Health Reforms Initiatives in India – A Brief Review

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Abstract

Globalisation has converted the world in a small town integrating its all activities making sharing of the same environment and diseases transparent in the modern times. Along with the increasing demand for infrastructure and foreign currency for economic development, the time has come to take crucial review of health initiatives in India. The increasing death toll and spreading of diseases due to non-native causes has become a real cause of concern for a developing country like India. The loss of population and money caused by diseases is really a tangible loss to our country's balance of payments position. The current paper throws light on the Health Reforms Initiative in India taken by the government especially in rural areas focusing on the role and performance of National Rural Health Mission. It is an attempt to bring to light the developments in the field of health as a part of human development in India.

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INTRODUCTION:

The Indian economy has emerged with remarkable rapidity from the slowdown caused by the global financial crisis of 2007-09. The ultimate objective of development planning is human developemnt or increased social welfare and well-being of the people. Increased social welfare of the people requires a more equitable distribution of development benefits along with better living environment leading to inclusive growth plans.

The HDI reported by the United Nations Development Programme (UNDP) shows the position of all countries depending upon three factors: a) Literacy and Education, b) Life Expectancy and c) Income. The factor Life Expectancy clearly indicates the importance of health in HDI reports.

OBJECTIVES OF THE STUDY:

1) To review the government initiatives.
2) To review the performance of National Rural Health Mission

REVIEW OF GOVERNMENT INITIATIVES:

The Indian government has undertaken many initiatives as a part of five year plans to ensure good health in the urban and rural areas. This statement can be justified by the statistical data presented in the article to show the Indian Government contribution in the field of health.

An analysis of the performance of health delivery facilities in terms of selected indicators suggests that significant progress has been made over the last three decades.

Table 1.1
India - Selected Health Indicators

Sr. No.	Parameter	1981	1991	Current level
1.	Crude Birth Rate (CBR) (per 1000 population)	33.9	29.5	22.5 (2009*)
2.	Crude Death Rate (CDR) (per 1000 population)	12.5	9.8	7.3 (2009*)
3.	Total Fertility Rate (TFR) (per woman)	4.5	3.6	2.6 (2008*)
4.	Maternal Mortality Rate (MMR) (per 100,000 live births)	NA	NA	254 (2004-06*)
5.	Infant Mortality Rate (IMR) (per 1000 live births)	110	80	50 (2009*)
6.	Child (0-4 years) Mortality Rate (per 1000 children)	41.2	26.5	15.2 (2008*)
7.	Life Expectancy at Birth:	(1981-85)	(1989-93)	(2002-06)**
	Total	55.4	59.4	63.5
	Male	55.4	59.0	62.6
	Female	55.7	59.7	64.2

Source: Ministry of Health and Family Welfare.
*Sample Registeration Survey (SRS).
** Abridged Life Table 2002-06, RGI India.

However, despite this progress, as per HDR 2010, India fares poorly when compared to countries like China and Sri Lanka in terms of parameters like per capita expenditure on health, number of physicians/hospital beds (per 10,000 persons) and IMR. In addition, within the country, the improvements have been quite uneven across regions/States, gender, rural/urban areas, etc. The health system in India is a mix of the public and private sector, with the NGO sector playing a small role. Over the last six decades, a large number of health institutions catering to the health needs of the people at primary, secondary and tertiary levels have been set up. The county has developed a well-structured three-tier public health infrastructure comprising community health centres (CHCs), primary health centres (PHCs), and sub-centres spread across rural and semi-urban areas as well as tertiary medical care comprising multispecialty hospitals and medical colleges located almost exclusively in the urban areas. However, the inadequate health-related infrastructure, including shortages of doctors and paramedical professionals has severely restricted the delivery of health services, particularly in rural areas. In order to bridge the gap in existing health infrastructure and to provide accessible, affordable and equaitable health care, the government of India has launched a large number of programmes and schemes as follows:

Performance Review of National Rural Health Mission (NHRM):

