Health and Healthcare under NRHM[1]

Ravi Duggal[2]

India's current economic growth is seen globally as a lever for India becoming a middle income country but does the ground reality reflect this. High economic growth over a period may have some trickle down effect but the real test of such a growth impact is what happens to the social sectors like education, health and social security. Economic growth should facilitate larger revenues for governments which in turn should spawn larger investments in health, education and social security and welfare. In the initial phases of high income growth the tax : GDP ratios declined to as low as 13% due to the macro economic reforms of liberalization, deregulation and drastic tax cuts but in the last five years there has been a rising trend which has made it possible for the UPA government to launch its various flagship programs under the Bharat Nirman banner, including the National Rural Health Mission. The tax : GDP ratio is today close to 20%[3]. But does one see any significant changes in the health scenario? Public health investment and expenditure has not witnessed any significant leap, still stagnating under 1% of GDP, and the new evidence of health and healthcare from the NSSO 60th Round, NFHS-3 and the 2nd RCH/DLHS surveys also does not suggest marked improvements in the health of the people from its preceding versions.

Health Scenario

The latest news is that India's Human Development rank got worse. India now ranks 128 out of 177 countries (year 2005) according to the 2007-08 UNDP's Human Development Report[4]. And this poor rank is largely due to India's poor performance in education and health, despite the Sarva Shiksha Abhiyan and the National Rural Health Mission. If we look at public health investment and expenditure here too India's ranking has got worse. In 2002 India ranked 6th from the bottom in proportion of public health expenditure to total health expenditure with countries like Guinea, Iraq, Cambodia, Myanmar and Sudan below it. In 2004 India bottomed out to position number 4 from below with Myanmar, Guinea and Afghanistan below it[5]. The irony is that India is the largest donor to Afghanistan for development assistance!

Health and healthcare trends as reflected in national surveys indicate that India's health scenario continues to suffer from the same deficiencies and inequities and is clearly moving in a direction which will only worsen the situation of the vast majority of the poor and underserved sections of society. The public health system is collapsing and it is no surprise that the health outcomes of the already impoverished sections worsen. Tables 1 and 2 indicate the declining share of the public health sector in hospitalization services and the growing burden of out-of-pocket payments over a two decade period. The increased share of the private health sector raises the household burden for seeking care

---

[1] Paper prepared for Social Watch India Report 2008. under publication

[2] Independent Researcher and Health Activist rduggal57@gmail.com

[3] Ministry of Finance: India Public Finance Statistics 2006-07, Govt. of India, 2007, New Delhi

[4] UNDP: http://hdr.undp.org/en/reports/global/hdr2007-2008/ accessed 22nd Jan 2008-01-24

[5] WHO: World Health Statistics 2007, WHO, Geneva

and this is reflected in the increased share of debt (borrowings and sale of assets) in financing hospitalizations which in 2004 had increased to 59% and 42% respectively for rural and urban households, a substantial increase from previous surveys[6]. This trend in healthcare utilization and expenditure is not good for equity in access for healthcare and its consequences are evident in the poor health outcomes, especially of the poorer sections of society. The NSSO 60th Round also tells us that the class, caste and gender inequities in healthcare access have become more disparate and this is best reflected in the increase in the proportion who did not seek healthcare when they were ill, and especially so for financial reasons, no facility available and lowered perception of seriousness of the ailment, the latter also being a function of purchasing power (Table 3).

Table 1: Trends in utilisation rates of public & private facilities for hospitalisation (%)

Type of Hospital	Rural			Urban		
	60th 2004	**52nd 1996**	**42nd 1987**	**60th 2004**	**52nd 1996**	**42nd 1987**
Public	42	44	60	38	43	60
Private	58	56	40	62	57	40
Source: NSSO 60th Round – 2004, Report No.507, NSSO, New Delhi, 2006						

Table 2: Trends in Average Medical Expenditure per Hospitalization (Rupees)

Type of Hospital	Rural			Urban		
	60th	**52nd**	**42nd**	**60th**	**52nd**	**42nd**
Public	3238	2080	320	3877	2195	385
Private	7408	4300	733	11553	5344	1206
Combined	5695	3202		8851	3921	
Source : NSSO, respective Rounds: 60th – 2004, 52nd – 1996, 42nd – 1987						

