the undermining of traditional health support are the reasons why the National Rural Health Mission has not delivered what it had set out to achieve.

The Alma Ata United National conference's mission statement, Health for All by 2000, has come and gone, but we continue to suffer from poor health status and a weak public healthcare system. Indian public health owes its framework to the Bhore Committee's (headed by Joseph Bhore in 1943) lofty recommendations made in the pre-independence years. The committee suggested an elaborate hospital and health centre network and free care for all. This top-down western model could not fully penetrate the entire country due to paucity of funds. In the 1970s the family planning obsession nearly wrested all other initiatives from the health department. This started the era of overseas agencies deciding our health plans and priorities. This weakened public health system withered and finally gave way to a competing private medical sector. Meanwhile in the same period, China was busy making its very own widely based pyramidal healthcare system – from a million barefoot doctors to provincial hospitals. The Chinese healthcare system has inspired the paradigm shift from the western model to the primary healthcare approach delineated at Alma Ata. India is still struggling to establish its healthcare system. The Alma Ata driven change of direction in India was short-lived. The Indian National Health Policy 2002 recognised the sorry health situation and suggested a basket of reforms from co-opting rural doctors to medical tourism. However, the Millennium Development Goals (MDGs) had finally replaced the Health for All 2000 plan with a selective health agenda. The consequent National Rural Health Mission (NRHM) launched in 2005 by the United Progressive Alliance government set out to attain the MDGs with "architectural corrections" in the health system. It would be useful to take a mid-course review of this yet another ambitious programme to know if we are on the right path.

The main objectives of NRHM are to reduce infant mortality and maternal mortality rates following the MDGs. This is expected to be achieved through promoting institutional births and thereby protecting both the mother and the newborn. The NRHM has woven everything around this core programme. The new Accredited Social Health Activist (ASHA) escorts the expectant mother to a public or private hospital. For this she is paid Rs 700 per case (as incentives plus costs), and the mother also gets cash maternity benefits. This is termed as the Janani Suraksha Yojna (JSY). Other expectations are that the health centres and hospitals will be improved; and the health sub-centre gets an additional nurse.

To manage all this better, the NRHM has a three-pronged strategy of (a) community involvement, (b) decentralisation to panchayati raj institutions-zilla parishads, and (c) programme management units in each district. The centre has increased funds for NRHM by repackaging ongoing schemes. Public-private partnerships (PPPs) are supposed to take the agenda to the private sector. All vertical (centre to state) programmes are now brought under a parallel system of societies – at state and district levels with separate fund flow. The village will have a Health and Sanitation Committee (VHSC) and a fund of Rs 10,000. The NRHM also mentions private sector regulation and health insurance in its guidelines. The entire mission has a provision of Rs 12,000 crore in the 2008-09 national budget and more is expected each year till 2012, presumably to a level of about 2 per cent of the gross domestic product from the current level of 1.2 per cent. The NRHM has another 46 months to go and a lot of ground to cover.

Decentralisation and Financing

Health is a state subject. The central government mainly provides the overall framework; plan funds and support for all national health programmes. Though flexibility is its keyword, the NRHM's design and budgeting leaves little creative freedom for states. The states have their own problems of rural health services and need special political will and strategies. The utilisation of NRHM funds in states is both tardy and ineffective. Many schemes

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are not understood properly even in the third year of NRHM. Vernacular versions of state/district plans are still non-existent. Bureaucrats have bypassed technical heads as mission directors, ostensibly in order to hasten the mission implementation. NRHM is also yet to catch the attention of the political community.

The NRHM provides for fund allocations and powers to states and district societies. The VHSCs get Rs 10,000 as untied funds, and this account is jointly operated by the sarpanch and ASHA or anganwadi workers. The district health action plans were often "a fill in the blanks" for some local officer or consultant. There was and is no scope for innovation, local resource use or lateral thinking. The district elected representatives have very little knowledge of the NRHM. Hence there is little scope for imagination and creativity for the stakeholders. In the light of the 73rd amendment, NRHM could have encouraged gram panchayats to create their own health stations with these funds, with a well-trained ASHA to help. After all, what most village people need and want is medical aid. "Communitisation" mainly implies control of health centres by the panchayats and other stakeholders through the Rogi Kalyan Samitis (RKS) and VHSCs. But the RKS rarely meet as revenue officials have little time for it. The VHSC exists more often as a bank account. Involvement of the panchayati raj institutions is essential, but only a few states have ensured that they have been given orientation on the NRHM (perhaps television campaigns would have served well).