The NRHM was launched in 2005 to provide accessible, affordable, and accountable quality health services to rural areas with emphasis on poor persons and remote areas. It is being operationalized throughout the country, with special focus on 18 states, which include 8 empowered action group states (Madhya Pradesh, Bihar, Jharkhand, Uttarakhand, Orissa, Chhattisgarh, Uttar Pradesh and Rajasthan), 8 north-eastern States, Himachal Pradesh and Jammu and Kashmir. The NRHM aims to provide an overarching umbrella to the existing programmes of Health and Family Welfare including the Reproductive Child Health Project and Malaria, Blindness, Iodine Deficiency, Filaria, Kala Azar, T.B., Leprosy and Integrated Disease Surveillance programmes by strengthening the public health delivery system at all levels. The sub-centres, PHCs and CHCs are being revitalized through better human resource management, including provision of additional manpower, clear quality standards, revamping of existing medical infrastructure, better community support and through untied funds to facilitate local planning and action. Flexible, decentralized planning is the pivot on which the mission rotates. Further, the mission addresses the issue of health in the context of a sector-wide approach addressing sanitation and hygiene, nutrition and safe drinking water as the basic determinants of good health. Keeping this in view, it seeks greater convergence among the related social-sector departments, namely AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy), Women and child Development, Sanitation, Elementary Educations, Panchayati Raj and Rural Development. The achievements under the NRHM as on September 2010 are as follows:

- ASHAs/Link Workers: So far 8.33 lakh accredited social health acitivitists (ASHAs) have been selected. Of these, 7.82 lakh have received training in at least the first module and 5.7 lakh have been provided with drug kits in their respective villages.
- Addition of Human Resources: Under the NRHM 1572 specialists, 8284 MBBS doctors, 26,734 staff nurses, 53,552 auxiliary nurse midwives, 18,272 paramedics have been employed on contract.
- Conversion of Health Facilties into 24 X 7: a total of 16,338 additional primary health centres, PHCs, CHCs and other sub-district facilities are functional on 24 X 7 basis.
- Janani Suraksha Yojana (JSY?) Beneficiaries: Over 3.4 Crore women have so far been covered under the JSY.

- Rogi Kalyan Samitis (RKSs): Around 599 district hospitals (DHs), 4210 CHCs, 1136 other than CHC hospitals and 17,097 PHCs have their own RKSs with untied funds for improving quality of health services.
- Village Health and Sanitation Committees: So far, 4.98 lakh villages (78 per cent) have their own village health and sanitation committees and each of them has been provided Rs. 10,000 as untied grant per year.
- Village Health and Nutrition Days (VH & NDs): Thirty-five lakh VH & NDs in 2006-07, 49 lakh in 2007-08, 58 lakh in 2008-09, 58.7 lakh in 2009-10, and 34.6 lakh so far in 2010-11 have been observed to reach basic health services to rural areas.
- Mobile Medical Units (MMUs): About 381 MMUs are functional under the NRHM so far.
- AYUSH: AYUSH services have been co-located in 14,766 health facilities and 9578 AYUSH doctors and 3911 AYUSH paramedics have been added to the system.
- Programme Management Units: Under the NRHM, 627 district programme managers, 618 district accounts managers, 539 district data managers, 635 district programme management units (DPMUs), 3529 block managers, 3261 accountants, and 3529 Block PMUs have been added.

Table 1.2

Health Care Infrastructure

Facilites	No.
Sub-centre / PHC/CHC* (2011)	176820
Dispensaries and Hospitals (all)***	27873
Nursing personnel (2009)**	1652161
Doctors (modern system) (2009)**	757377

Sources: *RHS: Rural Health Statistics in India 2011.