Table 3
Percentage distribution of untreated spells of ailments by reason for no treatment

India

reason for no treatment	rural		Urban	
	2004 *60th rd*	'95-96 *52nd rd*	2004 *60th rd*	'95-96 *52nd rd*
no medical facility	12	9	1	1
facility available but:				
lack of faith	3	4	2	5
long waiting	1	1	2	1
financial problem	28	24	20	21
ailment not considered serious	32	52	50	60
Others (incl. n. r.)	24	10	25	12
all (incl. n.r. cases)	100	100	100	100

Note: For the 52nd round, estimates relate to untreated persons

Source: NSSO 60th Round

[6] NSSO 60th Round – 2004, Report No.507, NSSO, New Delhi, 2006

As expected the health outcomes too continue to remain adverse and the class inequities as portrayed by the wealth index quintiles of NFHS-3 have even become sharper (Tables 4 to 6 and graphs). With regard to infant and under-5 mortality the large rural-urban gap continues to remain an area of concern, IMR being 50% and U5M being 60% higher in rural areas (Table 4). In the case of U5M there is a substantial gender gap also (males 70 and females 79). This apart what is of greater concern is the class inequities in infant and child mortality. The 20:20 disparity ratio is unacceptably high being over 200% for all variables and reflects the iniquitous healthcare system in the country**.** But what makes the situation even worse is that even in case of RCH services which have been the corner stone and highlighted focus of the public health system for nearly two decades the class inequities in access are huge with a 20:20 disparity gap of 682 percent for delivery in a healthcare facility (Table 5). So it is no surprise that India's key health indicators are grossly adverse and consequently India's human development rank globally in the bottom quartile.

Further despite huge investments in ICDS and other nutrition programs, which are supposed to be directed towards the poor, the nutrition status of women and children in terms of standard anthropometry indicators and anemia (Table 6) is highly adverse and class inequities also very sharp.

Apart from class and rural urban inequities both NSSO and NFHS data also reveal that gender and caste inequities in case of most of these indicators are also very significant.

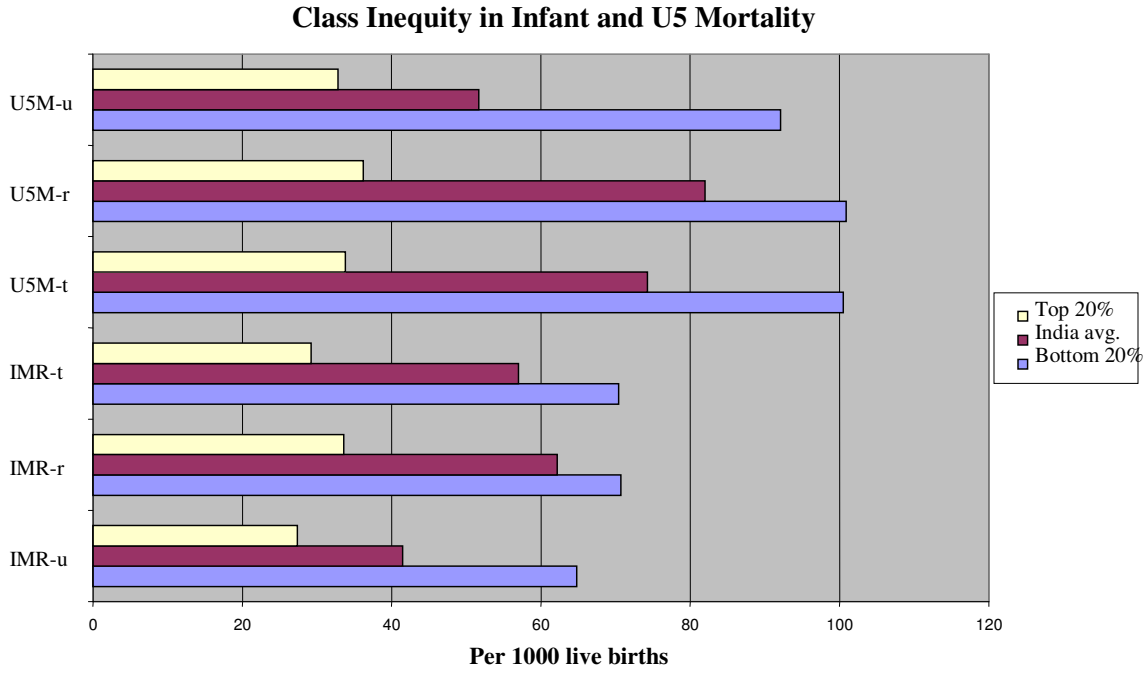
NFHS-3 also tells us that the child sex ratio has declined further from 927 in the 2001 Census to 918 in NFHS-3, especially in rural areas (from 934 to 921) and this is commensurate with the large rise in the use of ultrasonography during pregnancy, with NFHS-3 showing that there is an inverse relationship between the use of ultrasound and the number of sons. So India's sex ratio is getting further distorted and this menace is spreading rapidly to rural India and other states which were hitherto relatively unaffected.

