Public Health System in UP: What Can Be Done?

SANTOSH MEHROTRA

This article offers a menu of options for reform of Uttar Pradesh’s public health system. Though some actions have been taken after the introduction of the National Rural Health Mission in late 2005, a large number of very serious problems remain. Unless they are addressed, the monitorable targets of the Eleventh Five-Year Plan in regard to health and nutrition in India will not be met, since UP has such a large weight in the unmet needs of public health in the country.

It is common knowledge that social outcome indicators in the northern states are far worse than those prevailing in southern India. The outcomes are closely linked to the quality of services provided by the otherwise widespread and pretty adequate public health infrastructure. How effective the services are depends on how serious is the political commitment to improving the public health delivery. This has been amply demonstrated by the fact that Bihar, where the public health infrastructure is on many counts much worse than in Uttar Pradesh (UP), has recently shown a remarkable turnaround in the effectiveness of services and the utilisation of public health services has improved considerably, as the government of Bihar has demonstrated a political commitment to improve services.1

Given the improvement in health and education indicators in Rajasthan and Madhya Pradesh also in recent years, it appeared till recently that only UP and Bihar may remain within the erstwhile Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh (BIMARU) category of states.

However, there is now a political commitment, there could be a similar turnaround in UP’s health system as well, given that in terms of health infrastructure it is in most cases better endowed than Bihar. This paper diagnoses the problems with the government-provided health infrastructure, and goes on to suggest prescriptions for the medical malaise in UP.

Section 1 examines the health outcome and output indicators for UP, apart from analysing the infrastructure and human resource gaps that the state faces, which are part of the malaise of the government health system in UP. Section 2 discusses a menu of options that the government has in terms of policy prescriptions. Section 3 reviews briefly the actions that the UP government claims have been taken to address some of the problems identified in Section 1, drawing upon the National Rural Health Mission (NRHM) funding and guidelines. It also highlights the specific problems that remain with the implementation of the NRHM agenda of reforms in the government health system. The final section concludes.

1 Diagnosing the Malaise

In this situation analysis of the health indicators of UP, we will focus on a comparison with only one other BIMARU state – with which most of the Indian intelligentsia brackets UP – namely, Bihar. The comparison will also be with the Indian average for the same indicator.

The NRHM lays down the standards or norms that have to be achieved in the country. Therefore, the NRHM is making an effort to strengthen the public health system of: village level providers (at least one accredited social health activist (ASHA), anganwadi worker (AWW), village health drug day kit for 1,000 population); sub-primary health centre for five to six villages (with maternal and child health (MCH)/immunisation days) for population with a telephone link; primary health centre for 30–40 villages with round the clock services; and a block level hospital for 100 villages or 100,000 population.

Child Health: Table 1 (p 47) shows that the indicators of child health in UP in 2005-06 (National Family Health Survey 3) are not only much worse than for India on the whole, but actually worse than those in Bihar.

Preventable deaths of children under five have been dramatically reduced by public health interventions in all high-achieving developing countries in the world (Mehrotra and Jolly 1997) and also by high-achieving states in India. However, in UP barely 23% of all children below two years of age have been fully immunised, or half the Indian average, and 50% less than in Bihar.

Maternal Health: Institutional delivery is another good indicator of the demand for the public health system. Table 2 (p 47)
shows that barely 22% of UP’s mothers are delivering babies in an institutional setting, the same as in Bihar and again roughly half of the Indian average. Only half of Indian women had at least three antenatal care visits for their last birth, but the share of UP women is only half of the Indian average; Bihar was doing worse in this respect.

After birth, the mother should ideally receive health check-ups and supplementary nutrition, and there are arrangements ministry of rural development (department of drinking water and sanitation), has its work cut out for itself in UP as does the state government. What is remarkable is that 92% of hospitalisation cases in rural UP were on account of infectious and parasitic diseases, especially for diarrhoea and gastroenteritis. This indicates clearly the widespread problem of poor water quality and the absence of basic sanitation and hygiene (Jan Swasthya Abhiyan UP 2008).

