Policy Brief

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By AMARJEET SINHA

3 April 2024

Assessing NRHM Lessons in Public Policy for Health

The National Rural Health Mission was launched on 12th April 2005. It sought to provide accessible, affordable and quality health care to the rural population, especially the vulnerable sections. It had quantifiable targets for Infant Mortality (30), Maternal Mortality (100) and Total Fertility (2.1) Rates (IMR, MMR, TFR) with a seven-year time frame. NRHM recognized the leadership role of the States. The Framework for Implementation states – "The NRHM is an effort to strengthen the hands of States to carry out the required reforms. The Mission would also provide additional resources to the States to enable them to meet the diverse health needs of the citizens. While recognizing the leadership role of the States in this regard, it is proposed to provide necessary flexibility to the States to take care of the local needs and socio cultural variations. In turn, States will decentralize planning and implementation arrangements to ensure that need based and community owned District Health Action Plans become the basis for interventions in the health sector."

With an annual increase of 30-40% in the Central allocation and an equal thrust in States, NRHM aspired to reach 2 percent of Gross Domestic Product (GDP) public spending by 2012. 'Communitization' (refers to community connect), flexible financing, monitoring progress against Indian Public Health Standards, improved management through capacity, and innovations in human resource management, were the five key approaches adopted by NRHM in its Framework for Implementation. The National Health Systems Resource Centre (NHSRC) was set up to drive reforms with resources by building capacity at all levels. Strengthening the public system of primary health care

delivery with some partnerships as per need, was its avowed thrust. NRHM recognized the need for crafting a credible public system, given the information asymmetry and likely market failure in the health sector (Nobel Laureate Kenneth Arrow's work). Many years after the 2012 target NRHM (renamed NHM in 2013 when urban was added without adequate resources) has reached all the three quantifiable targets of IMR, MMR, and TFR with public spending barely a little above one percent of the GDP. Primary health care has many wider determinants that make attribution very difficult. The ability to do vaccination during Covid (2021) in the remotest locations with the active community connect role played by the Accredited Social Health Activists (ASHAs), with adequate cold chain and vaccinators at the cutting edge, is a tribute to the investments 2005 onwards in strengthening the public system with human and financial resources. What lessons in public policy does NRHM provide? There is a need for an evidence based assessment to identify what worked and what did not.

The first and foremost NRHM lesson is that crafting credible public system of primary health care delivery must remain the central thrust. Health as a sector needs the countervailing presence of a functional public system, even if private sector is to provide additional capacity for secondary and tertiary care. Tamil Nadu and Kerala have a vibrant and functional public system of health care alongside an equally strong private sector. This has consequences for cost and quality of care in the private sector. Even with health insurance, claims in government hospitals remain very high. Kenneth Arrow's paper on medical care and the role of information asymmetry and market failures, holds true even today. It is for this reason that crafting credible public systems of health care become necessary.

Second, health is a sector where human resources are critical for quality service delivery. From Hospital Managers to Nurses, para medics, doctors, Specialists, there is a need for a range of human skill sets, not all of which are necessarily available through public – private partnerships (PPPs). Effective management of PPPs also require a strong public system of health care. Innovative human resource interventions like the 24 week Life Saving Anaesthetic Skills Course for MBBS Doctors, 24 week Emergency Obstetric Care Course, Family Medicine Distance Education Programme for PHC doctors (Christian Medical College Vellore had designed an outstanding distance programme with long contact hours), One year Public Health Masters Programme, building capacity among Community Volunteers like ASHAs and providing for their HR continuum, recruiting resident ANMs, skilling PHC Nurses in Medical Colleges, setting up Nursing Skill Labs, are all geared to improving the quality of care. Capability building and continuous refresher capacity programmes are at the heart of good human resources for health.

Third, while NRHM's approach was to provide a horizontal platform at Primary Health Centres for all forms of health needs (Communicable, non- communicable, reproductive and child health, preventive, promotive care) many vertically stand-alone programmes like Tuberculosis (TB), Malaria, Filaria, Kala Azar, etc. never got fully integrated into the platform for community connect and care. In spite of it, the benefits of creating a horizontal platform of services from health care institutions, helped vertical programmes as well. Often the vertical management of health is a consequence of external funding as well as every development partner wants his/her own monitoring vertical! It is for this reason that the National Health System Resource Centre set up to drive

reforms in the health sector, had been established exclusively with domestic financial resources. This did help efforts under the NRHM. NRHM also focused on convergence to make a difference in wider determinants like clean water, sanitation, housing, school health, nutrition, etc. The ASHA, Aanganwadi Worker, ANM partnership really evolved as a consequence. The Health and Wellness Centres are attempting to address this challenge. The efforts under the Swachcha Bharat Mission, the Pradhan Mantri Awaas Yojana, Jal Jeevan Mission, do help in addressing the deficits in wider determinants of health care. However, large scale construction activity, automobiles, stubble burning, do also create new environmental health challenges.