The other issue of concern emerges from the findings of the 2nd round of the RCH Facility survey which shows that the conditions of the public health facilities has only deteriorated further. Table 7 indicates the results of the two rounds of Facility Survey and it is clear that over a five year period the situation of critical inputs required to maintain public health facilities has not only remained grossly inadequate but also declined across the board, the PHCs and CHCs which serve rural areas being the worst. This situation is again a consequence of neglect of the public health facilities via inadequate investments and expenditures in the public health sector. Has NRHM been able to address these issues or putting it differently does NRHM have the potential to change this dismal scenario of health and healthcare in India?

Table 4: Class Inequity in Infant and U5 Mortality – India

	Per 1000 live births			20:20
Indicator	Bottom Quintile	India Average	Top Quintile	Disparity percent
IMR-urban	64.8	41.5	27.4	236.50
IMR-rural	70.7	62.2	33.6	210.42
IMR-total	70.4	57	29.2	241.10
U5M-total	100.5	74.3	33.8	297.34
U5M-rural	100.9	82	36.2	278.73
U5M-urban	92.1	51.7	32.8	280.79

Source: NFHS-3, 2007



Note: r = rural, u = urban, t = total; Source: NFHS-3, 2007

Table 5: Class Inequity in Access to select RCH Services – India (percent)

Indicator	Bottom Quintile	India average	Top Quintile	20:20 Disparity percent
ANC by Doctor	22.5	50.2	86.2	383.11
Delivery in Health Facility	12.27	38.7	83.7	682.15
All basic vaccines for children	24.4	43.5	71	290.98