** National Health Profile, 2009

*** National Health Profile, 2011.

- Strengthening of primary health infrastructure and improving service delivery. There has been a steady increase in health care infrastructure available over the Plan period /(Table 1.2). However, there is still shortage of 20,486 sub centers, 4477 PHCs, and 2337 CHCs as per 2001 population norms. Further, almost 40% of the existing health infrastructure is in rented buildings

or rent-free panchayat / voluntary society buildings. Poor upkeep and maintenance and high absenteeism in rural areas are the main problems in the public-sector health delivery system. The NRHM seeks to strengthen the public health delivery system at all levels.

- Janani Suraksha Yojana (JSY): The JSY was launched with focus on demand promotion for institutional deliveries in States and regions where these are low and integrates cash assistance with delivery and post-delivery care. It targets lowering of the maternal mortality rate (MMR) by ensuring that deliveries are conducted by skilled birth attendants. The JSY scheme has shown rapid growth in the last three years, with the number of beneficiaries reaching 100.78 lakh in 2009-10. The strengthening of infrastructure, coupled with improvement in manpower and training, has resulted in significant improvement of institutional deliveries in all major states. A mid-term evaluation of the RCH II programme also confirmed the increase in the number of JSY beneficiaries. The issues of governance, transparency and grievance redressal mechanisms are now the thrust areas for the JSY.
- Pradhan Mantri Swasthya Suraksha Yojana (PMSSY): The PMSSY has been launched with the objectives of correcting regional imbalances in the availability of affordable / reliable tertiary healthcare services and augmenting facilities for quality medical education in the country. The PMSSY has two components in the first phase. The first is the setting up of the All India Institute of Medical Sciences (AIIMS) like institutions. The civil works related to the construction of medical colleges and hostels have commenced in all sites. The construction of residential complexes in Rishikesh and Patna is expected to be completed by March 2011 whereas in Bhopal and Bhubaneswar, it is likely to be completed by June 2011 and August 2011 respectively. As regards the work on hospital complexes, lay-out work is under way for all the institutions. The second component of the PMSSY is the upgradation of 13 existing Government medical college institutions. Civil works under this component have been completed in the medical colleges in Trivandrum, Salem, Bangalore and Lucknow are on the verge of completion in Hyderabad, Kolkata, Jammu, Tirupati and Mumbai and in Varanasi, Srinagar, Ahmadabad and Ranchi are likely to be completed by mid 2011. In the second phase of the PMSSY, two ore AIIMS like institutions will be set up and upgradation of six more medical colleges is being taken up.
- National AIDS Control: According to recent HIV estimates based on HIV Sentinel Surveillance 2008-09, the number of people living with HIV in India in 2009 was 23.9 lakh, with

an adult HIV prevalence and HIV incidence (new infections) in India. Adult HIV prevalence at national level has declined from 0.41 percent in 2000 to 0.31 percent in 2009. The estimated number of new annual HIV infections has declined by more than 50 percent over the past decade from 2.7 lakh in 2000 to 1.2 lakh in 2009. The epidemic is concentrated with high prevalence among the high risk groups (HRGs), injecting drug users (IDUs) (9.2 percent), men who have sex with men (MSMs) (7.3 percent), females' sex workers (FSWs) (4.9 percent), and sexually transmitted infection (STI) clinic attendees (2.5 percent). Based on sentinel surveillance, 156 districts have been identified as category 'A' districts where prevalence of HIV among antenatal clinic attendees (proxy for general population) is more than 1 per cent and 39 districts as category 'B' districts where prevalence amongst high risk population is greater than 5 percent. These districts are given high priority in the implementation of the programme. The National AIDS Control Programme for Phase-III (NACP-III) is being implemented for the period 2007-12 with a total outlay of Rs. 11,585 crore.