Fourth, community connect demanded the setting up of Village Health, Sanitation, Nutrition Committees as also Rogi Kalyan Samitis in Health institutions. Their effectiveness would have been significantly higher if we had institutionalized a role for local governments in such community formations. Institutionalizing decentralization and devolution of funds, functions and functionaries would have given even better and faster results in primary health care. The 29 sectors for Panchayats in rural areas and 18 in urban for Local Bodies, provide a perfect framework for convergence for outcomes. With civil society engagement through the Advisory Group for Community Action, NRHM demonstrated the need for constant people centric NGO oversight at the facility level for quality services. The over- reliance on community organizations without resolving the challenge of their integration with the Constitutionally mandated local government institutions, does dilute system transformation. Human professionals in local governments can make this transformation more significant.

Fifth, quality primary health care needs more financial and human resources and we must step up investments in healthcare, in line with the 2.5% GDP public expenditure commitment made in the National Health Policy 2017. The Public Health System needs more Health and Hospital Managers and institutions like the Tamil Nadu Medical Services Corporation with complete digitization and decentralized warehousing with batch-wise testing of rigorous pre-qualification based procurement of generic drugs and medical equipment. While over 25 States have set up Corporations, the last mile digitization and random batch-wise testing with Drug Passbooks in health institutions has not become a reality in many. Doctors, drugs and diagnostics still account for over two thirds of the out of pocket expenditure. We need to ensure uninterrupted supplies and services. Batch – wise testing and very rigorous pre-qualification requirements for supplies of generic drugs, along with stringent and salutary punishment for spurious drugs, is needed urgently.

Sixth, better decentralized management capacity requires a range of new skills in hospital and health management, finance, planning, programme management, accounts, procurement, information technology, etc. Many of these skill sets were brought in by NRHM but did not get institutionalized in most States. Before the scam in Uttar Pradesh happened in NRHM, all the new skill sets brought in for better management were set aside from responsibilities assigned to them. It is time we invested in institutionalizing and main streaming many of these skill sets through State Public Service Commissions (PSCs). PSCs need to speed up and innovate recruitment of doctors and nurses as year-long recruitment processes do not yield good results as doctors are always in demand elsewhere. We must appreciate the need for

campus and walk – in interview based selections to augment human resources for health. Decentralization without professionals and capacity is always fraught with dangers. We really need to heed to this need for social audit, local government role, social capital of women's collectives of the Rural Livelihood Mission, to drive decentralization. Connecting households to health facilities will only be possible through such an approach.

Seventh, the excess private sector capacity for secondary and tertiary care must be used for public health purposes at reasonable rates and that is what Pradhan Mantri Jan Arogya Yojana (PMJAY) is trying to do. Given the unequal social and power relations, many a time misadventures happen in such partnerships. The community connect and real time accountability framework for social audit is our only guarantee for effectiveness of partnerships.

Jean Dreze and Reetika Khera have published an excellent assessment of public health institutions in Himachal Pradesh, Bihar, Jharkhand, Rajasthan and Chhattisgarh, a few weeks ago in the Economic and Political Weekly. They have compared public access of primary health facilities and compared it with the situation in 2002, when a few studies had been undertaken. They found larger number of poor people coming to public health institutions, though performance in Bihar and Jharkhand left much to be desired. Rajasthan and Chhattisgarh also reported services that were as good as Himachal Pradesh, a state that has invested in good public services for citizens. The Dreze-Khera study also confirms the improvement in public health facilities and their services. This surely is attributable to the NRHM efforts at crafting credible public systems for health care.

The biggest lesson is the need to engage with States in a dialogue of equals (Samakhya) meaningfully as they alone can drive reforms with resources. The District Health Plans, the Appraisal and Approval process, the Common Review Missions, the Good Practices across States' presentations, the partnership for community owned institutional transformation through decentralization with professionals and untied grants to institutions, is the real way forward for quality health care for all. NRHM was surely a path-breaking public primary health care mission that had many strengths; weaknesses can always be tackled for even better outcomes.

***Amarjeet Sinha is a retired civil servant. The views are personal.**

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