Source: NFHS-3, 2007

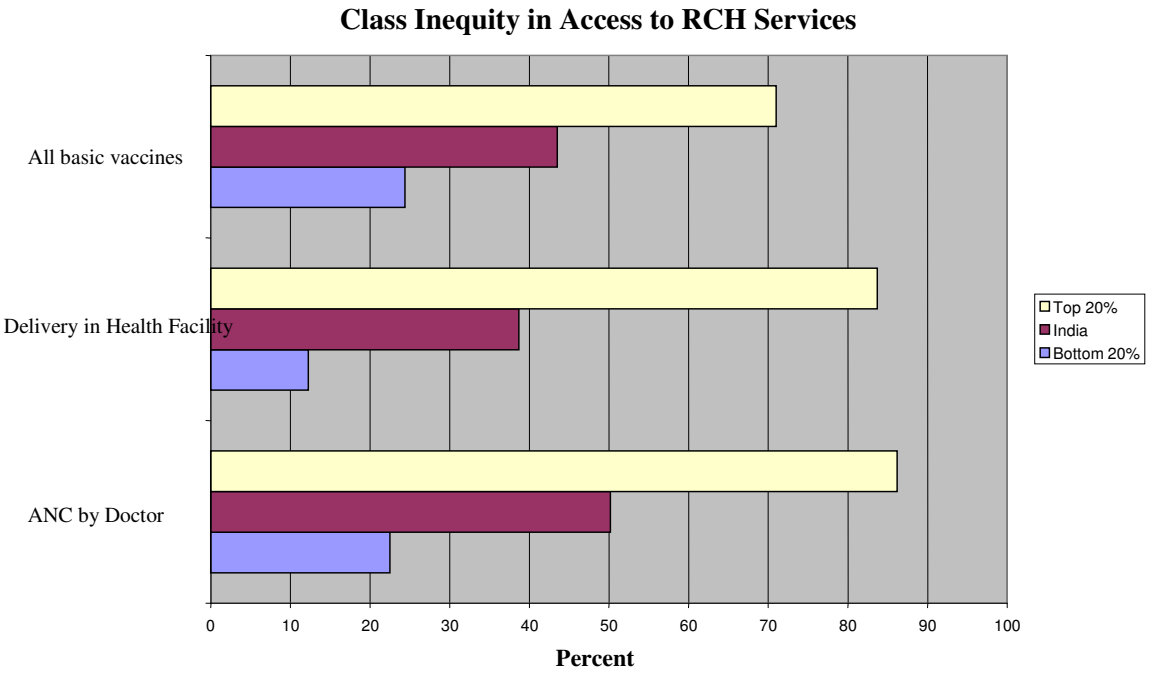


Table 6: Class Inequities in Nutrition Status of Children and Women – India (percent)

Indicator	Bottom Quintile	India average	Top Quintile	20:20 Disparity percent
Stunted	34.2	48	8.2	417.07
Wasted	25	19.8	12.7	196.85
Underweight	56.6	42.5	19.7	287.31
Any anemia child	76.4	69.5	56.2	135.94
BMI < 18.5 women	51.5	35.6	18.2	282.97
Any anemia women	64.3	55.3	46.1	139.48