The NRHM's financing model – fund flow from the centre to the state and then to district societies – was to provide flexibility to the mission. But since the mission is treated as being outside the treasury system and therefore not subject to internal audit by the respective departments of the state, has only resulted in a situation where corruption and financial scandals rule the roost. This red-tapism is a legacy of other programmes on reproductive child health (the old family planning programme), national AIDS control programme and health system development projects which were possible due to donors and organisations such as the World Bank. In essence, such unaccountability has resulted in the spawning of government authorised non-governmental organisations (NGOs), myriad NGOs, contractors, subcontractors, etc. The financial model of NRHM owes an explanation, for it has to be accountable to the public who finance it through the tax system. Such unaccountability in the NRHM is a threat to the already dilapidated state of the overall health system and its financing.

Improving Human Resources

The insitution of the Indian Public Health Standard (IPHS) is a good idea (akin to the International Organisation for Standardisation). IPHS lists physical and human resources requirements. However even after three years very few hospitals fall under the purview of IPHS. The causes are macroeconomic (power and water scarcity) and systemic – paucity of doctors and nurses and ubiquitous governance problems.

Doctors abhor rural centres because of poor infrastructure and working conditions; apart from the universal attraction of the cities. The salaries are poor (Rs 12,000-18,000 per month) and the lack of work-satisfaction is a genuine problem. In most states, appointments are mostly contractual and money is demanded at all levels. The annual salary given to doctors is so low that this acts as a deterrent to the commitment of the doctors. The idea of compulsory postings before postgraduation is not likely to improve matters. Many doctors attend rural offices only for a few hours and commute back to cities. Not ensuring a right skill mix of doctors (for example, the presence of anesthetists along with surgeons, etc) at every rural hospital is another reason for the mismanagement of rural health centres. The lack of a good and transparent human resources policy encourages corruption and discourages good work. The shortage of nurses is due to a thoughtless human resources management policy of the Nursing Council, and hence only 30 per cent nurses' positions are filled and that too with great difficulty. On the other hand, the idea of posting another auxiliary nurse-midwife (ANM) at sub-centres (a cluster of 5-10 villages) does not address the basic gaps in provisions at the village level facilities. The resources (Rs 5,000 per month for the ANMs) could have been better used for improving the ASHA programme in the cluster of 6-10 villages.

The institutional obsession of NRHM will discourage the ASHA, ANM and the multipurpose health workers (MPHWS) from extending any primary medical care to locals. The dai system is a major casualty of NRHM, depriving people from

remote villages, the only help in times of difficulty. Instead the NRHM could have offered graded care involving dais for perinatal care, occasional home delivery and as a JSY escort. This would have won community acceptance. The ASHA is anyway only escorting the expectant mother to a hospital. A major folly of NRHM is to completely bypass the MPHW system, which has fought major public health battles against diseases such as small pox, cholera, malaria, leprosy and now tuberculosis. The NRHM could have encouraged MPHW to combat the new infections and chronic diseases like hypertension and diabetes. This deliberate neglect of the base of the human resources pyramid questions the very wisdom of the structure and objectives of the NRHM. The NRHM is targeting only women as workers part of the mission and bypasses men MPHW, in a way eliminating the role of men in health work actions.

The ASHA Scheme

The ASHA scheme, after the deplorable withdrawal of the 1978 community health worker (CHW) programme, could have been better planned. The programme (a male and female community health worker in each village) was hacked to death by uncaring bureaucrats and the apathetic Congress regime in the mid-1980s. The eight tasks of the health activist in the ASHA scheme are only for namesake, the main being taking "delivery cases" to the rural hospitals and gathering children for pulse polio and other immunisations. This is ostensibly to raise the "demand" of health services among "clients" who otherwise either prefer home delivery or go to any nearby private doctor. To waste a potent programme like ASHA for merely escorting women to unwilling hospitals is a questionable strategy.

The average ASHA is hardly getting the promised Rs 1,400 per month. I found in my recent visit to Uttar Pradesh that the average monthly earning of ASHAs is just Rs 250. They are going through untold hassles at every level, more so in the north-eastern states. Training is poor, barely halfway and accreditation is yet to even begin. Drug kits are either not supplied or not refilled. The drug kit consists of just four medicines (iron tablets, chloroquine, paracetamol and oral rehydration therapy (ORT) packet for diarrhoea). Ayurveda and homeopathy remedies have not arrived. Thus the small kit is only to prevent the criticism that ASHAs are mere lackeys in the system. Denying ASHA a meaningful curative role ignores the fact that there exists a basic gap in our public health system. ASHAs are supposed to be activists but in reality, ASHAs are not equipped to undertake their complex social roles in rural areas. The NRHM has cleverly used this angle for making the ASHA a dispensable item.

