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ORIGINAL ARTICLE

RURAL HEALTH CARE SERVICE IN INDIA: AN OVERVIEW

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Abstract:

As a part of socially progressive Common Minimum Programme, the UPA Government launched the National Rural Health Mission (NRHM) in 2005. It aimed to undertake an 'architectural correction' of the public health system to enable it to effectively absorb increased expenditure to provide accessible, affordable and accountable primary health care services to poor households in remote parts of rural India.

INTRODUCTION

A regional equity component required the increase in central government plan outlay be channeled through a weighting system towards the development of health systems in eighteen 'focus' states with relatively poor health indicators, mostly the Empowered Action Group (EAG) states of the central north Indian belt and the northeast region of the country NRHM[1-7] is the largest primary health care programme being run in any single country.

Major objectives of this paper are to include the public spending on health. with improvements in community financing and risk pooling; to provide access to primary healthcare services for the rural poor, with universal access for women and children; to see a concomitant reduction in IMR / MMR / TFR; to prevent and control communicable and non-communicable diseases; and to revitalize local health traditions. In essence, these do not differ from health plan goals adopted by India over the last sixty years.

TARGET

The Mission's uniqueness lies primarily in the institutional instruments used to achieve these goals, foremost amongst which are attempts at structurally reconfiguring the public health system to facilitate decentralisation and communitisation, widely accepted as beneficial trends in the development sphere today. In recognition of the multidimensional causality of disease, to further promote inter-sectoral convergence in services which co-determine decent health outcomes, such as the provision of adequate food and nutrition, water, sanitation and hygiene; and to integrate previously segregated vertical disease-specific programmes at the national, state, district and block levels.

Visible manifestations of this 'architectural correction' include the provision of a flexible financial pool for innovative and need-based decentralised utilisation of funds at the state level, along side provisos for planning and management at the district level. Furthermore, the creation of female health activists (ASHAs) and PRIs, such as village health and sanitation committees (VHSCs), as a means of fostering a true partnership between the community and peripheral health staff in achieving desired outcomes. The key forward- thinking developmental agenda of the scheme, in common with other social sector initiatives introduced by the UPA (such as the Sarva Shiksha Abhiyan in education), thus lies in promoting a well-functioning devolved public delivery system through the provision of flexible grants to improve infrastructure, human resources and capacity, in addition to structural change in the direction of a bottom-up institutional framework of governance and accountability. The latter has been externally imposed at this stage, in the hope that local communities will eventually actively participate in shaping the public health

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system to better serve their varied needs.

NRHM Strategies

Creation and upgradation (on infrastructure / human resource / managerial fronts using untied funding) of SCs, PHCs, CHCs; Revitalising and mainstreaming AYUSH; Mission Flexible Pool untied funding: Janani Suraksha Yojana (JSY); Accredited Social Health Activists (ASHA5); Involvement of community at decentralised levels through Hospital Development Societies (HDS) or Rogi Kalyan Samitis (RKS) / Village Health and Sanitation Committees (VHSCs); Converging health, nutrition, water, sanitation and hygiene activities through District Health Plans; Integration of vertical health and family welfare programmes at national, state, district and block levels; Fostering public-private partnerships while regulating the private sector: Instituting Indian Public Health Standards.

METHODOLOGY

Strategies and guidelines for NRHM were finalised during the course of 2005-06, with an implementation framework approved by the Cabinet in July 2006. A separate budget head for NRHM was introduced only during the fiscal year 2006-07. In many ways, it is too early and too late for certain kinds of impact evaluation of the NRHM. Too early because improvement in health outcome indicators (IMR, MMR, TFR etc.), which may confidently be ascribed to the mission's efforts, will only become apparent after a significant time-lag. Too late because evaluation was not built into project design, hence baseline figures and consistent state-level data, especially in relation to targets, is lacking, thus hampering a yardstick assessment on how the mission is faring in various regions Moreover, a randomised evaluation is unfeasible at this stage because NRHM has already been introduced across rural areas, therefore a control area where the mission has been withheld — a political problem with government sponsored schemes in any case - is missing.

Consequently, an evaluation of service delivery in public primary health care at the decentralised district level is the singular focus here. A recent internal Planning Commission review of NRHM based on secondary data from the Ministry of Health and Family Welfare, as well as independent institutional sources (Gill 2008), confirmed the paucity of evidence-based material and systematic analysis of the delivery of health care in rural India found by other academics (Banerjee, Deaton and Dutlo 2004). A group presciently engaged on research in this area at the state level, albeit overview studies rather than detailed analysis based on field data gathering initiatives, is that lead by Prof. Jeffrey Sachs of the Earth Institute at Columbia University (inter a/ia, Bajpai and Goyal 2004, Bajpai, Dholakia and Sachs 2005).

On appropriate and feasible measures to assess quantity and quality of primary health care, the former is assessed on the static and dynamic condition of physical infrastructure; by the numbers of paramedical, technician and medical staff employed, as well as figures for attendance and gender (relevant to RCH interventions); by the supply, quality and range of drugs; by availability and usage of decentralised untied and maintenance funding of centres; and by actual availability of laboratory, diagnostic and service facilities. On quality of health care delivery, vignettes as a measure of process quality might be ideal but structural quality i.e. quality defined in relation to the condition of the above tangibles, have had to do for pragmatic reasons (Das and Leonard 2006). This is supplemented by subjective data on intangibles, such as patient satisfaction, gathered from the exit interviews.

CONCLUSION

The present study is restricted to a primary evaluation of service delivery at the district level and below, therefore strictly speaking financial issues pertaining to NRHM at the macro level lie beyond its purview. Given the importance of funding to the performance of the scheme at every level, whether real or perceived, I make an exception to analyse and discuss secondary data on financial aspects of the Mission before proceeding to a discussion of study results. After all, I do not want to disappoint the reader who will

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