Source: NFHS-3, 2007

Class Inequities in Nutrition Status - percent

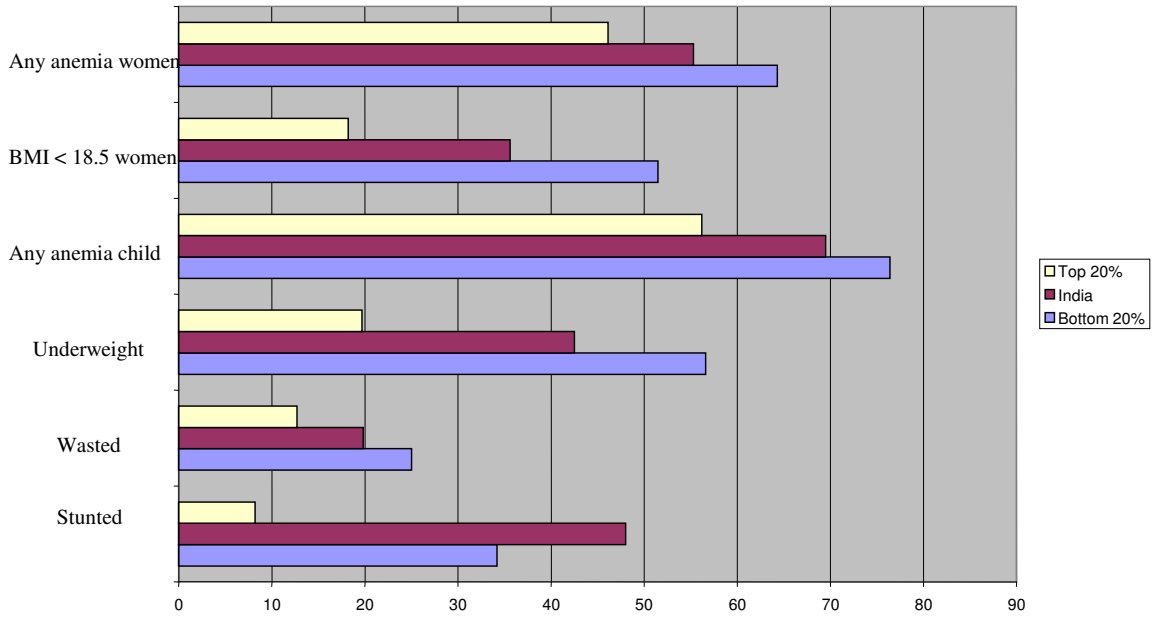


Table 7: Adequacy* of Critical Inputs in Public Health Facilities - Percent

Units	Infrastructure		Staff		Supply		Equipment	
	1999	2003	1999	2003	1999	2003	1999	2003
Dist. Hospitals	94	93	84	80	28	45	89	84
FRUs	84	76	46	37	26	32	69	61
CHCs	66	63	25	14	10	24	49	46
PHCs	36	32	38	44	31	40	56	41

*Adequacy is defined as facility having upto 60% of critical inputs

Source: 1. 1999: India Facility Survey Phase I, 1999, IIPS, Ministry of Health and Family Welfare, New Delhi, 2001. 2. 2003: India Facility Survey 2nd Round, 2003, IIPS, GoI, 2006

The NRHM Era

The NRHM which was launched with the 2005-06 budget makes a faulty start. The mission begins with the statement, "The NRHM seeks to provide effective healthcare to the poor, the vulnerable and to marginalized sections of society throughout the country" (NRHM Mission Document, Chapter 1, section 2, page 3). Further, in rest of the document it keeps referring to 18 states as the focus area. One acknowledges that these groups need special support from the public health system but the goal of the program cannot be selective because in doing so it distorts the design. It is well established today that anything designed specifically for the poor or marginalized does not work in

practice. If universal access is not at the core of the mission then it will never be able to achieve its goals.

Since universal access to comprehensive primary healthcare and referral services, which the 1982 National Health Policy committed, is not stated clearly as a goal, the financing strategy for NRHM also falls into the trap of "selective programs for targeted populations". Hence separate schemes like Rs. 10,000 for untied funds for the subcentres, Rs. 100,000 for rural hospital maintenance if Rogi Kalyan Samitis are formed, Rs. 750,000 per block for training ASHA's etc.. have been worked out, instead of determining what resources would the proposed package of comprehensive services require in order to implement it effectively.

Thus NRHM so far has been merely tinkering with the system. It has not made any significant structural inroads to making the architectural changes it proudly boasts about in the mission document. This is because while the government on one hand talks about NRHM on the other hand it is letting the corporate sector, including multinationals, have an unregulated and open environment to boost the private health sector and profit from it.

Health industry sources estimate that the growth of the corporate hospital and medical care sector is a whopping 30% per annum and this expansion is not only in metro cities but also in level 2 cities. Infact, a number of hospital chains and franchises have emerged across the country. There are two major factors which have provided this boost. One is the private health insurance sector which is also booming at 30% - 40% growth per year, and second is the global demand for what is popularly referred to as medical tourism. India is a major destination for patients from across the world and current estimates show that annually about 250,000 patients come to India for treatment and each patient on an average spends $5000 and this totals to revenues of $1250 million per year. And this is growing at 25% annually. These developments are completely distorting the health sector in India and making it increasingly elitist and oriented towards a private health insurance based system[7].

This unregulated market driven reform of the health sector in India makes the NRHM initiative look insignificant. Infact, NRHM also promotes public-private-partnerships aggressively and a number of initiatives in this line have been launched, the most talked about being the Chiranjeevi scheme in Gujarat for deliveries in private hospitals but financed by government,, Rogi Kalyan Samitis, handing over of PHCs/CHCs to private sector/NGOs in Arunachal Pradesh, Gujarat and Karnataka, contracting out of specific services in hospitals like laundry, diagnostic, security, catering services, etc.. So an increasing proportion of public resources are being directed for the benefit of the private health sector in addition to various subsidies which already exist[8].