Inter-sectoral Coordination

Coordination and cooperation with the water and sanitation sections of the rural development department and with the Integrated Child Development Services (ICDS) (department of women and child) are much needed for the NRHM's successful implementation. Yet, sanitation work is still in the "pits" in most states, as stories of coercion for installation of toilets abound rather than persuasion and education, to quote one example.

Anganwadi workers look at the ASHA as some kind of an adversary in the same field of work. This is because of the fact that such workers get a salary of Rs 1,400 per month while ASHAs have the opportunity to earn Rs 700 in one instance of work done. The anganwadi worker also has the herculean task of combating malnutrition and other socio-economic adversities.

Lots of potential exist in the prospect of integrating the ayurveda, yoga, unani, siddha and homeopathy sector (the AYUSH sector) in some spaces of the NRHM, but such a presence is quite lacking. The AYUSH medicine, equipment and knowledge base is inadequate in the ASHAs' kit and capabilities.

As regards, coordination with the private sector, a proper form of it is not possible unless there is a concrete PPP policy and strategy for providing a guarantee for universal health coverage. The NRHM is relying upon the private medical sector only for JSY maternity services. Gujarat, for example, has used this scheme fully through the Chiranjeevi Yojna, albeit at the cost of public hospitals. Public hospitals have started losing clients and government doctors have resented their counterparts in the private business of health. Also, the business of clandestine referrals from public to private sector was already on, the JSY has only formalised it. On the whole, good inter-sectoral business is still missing in NRHM.

Conclusions

The three years of NRHM have made only marginal impact on the health system; apart from some rise in institutional deliveries. The ASHA can be a positive feature of NRHM but it remains weak in training, accreditation, drug kit/refill, payment. This reduces the activist (envisaged to be a committed worker) into a lackey of the system. NRHM is using the system of providing incentives for institutional births (and family planning). This is neither sustainable nor wholesome. Home births will still be around for some time, and not supporting dais is bound to hurt those home births seriously.

The IPHS may be confined to some repair and equipment, but with non-participation of doctors and paucity of nurses these tangential IPHS decorations will erode. We need better working and service conditions for doctors and nurses rather than coercive laws. The NRHM-ICDS integration is in jeopardy, due to the very JSY wedge.

The private sector has a 70 per cent share in healthcare but is largely bypassed in NRHM, leading to no great progress in the integration of the health sector. Involvement of the private sector with a well thought-out long-term plan for integration of the two sectors through regulation is necessary. PPPs are a pragmatic need but this has happened only in the "creamy" layers and not much in delivery of services save perhaps the Marigold initiative in UP. The RKS are also functioning poorly. Community monitoring of NRHM is limited to some NGOs. Monitoring itself is weak. Transparency and public reporting are scant, especially in the vernacular press. However, the advertisements on TV have certainly helped spread the word on NRHM.

States (and hence panchayati raj institutions) deserved more creative freedom for their perceived needs. Is NRHM's diminishing the role of states in healthcare by

pushing centrally fabricated schemes? There is a serious mismatch between the local needs and NRHM prescriptions. States have however not graduated to raise such a question even in the sixth decade of independence.

Use of funds at state and district levels is either tardy in many states or hasty in some states like Madhya Pradesh. Audit reports are not made public, as is expected of NRHM. The untied fund is verily a problem rather than a solution. The donor dominance has damaged the cause of the National Mission. Unfortunately now more donors are at play, like the case of the Norway-India project (for the Home-Based Neonatal Care) worth $ 80 million in a nearly opposite direction of the JSY driven institutionalisation. Thus issues concerning the infant mortality rate and maternal mortality rate will now be discreetly pursued by donors. The donors can redesign our programmes upside down. This sad legacy continues from the days when the family planning department started dominating the health ministry.

India's health performance is rather low because of weak fundamentals like nutrition, sanitation, hygiene, gender inequality, and helpless urban migration. The widening India-Bharat divide has worsened these factors. In addition we have severe mal-distribution of health services – both public and private. The Indian healthcare system has become an inverse pyramid with very little primary care as foundation and ever-ballooning "medical" sector through a hospital-doctor-centric and urban model which is largely privatised, unregulated and western-oriented. The rights approach of NRHM may unwittingly come in handy for promoting the health institutional sector. But can NRHM help? The NRHM has however turned out to be an antithesis of primary healthcare – which was supposed to be essential, acceptable, accessible, affordable, participatory and appropriate healthcare for all. NRHM may prove to be a costly and irrational donor tonic for the sick health system of India. We can ill-afford the NRHM in its present structure and as it is implemented today. There is need to pause and rethink.