### Table 1: Child Health Indicators

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Uttar Pradesh</th>
<th>Bihar</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate (%)</td>
<td>75.0</td>
<td>64.0</td>
<td>72.7</td>
</tr>
<tr>
<td>Child mortality rate (%)</td>
<td>—</td>
<td>25.6</td>
<td>—</td>
</tr>
<tr>
<td>Total fertility rate (%)</td>
<td>4.13</td>
<td>2.95</td>
<td>3.82</td>
</tr>
<tr>
<td>Children age 6-35 months who are anaemic (%)</td>
<td>85.7</td>
<td>82.5</td>
<td>85.1</td>
</tr>
<tr>
<td>Children 12-23 months fully immunised (%)</td>
<td>20.5</td>
<td>32.6</td>
<td>22.9</td>
</tr>
<tr>
<td>Percentage of children with a birth weight less than 2.5 kg</td>
<td>—</td>
<td>25.1</td>
<td>—</td>
</tr>
</tbody>
</table>

Source: National Family Health Survey (NFHS-3), 2005-06.

### Table 2: Maternal Health Indicators (in %)

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Uttar Pradesh</th>
<th>Bihar</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers who had at least three antenatal care visits for their last birth</td>
<td>22.6</td>
<td>40.9</td>
<td>26.3</td>
</tr>
<tr>
<td>Trends in institutional deliveries</td>
<td>18.0</td>
<td>40.0</td>
<td>22.0</td>
</tr>
</tbody>
</table>

Source: National Family Health Survey (NFHS-3), 2005-06.

for this at the anganwadi centre (AWC). However, the AWCs in the entire country have been notoriously ineffective in performing this role (Table 2), but in UP they have functioned even worse than in the rest of the country.

### Health Inputs: Without clean water and sanitary means of excreta disposal there is little possibility of a dramatic improvement in health outcomes. The remarkable phenomenon here is that even in urban areas where piped water is available to three-fourths of the nation’s population, only 35% of urban UP residents have access to piped water (Table 3, p.48).

The share of rural households that have a toilet is barely 16% in UP (same as in Bihar), and way below the national average (26%). Overall, a third of UP residents have access to a toilet facility, while that share is 45% in the country as a whole. Clearly, the Total Sanitation Campaign, the centrally-sponsored scheme of the

### The Health Infrastructure: The population served in UP per government hospital, per government hospital bed, per doctor, per primary healthcare sub-centre, per primary health centre (PHC) and per community health centre (CHC) are all systematically lower than the national average, but at the same time in all cases better than in Bihar (Table 4, p.48). That clearly suggests that there is a desperate need to address the infrastructure disadvantage that UP’s public health system suffers from and which should be funded from NRHM – which is already allocating some Rs 7,000 crore to UP (2006-07).

The population served per government hospital in India on average is 1.45 lakhs, in UP it is 1.98 lakhs and in Bihar 8.7 lakhs. Similarly, the population served per government hospital bed is 2,257 in India, but 5,646 in UP and an astounding 28,959 in Bihar. However, the situation is not so bad in respect of sub-centres and PHCs, in which case the population served in UP is reasonably close to the national average. In other words, the problem is primarily with government hospitals and with government hospital beds.

The remarkable situation is that in UP the number of sub-centres stood at 20,153 at the end of the Seventh FYP (1990) (after having increased from 15,653 at the end of the Sixth FYP in 1985); but the numbers did not increase during the Eighth FYP (1992-97), nor in the Ninth FYP (1997-2002). Hence at the end of 2005, the number of sub-centres stood pretty much where it was at the beginning of the 1990s.

Something very similar happened in respect of PHCs in UP. Their numbers had doubled (from 9,115 at the end of the Sixth FYP to 18,671 at the end of the Seventh FYP). Over the Eighth FYP the numbers increased by about 12%, but almost not at all during the Ninth and Tenth FYP periods, so the total number ended up at only 23,236 by September 2005.

Two other indicators are very important to determine the effectiveness of the public health system: the average rural population served by the population health infrastructure and also the average rural area/radial distance covered by it. Both the average area (in sq km) and the radial distance (in km) in UP from sub-centres (1.91 km radial distance), PHCs (4.51 km), and CHCs (13.9 km) is less than the national average (2.61, 6.3 and 17.22 km, respectively) and not significantly different from that prevailing in Kerala. In other words, if the sub-centres, PHCs and CHCs were to function it would not be that difficult for people to actually seek medical care in them. However, part of the difficulty is that the average rural population covered by the primary healthcare infrastructure is higher in UP than the national average (6,416 as against 5,085 for sub-centres, 35,972 vis-a-vis 31,954 for PHCs, and 341,084 vis-a-vis 221,904 for CHCs). The further difficulty is, of course, that doctor and paramedical staff absenteeism from duty is endemic in UP, slightly more so in UP than in other states of the country (according to a World Bank study of 2004).