---

[7] See a review of such hospitals in the National Capital Region by Rita Dutta in Express Healthcare, Vol. 1, No.12, Dec 2007

[8] Some of the prominent subsidies to private health sector include medical education with 80% of graduates from public medical schools joining the private sector, tax waivers to Trust/Society managed hospitals which do not reciprocate the legal responsibilities of treating 10-20% poor patients free of cost, supply of patients paid by the public sector to corporate hospitals like Apollo, Escorts etc.., tax rebates for import of medical equipment and supplies…

Thus do we have any hope from the NRHM to change the health scenario in India to create more health equity? The evidence of the impact of NRHM is still not available even though various success stories in different parts of the country are being touted. The only firm data we have is from the budgets and hence in the subsequent paragraphs we review the NRHM from the perspective of the resources allocated under it starting from 2005-06 when NRHM was launched.

For 2005-06, the mission document states that Rs. 6713 crores had been allocated for NRHM. If we look at the 2005-06 Central government budget we do not see NRHM figuring as a separate budget item, though in 2006-07 a separate header in the Budget is introduced for NRHM. The reality is that NRHM is using funds of existing programs like RCH-2, NDCP, Integrated Disease Surveillance Project and the AYUSH program (Annex 5, page 3). NRHM is being seen as an omnibus for the above programs (Chapter 3, page 12). The budgets also reflect this.

Thus in effect NRHM is only a brand label for selected activities from amongst existing programs. The only "new" component is the ASHA scheme, which is actually a revival of the erstwhile CHV scheme of 1978, which became defunct in the nineties in most states.

At the national level today the Central and State governments spend about Rs.43,000 crores annually on healthcare (excluding water supply and sanitation), which is just about one percent of GDP. If these resources were to be distributed on a per capita basis equitably, then rural healthcare should get Rs. 30,000 crores (@430 per capita) in contrast to about Rs. 18,000 crores or Rs. 250 per capita it receives today. Ofcourse, this does not happen because the more expensive hospital services and the elaborate health bureaucracy are located in urban areas.

There was great expectation that the Budget 2005-06 would make a marked deviation using the NRHM as the peg for atleast launching a process for changing the political economy of healthcare in India. Unfortunately the only mention of the NRHM within the budget was in the Finance Minister's speech, "The National Rural Health Mission (NRHM) will be launched in the next fiscal. Its focus will be strengthening primary health care through grass root level public health interventions based on community ownership. The total allocation for the Department of Health and the Department of Family Welfare will increase from Rs.8,420 crore in the current year to Rs.10,280 crore in the next year. The increase will finance the NRHM and its components like training of health volunteers, providing more medicines and strengthening the primary and community health centre system."[9]

When we look at the expenditure budgets and demand for grants of Budget 2005-06 (Tables 8 and 9) we find that there is no mention of NRHM as an item of expenditure. The Finance Minister says that the increase (Rs. 1860 crores) over the previous budget will finance the NRHM component. This overall increase of 24% in the budget appears

[9] Budget Speech 2005, http://indiabudget.nic.in/ub2005-06/bs/speecha.htm

substantial and if it were to be divided equally among all PHCs then each PHC would get additionally about Rs. 8 lakhs, that is a 50% additionality to what it gets today on average. However the budgetary allocations belie this fact when we see that the increase for the HIV/AIDS program is 105% from Rs. 232 crores in 2004-05 to Rs. 476.5 crores in 2005-6. Similarly for the RCH program the increase is a whopping 94% from Rs. 710.51 crores to Rs. 1380.68 crores, for medical education also a high of 50% from Rs. 912.82 crores to Rs. 1360.78 crores and as much as 80% for Indian Systems of Medicine and Homoeopathy (AYUSH) from Rs. 225.73 crores to Rs. 405.98 crores. Just these four programs account for Rs. 1543 crores (or 83%) of the increased amount of Rs. 1860 crores. So the finance ministers promise of more medicines and a strengthened primary and community health centre system was an eyewash. The pattern of allocation remains more or less similar in 2006-07 and 2007-08. (Table 10)

Thus the FMs statement in the budget speech is clearly a populist pronouncement and like all such pronouncements of past budgets similar to the various versions of health insurance packages of different finance ministers, sickness assistance funds etc.. is pure gas and disappears as soon as the budget euphoria dies down. The overall budget of the Ministry of Health and Family Welfare for 2004-05 (pre-NRHM) and 2005-06 (NRHM launch) is outlined in Table 8.