- Others : Others programmes like the Revised National TB Control Programme (RNTCP), National Vector Borne Diseases Control Programme (NVBDCP), National Programme for Control of Blindness (NPCB) and National Leprosy Eradication Programme have also been strengthened and are being implementation in a time-bound and focused manner. The Integrated Disease Surveillance Project (IDSP) has been launched with the objective of detecting and responding to early warning signals of disease outbreaks. Surveillance units have been established at all State and District headquarters. The Central Surveillance Unit of the IDSP presently receives weekly disease surveillance data from 85 percent districts in the country. Of these, 55 percent districts report data through portal also which is for data entry, view reports, outbreak reporting, data analysis, training modules and resources related to disease surveillance. A total of 553 outbreaks were reported and responded to by States in 2008, 799 in 2009 and 938 in 2010 (up to December 2010).
- Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH): Mainstreaming of AYUSH in national health care delivery is an important goal under the NRHM, for which the Government has sanctioned Rs. 165.70 crore in the current financial year upto 31 January, 2011. In September 2009, a new component 'Upgradation of AYUSH Hospitals' in the States was incorporated in the existing Centrally Sponsored Scheme of Development of AYUSH Hospitals and Dispensaries. Further, in July 2010, 'Upgradation of

AYUSH Dispensaries' in the States has been incorporated as a new component in the existing Centrally Sponsored Scheme of development of AYUSH Hospitals and Dispensaries. The Government has already recognized Ayurveda, Yoga and Naturopathy, Unani and Siddha as official Indian Systems of medicines. It is implementing the National Mission on Medicinal Plants which is aimed at supporting market-driven medicinal plant cultivation on private land with backward linkages of establishment of nurseries and supply of quality planting material and forward linkages for post-harvest management, marketing infrastructure, certification and crop insurance in a Mission mode. During the current financial year 26 States have been covered and financial support of Rs. 46.41 crore was released for undertaking different activities under the schemes including cultivation of important medicinal plant species in over 24,214 hectare of land.

The demand for health services is likely to rise considerably in the future with increase in health-seeking behaviour resulting from better levels of education, income status and urbanization. The role of the government is critical for meeting the health-care needs of major sections of the population and to control escalation of cost of health care, while private-sector investment is crucial for satisfying the increasing demand for the health services. The private sector plays a dominant role in the delivery of health services in the country. The sector is predominant in medical education, training, diagnostics and technology, manufacture of pharmaceuticals, hospitals design and construction and management of ancillary services. As per the National Commission on Macroeconomics and Health (NCMH) 2005 around 70% of all hospitals and 37 % of the total beds in the country are in the private sector.

Another important development in the Indian Health-care sector has been the growing use of telemedicine. In 2001, the Indian Space Research Organization (ISRO) launched a pilot project that connects 78 hospitals in the cities. Telemedicine has opened up possibilities of patients in India availing of professional adv ice from physicians in the developed countries.

As per the recent report, large number of medical and paramedical staff has been taken on contract to augment the human resources. During the year 2009-10, about 2475 MBBS doctors,

160 specialists, 7136 ANMs, 2847 staff nurses, 2368 AYUSH doctors and 2184 AYUSH paramedics were appointed.

Human resources are the critical variable for effective provision of health care to the population. To increase human resources in medical education, the Central Government has revised the teacher-student ratio from 1:1 to 1:2 which has resulted in approximately 4000 additional postgraduate seats in various disciplines in Government medical colleges from the academic year 2010-11. Further, in order to increase the number of medical colleges and specialist, the Central Government has also relaxed the norms in respect of land requirement, bed strength, bed occupancy, mai8xmeum admission capacity and age of teaching faculty. Besides, the Central government also provides financial assistance to State Government medical colleges for increasing the postgraduate sears to strengthen the exiasiting public health delivery system. 34 Government medical colleges have been approved for Central assistance during 2010-11. With the implementation of the scheme by 2011-12, approximately 4000 additional postgraduate seats would be available.

Conclusion:

From the above facts, it can be stated that the government initiatives and performance of National Rural Health Mission are progressive in their approach. However, still the gaps between the targets and the achievements are to be fulfilled. Still more and more health programmes especially in rural areas are required with actual achievements and less deviations rather than the rosy picture on the paper. It is necessary to develop this aspect of the HRD by dealing with this issue with all sensitivity and a sense of responsibility.

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