In addition to the primary healthcare infrastructure discussed above, UP also has one of the country’s most extensive
publicly-funded ayurveda, unani, siddha, yoga, naturopathy, homeopathy (AYUSH) hospital and dispensary systems in the country. While India has 3,198 such hospitals, UP alone had 1,973 of them, or nearly two-thirds. In addition, it had 1,871 such dispensaries, of the over 21,000 in the country. In other words, quite clearly the primary health infrastructure in UP is not exactly poor. The real issue is the kind of services provided by the personnel employed there.

Health Personnel and Their Facilities:
The impact of the infrastructure shortfall has a corresponding shortfall in staff. Although the ASHA is the community outreach worker as of 2005, the auxiliary nurse midwife (ANM) or multi-purpose female worker is the real front line health provider within the public health system, located at the sub-centre. The number of ANMs required in UP was over 20,000 (as of September 2005), a number twice as large as in the next highest state and the shortfall was of the order of 3,198, which was greater than the shortfall (relative to requirements determined by norms) in all other states taken together.

If staff is going to be found at the health facility, there is a higher likelihood that patients will be attracted to them. One factor determining whether medical staff will arrive at work is if they have staff residential quarters at the health facility. Of the 20,521 sub-centres (as of September 2005), 32% had ANM quarters and in most of them the ANM was actually living in the quarter (5,183 of 6,494) (Table 5, p 49). But given that two-thirds of the sub-centres did not have staff quarters, it would be hardly surprising if the ANM rarely showed up for work.

Even if staff showed up for work, they can do their job only if minimal facilities are available: water supply, electricity and all weather approach road. Of all sub-centres in UP, 59% did not have regular water supply, 75% did not have electricity, and 56% were without an all weather approach road (Table 5). Under such conditions, it is no surprise that the public health infrastructure suffers from under-utilisation of its facilities.

Nutritional Outcomes: It should have shocked the nation that half of India’s children are malnourished (2005-06) and the situation has not improved at all since 1998-99, the last time a comparable survey was done. UP is doing as badly as India on average and not much worse, though its child rate of underweight is lower than that of Bihar. However, it is unclear whether this is any consolation, since a higher proportion of UP’s children are stunted compared to Bihar children, while Bihar children are doing worse in terms of wasting.

The most important intervention by the government to address malnutrition has been the Integrated Child Development Scheme (ICDS), with awcs in each village. The awc is supposed to provide six services: (a) supplementary nutrition; (b) pre-school education; (c) immunisation; (d) health referrals; (e) growth monitoring; and (f) health check-ups. But for awcs to provide these services they have to be universally available. UP has one-seventh of all the awcs operational in the country, and the number is likely to increase, since awcs are to rise in number to universalise ICDS, as per the instructions of the Supreme Court. But for awcs to function, they must have the awcs and helpers; but over 15,000 awcs and 17,000 helpers are in short supply, and have to be appointed (funds for which are made available by the central government).

Even if the shortfall in infrastructure and staff were met, the real issue is whether the parents perceive the programme to be effective. The evidence from both the focus Survey in 2006 as well as the NFHS 3 in 2005-06 does not seem to be encouraging. One reason is that the government of UP has shown little interest in switching from centrally procured panjiri, which is currently distributed to children and mothers by way of supplementary nutrition, to hot cooked meals – which is the practice in at least 15 states around the country but is also a requirement as per instructions of the Supreme Court.

Public and Private Expenditure on Health: The state of primary healthcare in UP is partly reflected in the fact that compared to the rest of India, patients have to spend more out of their pocket.

<table>
<thead>
<tr>
<th>Table 3: Water and Sanitation (in %)</th>
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</thead>
<tbody>
<tr>
<td>indicators</td>
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<tr>
<td>Households using piped drinking water</td>
</tr>
<tr>
<td>Households with access to a toilet facility</td>
</tr>
</tbody>
</table>

Source: National Family Health Survey (NFHS-3), 2005-06.

<table>
<thead>
<tr>
<th>Table 4: Health Infrastructure as on March 2006</th>
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</thead>
<tbody>
<tr>
<td>Parameters</td>
</tr>
<tr>
<td>Population served per government hospital</td>
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<tr>
<td>Population served per government hospital bed</td>
</tr>
<tr>
<td>Population served per doctor</td>
</tr>
<tr>
<td>Population served per sub-centre</td>
</tr>
<tr>
<td>Population served per PHC</td>
</tr>
<tr>
<td>Population served per CHC</td>
</tr>
</tbody>
</table>

Population served per government hospital includes central government, state government and local government bodies.

NR = information not received, NA = not available.