Table 8: Demand for Grants of Ministry of Health and Family Welfare (Rs. Crores)

Category	Budget 2004-05	Budget 2005-06
Medical and Public Health	3103.12	4253.84
AYUSH	225.73	405.98
Family Welfare	6696.37	7769.01
Gross Total Health	10025.22	12428.83
Grants to States and UTs	4663.00	5158.00
Total Health Central govt.	5362.22	7270.83
Less recoveries	(-)1587.10	(-)1741.72
Net Health Central govt.	3775.12	5529.11

Source: Budget 2005-06, Demand for Grants, Demand Nos. 47, 48, 49, Ministry of Finance, GOI, New Delhi, 2005

The budgetary situation in subsequent years, that is 2006-07 and 2007-08, has not changed significantly. We still have overall allocations for health in the state sector below 1% of GDP (Table 9). Tables 9 and 10 also indicate recent trends in public health spending. Table 9 reveals that Central government's own expenditure is increasing rapidly whereas its grants to states have shrunk, and that the state government health spending is stagnating and as a consequence the overall public health expenditure remains below 1% of GDP.

Table 10 looks at some of the key programmatic allocations in the Union Health Budget. Here we see that traditional sectors like hospitals and medical education and family planning services are now receiving a smaller chunk of the health budget in comparison to the "new" sectors like RCH, HIV/AIDS, immunization (especially pulse polio). From

the 2005-06 budget onwards the NRHM has hijacked the RCH and Family Planning budgets giving a boost to rural health allocations. But the question here is will the enhanced rural health budgets via NRHM address the demand side issues of rural health provision which is primarily access to reasonable medical care? The NRHM document and the NRHM budget data in Table 11 do not provide any evidence for that. The focus of NRHM will continue to be what was under the old Family Welfare and Disease Control programs, that is family planning services, immunization, ante-natal services, and selected disease surveillance and epidemic control. The NRHM along with RCH 2 adds a new focus on universalizing institutional deliveries and strengthening reproductive health services. The latter was also the goal under RCH 1 but was not realized.

Table 9: Demand for Grants of Ministry of Health and Family Welfare Rs. Crores

Category	**BE 2004-05**	**Actuals 2004-05**	**BE 2005-06**	**RE 2005-06**	**BE 2006-07**	**BE 2007-08**
1. Central Health, FW and Ayush	8438.12	8086.46	10733.54	10086.26	13081.82	15856
2. *Of which Grants to States and UTs including NE component*	*4487.77* (748.10) [0.94]	*3775.09* [0.75]	*4969.12* (968.20) [0.97]	*3780.15* (880.00) [0.74]	*5078.98* (1168.80) [0.90]	*5196* [0.75]
3. Net Health Central Govt. (1-2)	3950.35 [0.83]	4311.37 [0.86]	5764.42 [1.12]	6306.11 [1.24]	8002.84 [1.41]	10660 [1.53]
4. State/UT Govt. Health and FW (including 2)	20982.24 [4.36]	21465.19 [4.32]	24336.63 [4.57]	25479 [4.19]	29137 [4.36]	31383 [4.10]
5. Total Health (3+4) as % GDP@	24932.59 0.80	25776.56 0.82	30101.05 0.84	31785.11 0.89	37139.84 0.90	42043 0.90

Figures in parentheses is NE (Northeast Region) component and in square brackets % to respective Total Budget or Expenditure. BE = Budget Estimate, RE= Revised Estimate; @ GDP at market prices from RBI – Handbook of Statistics, RBI, Mumbai, 2007

Source: Expenditure Budget Volume 1 2006-07 and 2007-08, (Demand Nos. 46 and 47) Ministry of Finance, GOI, New Delhi, 2006/2007. For 2004-05 BE from Expenditure Budget Volume 1 2005-06 and actuals 2004-05 from Annual Financial Statement 2006-07. For State/UT governments from RBI – State Finances 2005-06, 2006-07, 2007-08, RBI, Mumbai, 2007/2008

Table 10: Allocations for Selected Key Programs in the Union Health Budget Rs. Crores

