

Health Evidence from the States

AMARJEET SINHA

The quality of implementation of the National Rural Health Mission in a number of states has transformed the public healthcare system considerably. Learning from these improvements which have focused on the grass roots, local recruitment is the best way to forge a credible public health system that has public accountability.

Amarjeet Sinha (amarjeetsinha@hotmail.com) is a civil servant with a keen interest in the social sector.

There is a lot to despair as far as India's health indicators are concerned. They do not match our economic performance over the last two decades. Public expenditure on health in India as a proportion of the gross domestic product (GDP) continues to be one of the lowest in the world, in spite of an increase from below 1% to a little over 1% with the National Rural Health Mission (NRHM). The crib deaths in West Bengal, the misuse of NRHM funds in Uttar Pradesh, the poor state of maternity homes in the country's capital among other such similar happenings have rightly resulted in a public outcry. The state of the public system, subjected to unprecedented neglect for decades, is truly shocking in many parts of the country. The conduct of government health workers in some health facilities also does not generate confidence that the public system will deliver basic health services of a decent quality. The despair is so overwhelming that often the

critics miss out on some of the emerging positive trends in many hitherto backward states. Though the NRHM is a centrally sponsored programme, health is a state subject and it is the leadership at the state level that makes all the difference.

The Evidence

The just published Sample Registration System data from the Registrar General of India (RGI) census office places the infant mortality rate (IMR) of the country for 2010 at 47, a three-point decline for the second consecutive year. The IMR declined by a bare three points, from 60 to 57 between 2003 and 2006. Between 2007 and 2010, the decline is of 10 points. More interestingly, the rate of decline in rural areas is almost double that of urban areas during this period. The IMR decline in hitherto backward states like Bihar, Rajasthan, Madhya Pradesh, Chhattisgarh, and Orissa, has been between three to five points per year, a rate never achieved previously in consecutive years. States like Tamil Nadu and Gujarat have also made significant gains during this period. It is true that Uttar Pradesh and Assam have lagged behind in the rate of decline over the last two years,

putting the national level decline at three instead of four points. Surely, there is a change that needs to be taken note of.

Credit to the Public System

Unfortunately, these declines have not got the attention that they deserve. Perhaps this is so because it is the public system that has made the difference and a good word for it in the media is rare. The Ministry of Health and Family Welfare also seems reluctant to take credit for this change as the NRHM is actually implemented by the states. The performance audit of the NRHM by the comptroller and auditor general (CAG) had some good words as well on the work done in the states in this regard. However, the Public Accounts Committee (PAC) expected speedier implementation (even though the additional funds as projected were never made available at that rate!) and a bigger role for Members of Parliament (MPs) as well. Since primary health is a subject transferred to panchayats by the Constitution, the NRHM's framework for implementation provided a very active role for the panchayats, civil society, community organisations and for community monitoring.

View from the Field

A person travelling across the length and breadth of the country will realise that the change brought about by the NRHM is a very real one. Dirty, dingy and uncared for health facilities are receiving a facelift with the NRHM's untied grants. Nurses and doctors have been recruited on an unprecedented scale for the public system. Innovations and partnerships for emergency transport, diagnostics, drug availability, human resources for health and infrastructure development, are going on at a significant scale. Professional managers, accountants, and data professionals are available to the public health-care system for the first time and in large numbers. The Janani Suraksha Yojana (JSY) has brought women to health facilities for institutional deliveries on an unprecedented scale, taking the national coverage to over 70% from a low of 44% just five years ago. It is true, however, that there are huge quality gaps in many places.

Nothing exemplifies the transformation as dramatically as Bihar does. From

39 patients a month at block primary health centres (PHCs) in 2005, the state has recorded more than 3,500 patients per month for the last three to four years. Institutional deliveries are up from 1.4 lakhs to over 13 lakhs a year. Drugs, diagnostics and doctors are available round the clock at all the PHCs with outsourced arrangements for generators, ambulance, security and cleanliness. The dead health sub-centres and additional PHCs have also been revived with the outpatient department (OPD) services by the auxiliary nurses and midwives (ANMs) and the ayurveda, yoga, unani, siddha and homeopathy (AYUSH) doctors. Surely, the change in the public system is remarkable. Bihar now almost equals the national IMR and its death rate is better than the national average!

Transformation in States

Every state has its story of transformation of the public system. Tamil Nadu leads the way with NRHM funds being put to very good use to ensure that the PHCs work round the clock and are fit for quality institutional deliveries. The turnaround is seen in the cascading decline of maternity mortality ratio (MMR) and IMR there. Very silently, Madhya Pradesh has pushed its institutional deliveries to over 80% and Chhattisgarh has engaged over 800 rural medical assistants (RMAs) and 34,000 mitanin community workers to meet the human resource gaps. Orissa has focused on strengthening its PHCs and district hospitals while Rajasthan is now trying to guarantee full availability of medicines free of cost.

The efforts at crafting credible public systems under the NRHM began with provision of management, accountancy and data professional at all levels. The thrust on decentralised planning and need-based provision of human resources and flexible untied funds to cover gaps, created confidence in the failing public systems to start delivering quality services. The Accredited Social Health Activist (ASHA), the most visible face of the NRHM, has helped in connecting households to health facilities and in putting pressure on the availability of services. Innovative programmes like the 18 week life-saving anaesthetic skills (LSAS) or the 16-week

emergency obstetric care (EMOC) for MBBS doctors, helped in partially bridging the gaps in the provision of services. The thrust on nursing services, local resident criteria in recruitment, and reforms in public recruitments, have all contributed to the public system becoming functional again in many parts of the country. There is a long way to go but surely a beginning in crafting a credible system has been made. The states are learning from each other to adopt innovations that have worked. Today over six states have set up corporations like the Tamil Nadu Services Corporation to provide quality generic drugs and equipment at reasonable costs.

Under-Nutrition Efforts

Had reforms in nutrition programmes been speeded up and the Integrated Child Development Scheme revamped to focus attention on the 0-3 year olds, the adolescent girls and the pregnant women (the three distinct groups among whom universal intervention is required to reduce malnutrition), the decline in IMR would have been even more significant. Unfortunately, nutrition does not lend itself to narrow departmentalism and needs a wider human development approach. There is agreement among policy experts in this regard, but the consequential reforms in programmes continued to be on the back-burner, the efforts against under-nutrition thus becoming limited and narrow. Bihar has recently set up the Manav Vikas Mission (Human Development Mission) as a cabinet sub-committee under the chief minister, to ensure convergent action for the achievement of 14-18 key priorities in human development. Perhaps the nation needs to learn from this initiative which will surely show results in the years to come. Bihar's Nayee Peedhi Swasthya (New Generation Health) Guarantee programme, an effort to remove health-care deficits for all 0-14 age boys and 0-18 age girls is also a unique innovation whose results need to be observed carefully over the coming years.

MDGs Are Achievable

I have always maintained that achieving health millennium development goals (MDGs) is eminently possible; we have to