Source: National Health Profile, 2006.
2 Prescriptions

A Menu of Prescriptive Options

The situation analysis of outcomes in UP demonstrates in no uncertain terms that the public health system is not delivering; this implies that public health is not prioritised by policy. Moreover, there is a clear impression from the government of UP (goup) policies that the focus of the government health system still remains curative and clinical care, rather than preventive and primary health services – when rural areas for at least three years. The UP government should initiate such a course in medical colleges at the earliest.

(2) There is a large body of "registered medical practitioners" (RMP) of highly uneven quality in UP, who claim to provide medical services. There are essentially two types of such providers (even though both may be lacking in verifiable qualifications and credible training) – complete quacks and those who have some medical experience. There is no alternative to totally eliminating the first category – and it is entirely unclear what action the UP government is contemplating to achieving this task. The point is not to enforce a ban that already exists, but rather to weed out the system of illegal registration of such "RMPs" that has flourished. At the same time, the public would need to be educated that without a legal registration, a RMP is a quack, and should not be approached. The second category, however, needs to be incorporated into the health provision system, through a process of professionalisation focused on their training – which could serve as a means of incentivising and thus legitimising them. The Rajasthan Registered Medical Practitioners Association has adopted a criteria to identify such providers who could be "professionalised" through regular training. This requires that the UP health department prepare a checklist to facilitate identification of such providers, who would then be provided training at existing training schools for ANMs and ASHAS.

(3) There is need for greater synergy in the training efforts of the National Institute for Health and Family Welfare (New Delhi) and UP’s State Institute of Health and Family Welfare (SIHFW,Lucknow). The State Institute needs to lead the training of the second category of RMPs. However, it is likely that the SIHFW would itself be understaffed, and would therefore need additional trainers in order to undertake the large-scale training of potential RMPs that would be required to meet the needs of the population. The NRHM funds are already available under the flexi-pool of funds from the central government for hiring consultants at the SIHFW in Lucknow, to strengthen the faculty to conduct such training.

(4) Training of rural practitioners should be to promote and actively support public health measures, including immunisation, oral rehydration therapy for diarrhoea, diagnosis and treatment of pneumonia, support of family planning and the regular provision of oral contraceptive pills, condoms and other spacing methods. They should, at the same time, recognise and refer the more severe and chronic health conditions, especially tuberculosis (TB), leprosy, kala-azar, Japanese encephalitis, malnutrition, human immuno deficiency virus (HIV), etc, to the PHC.

(5) The Goup needs to encourage the attachment of rural practitioners to qualified doctors that would result in a continuing relationship of guidance and upgraded knowledge.

(6) Now that the Goup has finally decided, following the very successful experience of the Tamil Nadu Drug Procurement Corporation, to create a drug procurement corporation of its own, drugs should be made available with RMPS, PHCs and sub-centres. An audit mechanism has to be created that also monitors PHC doctors’ prescriptions behaviour, since doctors tend to prescribe drugs that are not available in the PHC pharmacy – since there is collusion between outside private pharmacies and those of the PHC. The PHC doctors’ prescriptions should naturally be based on a list of generic essential drugs. Use of such drugs would increase the effectiveness of the treatments prescribed by RMPS and PHCs, and discourage the use of injections; together such actions would enhance the credibility of RMPs in the eyes of the public, and thus increase their practice.

Preventive/Promotive Measures

The following public health measures need to be addressed.

(i) There is a need for doctors in rural areas, since qualified MBBS doctors have shown unwillingness to live and work in rural areas. To address the need for doctors in rural areas, both the UP government and the Planning Commission’s Eleventh Plan make a case for starting a three-year as opposed to the current five-year MBBS course. There is an urgent need to initiate such a course in UP, with the objective of part meeting the needs for rural doctors; once appointed these doctors would be required to serve in places that are remote.

(ii) Doctor soonest, the focus should be exactly reversed, with the latter taking primary priority over the clinical care services.

Table 5: Facilities Available at Sub-Centres (as on September 2005)

<table>
<thead>
<tr>
<th>States</th>
<th>No of existing</th>
<th>No of Sub-Centres with ANM Quarter</th>
<th>No of Sub-Centres with ANM Living in Sub-Centre Quarter</th>
<th>Without Regular Water Supply</th>
<th>Without Electric Supply</th>
<th>Without All-weather Approach Road</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uttar Pradesh</td>
<td>20,521</td>
<td>6,494 (32)</td>
<td>5,183</td>
<td>12,083 (59)</td>
<td>5,183</td>
<td>11,572 (56)</td>
</tr>
<tr>
<td>Karnataka</td>
<td>8,143</td>
<td>4,493 (55)</td>
<td>4,493</td>
<td>15,332 (75)</td>
<td>15,332</td>
<td>15,332 (56)</td>
</tr>
<tr>
<td>Kerala</td>
<td>5,094</td>
<td>2,528 (50)</td>
<td>1,659</td>
<td>1,292 (25)</td>
<td>913 (18)</td>
<td>351 (7)</td>
</tr>
</tbody>
</table>

Figures in bracket give the corresponding percentage.