Program	BE 2004-05	BE 2005-06	BE 2006-07	BE 2007-08
Hospitals & Disps.	240.75	309.79	263.25	261.40
Medical education & Research	912.82	1360.78	1436.64	1520.41
AYUSH	225.73	405.98	447.89	563.88
NACO – HIV/AIDS	232.00	476.50	636.67	719.50
RCH	710.51	1380.68	1765.83	1672.20
Pulse Polio	1186.40	1304.60	1004.00	1289.38
Routine Immunisation			326.50	300.50
FW services and contraception	1948.71	2412.41	1942.61	2295
Area Projects	123.01	109.76	205.57	50.01
NRH Mission Flexible Funds			1530.88	2682.72

Source: Demand for Grants, respective Budget years, Ministry of Finance, GOI, New Delhi

Table 11: NRHM component of the Union Health Budget Rs. Crores

NRHM component of major heads	RE 2005-06	BE 2006-07	BE 2007-08
Disease programs	648.59	755.64	884.06
Ayush	45.00	65.00	108.00
Family Welfare, including RCH	5426.58	7386.26	8954.94
NE region special scheme	668.04	891.53	1387.50
NRHM Total *of which Grants to states, UTs and NE*	**6788.21** *3410.75*	**9098.43** *4496.20*	**11333.56**

Source: Demand for Grants Budget 2006-07, Ministry of Finance, GOI, New Delhi, 2006

Thus NRHM which is strongly centrally driven cannot see the ground realities and the NRHM is becoming a mechanism to increasingly wrest control budgets by the Centre, instead of pursuing the policy of devolution of resources that decentralization governance demands. Unfortunately those in decision making positions at the Centre and State levels feel that increased resources in the rural areas will not help because there is limited "absorption capacity". Hence, unwillingness on behalf of these decision makers for fiscal devolution to the district and panchayat levels. This business of absorption capacity is a façade.

While governments have created the infrastructure, like hospitals, primary health centres, subcentres etc.., they have not endeavoured to assure that the complete inputs for the efficient functioning of these are provided. The government's own RCH Facility surveys highlights the pathetic conditions of public healthcare facilities (Table 7), which is largely due to inadequate resources being allocated, but very little has been done to use this most valuable information to improve the public healthcare facilities.

Thus this absorption capacity pretense has no meaning; it is sheer indolence that drives this belief leading to curtailment and/or non-allocation of resources for peripheral health institutions. If autonomy is given to districts and panchayats to use resources as per their local needs and demands within a defined framework that is open to social audit then one will see a wide range of innovations in setting up local healthcare delivery systems and provision of healthcare for the people. Thus a good strategy would be to provide the entire health budget to each level of provision as block funding or what is called global budgeting so there is equity in access to resources at each level of healthcare. For example if we need Rs. 45 lakhs to run a good quality PHC catering to 30,000 population (as against about Rs. 16 lakhs per PHC on an average) then each PHC should get that amount and plan and strategise its use as per local needs and demands under the oversight of local government institutions and the Village Health and Sanitation committees to whom they should be made accountable. Similarly if it takes Rs. 300,000 per bed per year to run a good quality CHC then each CHC must be given Rs. 9 million for its 30 beds instead of the Rs. 4 million on the average it is getting today. That is, provide an adequate budget to meet the objectives of each level of healthcare in a comprehensive way with local autonomy in decision making and only then will we see any change in the health scenario of the country.

Thus the overall NRHM strategy needs a drastic makeover and reoriented into a universal access framework for which financial resources need to be determined on the basis of needs and demands of people, and this would be best met if resource allocations are based on assessments of such needs and demands and given to local governments to plan their use autonomously.

To conclude the NRHM should be used as an opportunity to work out a new health financing and delivery strategy, which devolves financial resources to local governments and uses a social audit framework to monitor its implementation. And to do this we need policy makers and planners who can think out of the box and decision makers at the top who are willing to devolve their powers to those who actually manage and deliver healthcare. This will be a true architectural change to realize health for all with equity and justice.

Ravi Duggal
Independent Researcher/Consultant and Health Activist
Email: rduggal57@gmail.com