Source: Rural Health Statistics in India 2006.
Population-Based Public Health Measures

Sanitation: There is little likelihood of a decline in child malnutrition rates or IMR unless coverage of safe sanitation improves. The Total Sanitation Campaign (TSC) requires the states to compete in engineering behavioural changes; the latter requires that villages are declared open-defecation free (ODF) zones.

Of the 70 districts in UP, only 30 have more than 33% sanitation coverage. The Goup cannot expect much improvement in addressing malnutrition and reduction in communicable diseases in the absence of a serious effort to implement the TSC programme, and without advancing the date (2012) for coverage of the entire state.

Malnutrition: The National Family Health Survey III (2005-06) shows that UP’s child malnutrition rate is 47%, while the national rate is 46%. The ICDS coverage is low, even though the Supreme Court has for several years been instructing state governments to universalise ICDS, and to end contractor-driven supplementary nutrition. However, UP risks being now in contempt of the Supreme Court if it continues with the contractor-driven supplementary nutrition. Second-ly, the allocation for ICDS is being significantly increased during the Eleventh FYP for ICDS; the programme must be rapidly universalised, with a focus on scheduled caste communities, since it is their hamlets which are currently under-provided in UP with AWCS.

Immunisation: The immunisation programme has been overtaken by the focus on the “polio-plus” campaign, to the detriment of the entire immunisation effort. Not surprisingly, the increase in the immunisation rate in UP between 1998-99 (NFHS 2) and 2005-06 (NFHS 3) was barely 3 percentage points, from 20% to 23%. It is obvious that polio might be a special problem besetting UP in particular, but it cannot be addressed at the expense of the remaining preventable diseases.

Campaigns: There is a special need to adopt a campaign approach in the following areas on an urgent basis, since these are low-hanging fruit which can be plucked by the Goup to bring about quick results: (1) Data shows that reducing or eliminating births that occur less than 24 months apart could attain the greatest reduction in child mortality. However, unfortunately the entire health and family welfare programme is oriented towards sterilisation, when it should be focused on increasing birth spacing through condom use. Also, child bearing in the age group of below 20 is five times more as compared to the 35 plus age group, and these births are at short birth intervals (Second Human Development Report of UP 2007). The mean age at marriage in UP remains around 16. Thus campaigns are needed to discourage child bearing among women less than 20, to raise the age of marriage, and encourage birth spacing. (2) By far the largest differential between female and male child mortality is in the age group 1-5 (i.e., not in the first year after birth), with female child mortality being much higher. Females under one year may be less disadvantaged relative to males because children of both sexes are breast-fed. After breast-feeding stops, the potential for differential treatment of boys and girls increases. Clearly, a campaign is needed informing people all the facts, and advising corrective action within the household.

System-Wide Needs of Infrastructure: First, the shortage of ANMS arises because the training centres have not been conducting training since 1992 – encouraging a de facto privatisation of the healthcare system in the state of UP. During 1992-2004 pre-service training of ANMS did not take place; training was restarted only in 2004. There are 40 ANM training centres in the state, each with a training capacity of 60 per batch. Of these 30 have been made partially functional. There is a problem as regards the availability of tutors, which should be resolved, by hiring them on a consultancy basis for temporary periods, against funds to be drawn from NRHM. In addition, there are 30 district training centres which are non-functional at present, and should be reactivated, and if necessary, funds utilised from NRHM for the purpose.

The Goup has made a request to the central government that as part of a package for Bundelkhand and Poorvanchal regions of UP, three new requirements should be met. First, Jhansi needs an All-India Institute of Medical Sciences (AIIMSS). The ministry of health of the union government has already decided, meanwhile, that of the six new AIIMSS being created in the country during the Eleventh FYP, one should be set up in Varanasi.

Second, the Goup would like to see a National Institute of Virology (NIV) in Gorakhpur, to help UP address the problem of Japanese encephalitis, a disease which is endemic in the north-east of UP (UP accounts for 60% of India’s cases of Japanese encephalitis). The NIV in Pune already has an outpost in Gorakhpur. However, it is not entirely clear what purpose will be served by a new national institute, when one already exists; nor was it made clear how a national institute of virology will resolve the problems of sani-tation, water quality and hygiene, which are the underlying and proximate reasons for the high incidence of Japanese encephalitis in the sub-region. Nevertheless, a NIV has already been sanctioned for Gorakhpur by the central government.

Third, medical colleges in UP are severely short of staff; so the Goup wants the union government’s to provide financial support to create new medical colleges to train such staff. However, it is not clear how the latter is a solution to the problem of staff shortage in medical colleges. Apparently, the real problem is that while the existing UP medical colleges do get enough good applications for staff for clinical faculty positions (e.g., medicine, surgery), they do not for para-clinical (social and preventive medicine, pharmacology, etc) and for pre-clinical (e.g., biochemistry, physiology, anatomy). This is because not enough students wish to register for post-graduate training in the latter two sets of disciplines as they prefer only clinical disciplines. If existing medical colleges cannot adequately staff faculty positions for para- and pre-clinical positions, it is totally unclear how creating new medical colleges will solve the problem.

Fourth, to fill vacant positions for doctors in rural PHCs, Goup is making the legitimate case for creating a new course
which will require fewer number of years than the current five years for a medical (MBBS) degree.

Fifth, the goup also made a case for budget support from the central government to create new medical colleges, with total capital costs being shared equally between the state and central governments. Based on the norm of one medical college for every 50 lakh population, there is indeed a deficit of 24 medical colleges in up. There are 11 medical colleges in up – seven in the public sector and four in the private sector. By contrast, the southern states more than meet the norm. Naturally, the southern states produce more doctors than up, although up’s population is much larger. However, the southern states have a larger number of private medical colleges than public ones. up, on the other hand, has failed to attract private investment in medical education.

Sixth, even if new medical colleges were to come up in up, without putting in place a mechanism to ensure that the doctors produced by medical colleges will actually be willing to serve in rural areas, it is unclear how the larger supply of physicians and surgeons will solve the problems with the health delivery system. Tamil Nadu has an effective system to ensure that doctors employed by the government actually serve in rural areas, which the goup has signally failed in ensuring. Besides, there is a provision in the Eleventh FYP for converting some district hospitals into medical colleges, through the public-private partnership mode.

Seventh, in addition to the measures proposed to revive the government health system in up, there is a nation-wide proposal to introduce health insurance for the below poverty line (bpl) families. There are one crore bpl families in up (bpl population is 5.4 crore). With a premium of Rs 500 to provide coverage of Rs 30,000 per bpl family of five, the goup will need Rs 500 crore to cover the cost of health insurance premium to cover all bpl families. The goup is willing to contribute Rs 100 crore of the Rs 500 crore required; it also believes that families could be required to contribute Rs 100 per family towards the premium (or Rs 100 crore for all bpl families per annum). The remaining Rs 300 crore would need to come from the central government. A pilot project (with a goup allocation of Rs 10 lakh) has been initiated. Urgent action is needed to quickly put in place the project, so that the learning from the project could be used to universalise health insurance for bpl families in up.

3 Changes under NRHM

It should be recognised that within the last year, some changes have indeed occurred in up’s public health system – thanks to the NRHM. It should be noted, of course, that health is a concurrent subject in the Constitution, and state governments are dominantly responsible for health provisioning. The goup has claimed that the following actions have been taken and improvements in services have occurred.

Janani Suraksha Yojana has already increased the number of institutional deliveries by more than twofold. It is proposed to operationalise one district women’s hospital and at least two chcs per district. The comprehensive child survival programme – Janani Shishu Bhima Yojana (hereafter Jsb) – has been included for pre-school children under NRHM. IMR and ans are being trained under the project. Fixed day, fixed time, fixed place schedule is being followed for village level monthly immunisation days.

As regards malnutrition, a bi-annual Bal Poshan Swastha strategy is being implemented in all the districts with the help of unicef and icds. Iron administration has been included for pre-school children under NRHM, and also compulsory iFA to all pregnant women. Iodine deficiency control programme has been expanded under NRHM umbrella.

As regards, the poor health infrastructure sub-centre and PHC construction is under way in a phased manner.

Table 6: Public and Private Expenditure on Health, 2001-02

<table>
<thead>
<tr>
<th>States</th>
<th>PER Capita Expenditure (Rs 1000)</th>
<th>Public Exp</th>
<th>Private Exp</th>
<th>Total Exp</th>
<th>Expenditure (Rs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Public</td>
<td>Private</td>
<td>Total</td>
<td>As a % of Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>as a %</td>
<td>as a %</td>
<td>of</td>
<td>Expenditure</td>
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<tr>
<td></td>
<td></td>
<td>Total</td>
<td>Total</td>
<td>Expenditure</td>
<td>Expenditure</td>
</tr>
<tr>
<td>Uttar Pradesh</td>
<td>14,40,88,564</td>
<td>7.5</td>
<td>92.5</td>
<td>100</td>
<td>1,40,88,564</td>
</tr>
<tr>
<td>Bihar</td>
<td>77,08,790</td>
<td>11.8</td>
<td>88.1</td>
<td>100</td>
<td>77,08,790</td>
</tr>
<tr>
<td>India</td>
<td>21,43,91,018</td>
<td>20.8</td>
<td>79.2</td>
<td>100</td>
<td>21,43,91,018</td>
</tr>
</tbody>
</table>

All India total expenditure includes expenditure by NGOs, firms and households. Source: National Health Profile 2006, National Health Accounts and M/o Health and Family Welfare, GoI.

As regards, the poor health infrastructure Sub-centre and PHC construction is under way in a phased manner.

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component. Untied funds have been another successful component at all levels, provided to the sub-centre, PHC and district hospital. Hospital development societies (Rogi Kalyan Samitis) have also been formed in most states, and along with the provision of untied funds to them are acting as enablers of facility development. The Indian Public Health Standards (IPHS) have been introduced, and widely circulated; they are acting as a valuable benchmark for facilitating states to reach desirable levels of both infrastructure and human personnel.

Of the 13 states visited by the NRHM Review Mission almost all have reported increased performance in terms of absolute attendance and to a lesser extent in terms of quality of care. Since we started our analysis in Section 1 by comparing UP’s performance with that of Bihar, it is worth quoting the NRHM Review Mission’s summary finding on Bihar:

...there is an increase in block PHC OPDs [out-patient department examination of patients] from 39 per month two years ago to over 2,500 per month now for many months, and from 7,000 institutional deliveries in government institutions in October 2006 to over 100,000 deliveries in October 2007...Given the low utilisation of public services in Bihar as reported by NSSO 60th Round 2004-05 (5% out-patient and 11% in-patient treatment in government institutions), this is indeed outstanding. There is a confidence that the public system shall deliver quality healthcare services and people are flocking to the public system to utilise services even on holidays and over weekends.

We turn our attention now to UP’s performance under NRHM, by key subject.

ASHAs
The guidelines state that the selection of ASHAs should be done in consultation with all the villagers. She should be a married/divorced woman residing in the village. At least three-four consultations should be done with the villagers and a final list should be approved in the gram sabha. The JSA Report for UP finds that 56% of the ASHAs were selected in a meeting, the remainder were recommended without such procedures. There could be an opportunity for auto-correction since poorly selected ASHAs, who were expecting regular remuneration or a government job, tend to drop out and replacements could be done better.

Drug kits are supposed to be given to each ASHA. The review mission report notes that while drug kits have been given to all Mitansins (ASHAs by another name) in Chhattisgarh, and about 50% of ASHAs in Rajasthan and Assam, they are not yet distributed in UP, since drug procurement is not complete. This deprives the programme of much effectiveness.

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**International development and relief NGO seeks staff for Regional Office based in Delhi**

**Documentation and Information Officer**

DanChurchAid South Asia, Delhi Office is looking for a well qualified person to

- Be responsible for developing documentation and information material for internal and external use for DCA Regional Office South Asia
- Be responsible for providing support and capacity building on communication and media to DCA partner organisations
- Be responsible to support and provide input to DCA Denmark Media unit
- Function as Focal Person for Most Significant Change method
- Be an active, critical and constructive member of DCA South Asia team

Applicants for the job must have the following qualifications: a postgraduate degree in communication, journalism or social sciences with excellent writing skills in English and Hindi. The candidate must have minimum five years of working experience as communication/information worker in national/international NGO with similar responsibilities and field work experience in advocacy an advantage.

The candidate must have firm personal commitment to social equity and equal rights. The position requires strong analytical, facilitating and writing skills as well as fluency in written English and Hindi. The Regional Office needs a person with a strong commitment to her/his work, excellent interpersonal communication skills and a sense of humour. Willingness and ability to travel and be flexible is essential. The national position will be based in DCA Regional Office, New Delhi.

Preference will be given to women candidates. Candidates should send their applications to sadocinfo08@gmail.com. Deadline for applications is 19.12.08. Candidates will be invited for an interview in the beginning of January in Delhi. Only short-listed candidates will be contacted.

DanChurchAid is an independent Danish faith-based organisation working on humanitarian emergency response; rights based development; information and advocacy in partnership with secular and church-based organisations. DCA is committed to promoting equal opportunities for women and men from different caste, ethnic and religious backgrounds and encourages candidates of diverse backgrounds to apply for this position. For further details about DCA visit our website www.danchurchaid.org.
The JSA finds that since there is no provision of salary to ASHAs, the work done by ASHAs clearly reflects the attitude that she does only that work where incentives are paid (like Rs 300 for SIFA survey, Rs 600 for every delivery case though JSY, Rs 150 per immunisation session, and Rs 50 per day for pulse polio campaign). At least for the pulse polio, the incentive should be eliminated as part of a larger strategy to de-emphasise the polio campaign since, as we noted earlier, it is undermining the larger immunisation effort.5

**Training and Need for Multi-skilling:**

The NRHM Mission Review notes that none of the new skill based trainings – like Skilled Birth Attendant training, IMNCI, multi-skilling for specialist skills, etc, have reached these districts. Even on institutional delivery or new born care, the skill levels of the nurses and ANMs who are actually conducting them needs considerable strengthening to achieve a quality that would have an impact on indicators. There could be much progress made in reaching the levels of IPs/PS specified service provision through closing skill gaps in existing staff. Training activity is almost invisible at the district level.

One hope of the reform process through NRHM was that vertical programmes would get integrated with functional public health services at every level. However, the NRHM Mission Review for UP finds that integration of vertical programmes still remains a challenge.

**Drug Availability:**

Drug availability has improved, but prescriptions for buying from outside pharmacies are still high. The procurement and disbursement system needs to be rationalised to prevent delays from procurement by the central store and make distribution responsive demands.

**Functionality of CHCs, the 24 Hour PHC and Appointment of Staff:**

There can be no 24 hour PHC without the appointment of additional staff at para-medical level. There continues to be a shortage of nurses. The NRHM Mission Review for UP notes that there is a lack of nurses at almost every level of public health facility. “No facility has anywhere near the nurses needed”. Even posts have not been created. Block PHCs could have asked for nine nurses and as an intermediate stage could have asked for three nurses or ANMs but in fact they have none or at best one ANM. This constrains both quality and quantity of services provided. Second ANMs are not in place.

**Untied Funds and the Rogi Kalyan Samiti:**

The NRHM provides a major part of its funding through untied funds: The UP segment of the NRHM Review notes the activation of sub-centres through untied grants and the presence of ASHAs having connected households with health facilities. The Rogi Kalyan Samitis have also been set up and beginning to use the resources. The RKS is a vehicle that can ensure the proper utilisation of untied funds and forms a framework of both accountability and outcomes for it. In UP, the state already had a system of user charges that has been modified after the RKS came into existence. The earlier system of depositing 50% of user charges collected into the treasury account is being discontinued, and should clearly be done as a priority. The international evidence is overwhelming: user fees for health services only work if the revenues generated are used to improve services at the site where they are collected, not if they flow into the treasury account of the government. In this context, the RKS – a kind of hospital management committee – can become the instrument to improve quality and accountability of services, and in addition facilitate effective use of untied funds.

**References**

1. Note that the figures in this paper on Bihar are for 2005-06 at best, i.e., for a period before the new state government came to power two years ago in Bihar.

2. Bihar’s principal secretary for health claimed in the Planning Commission in January 2008 that institutional deliveries have gone up in Bihar from 22% to 70% of all deliveries. Whether or not the 70% figure is correct, there must have been a significant increase for the government to make such a claim.

3. The NRHM team visited facilities in two districts and Jan Swasthya Abhiyan visited eight districts of UP.

4. The JSY offers the following incentives: women delivering in rural areas Rs 1,400; for women delivering in urban areas Rs 1,000; for the rural motivator Rs 250 for transport, Rs 150 for other expenses, and Rs 200 as incentive (for urban motivator Rs 200 in all). JSY scheme benefits are also given to recognised institutions for BPL, SC and ST women. Home delivery in rural areas fetches BPL women Rs 500 each for the first two children.

5. In private conversations, provincial medical services doctors in UP said to us that polio will never die in UP, for the reason that there is “too much money to be made by a sustaining the incidence of polio, and since excessive government funds are allocated to the Pulse Polio campaign”.

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