Rural Health: Absence of Mission or Vision?

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It is time to recognise that the utter neglect of primary healthcare and its related institutions has influenced the utilisation of health services and contributed to a worsening epidemiological profile in the country. In its present form, the proposed Rural Health Mission adds to the confusion about the country's approach to healthcare. Cost-effective interventions, such as the rational distribution of medical and financial resources, should be part of the vision but they are often brushed aside in favour of the privatisation logic.

The 'mission mode' has once again entered governance, this time in the health sector but without an evidence based approach. The recent announcements and press reports indicate that the government is all set to launch a scheme packed with strategies to please all. One of the key strategies that has some political mileage (the press has highlighted only this!) is the designation of health workers in villages, and there is also some suggestion of privatisation of programmes such as maternity care, family planning services, etc. The mission is to be formally launched on November 14, 2004 in 17 states of the country and will be operational from April 2005 with an outlay of Rs 8,000 crore.

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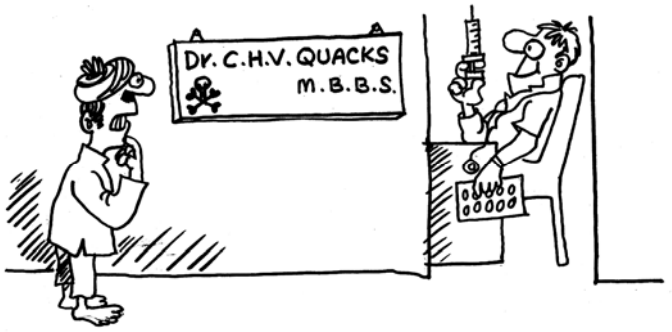
The idea of a health 'worker' from the community is not a new one; from a public health point of view, it may be an ideal vehicle for another development in the field. But it failed miserably in the case of the Community Health Guide/Volunteer (CHV) scheme due to several reasons. The most serious problem with the CHV scheme was the selection process; it was misused to distribute political patronage and even close relatives of *panchayat* leaders were selected. The training was extremely limited, but in the course of time most of the CHVs became quacks. In many villages, one can see them practising medicine, with huge boards outside, consulting timings, etc! A programme meant to give 'people's health in people's hands' ended up as mere quackery. It seems that the government has not learned from its mistakes and is foisting more of the same on people again using



public money.

The key strategies of the Rural Health Mission include: ensuring intra- and inter-sectoral convergence, strengthening public health infrastructure, increasing community ownership, creating a village level cadre of health workers, fostering public-private partnerships, emphasising quality services, and enhanced programme management inputs. The mission has also suggested certain concrete measures. For instance, inter-sectoral convergence is proposed to be achieved by establishing yet another organisation, this time probably a quasi-government society at the state and district level.

The public health infrastructure will be strengthened by several

measures; a few of them would probably script the demise of the public sector. These include the engagement of private doctors and health committees with the power to charge user fees, etc. Community participation will be enhanced by giving functional responsibilities and powers to the *panchayat raj* institutions, apart from creating a cadre of voluntary accredited social health activists, and a drug and contraceptive depot at the village.

The public-private partnership aspect is most controversial. The actions proposed are largely for family planning services and include social marketing and social franchising of services, such as institutional maternity care, immunisation services and provision of bank loans for setting up family welfare clinics. It also suggests the addition of other curative services and the gradual evolution of reproductive and child health to a community insurance programme. The mission will also use management experts, CAs, MBAs, and GIS specialists for its management units.

The mission expects that, through this strategy, the communicable disease burden and disability adjusted life years can be reduced and that the level of universal immunisation can be increased from 50 to 90 per cent. The proposed private participation in institutional deliveries is expected to improve the infant mortality rate and maternal mortality ratio. This is indeed wishful thinking!

We see that from Rajkumari to Raj Narain to Ramdoss, the country's public sector health system stands discredited by constant neglect and lack of effective and efficient governance. Added to these, cut-backs, preferential treatment for the private sector and the lack of an

epidemiological vision for rural health have added to the misery of public sector health services. It is this ambiguity, double thinking, and selective and half-hearted actions that have been the bane of public health planning in this country.

The *Bhore* committee contained a vision for India's health services in unambiguous terms and many of the recommendations were implemented selectively during subsequent years. The Bhore committee had recommended that a health committee consisting of five to seven individuals should be established in all villages. However, this was largely ignored. The need for universality, equity, and comprehensiveness of healthcare was also underlined by the committee. Henry Sigerist's quote in the *Bhore* committee report reflects the vision which prevailed at that time.

> Health is one of the goods of life to which man has a right; wherever this concept prevails the logical sequence is to make all measures for the protection and restoration of health accessible to all, free of charge; medicine like education is then no longer a trade, it becomes a public function of the state (vol 2, p 10).

There is no doubt that health services in India are in flux and have moved away from the above vision. The roots of the health service system have to a large extent been uprooted and the offshoots do not appear to be flourishing. The epidemiological and integrated vision at the time of independence has given way to a market-oriented approach. The half a century or more has also witnessed a number of changes in the organisation of health services, most of them concentrated during the last one decade or less. The reasons for this new thinking are quite apparent: the influence of the World Bank and accompanying reforms

during the post-structural adjustment period, apart from the liability of the ruling classes.

It is possible to discern a consistent disdain for public health services, which are viewed as the reason for the poor state of health in India. This view is articulated not only in academic or independent scholarly writings but also in many plan documents. This view is sometimes used as a rationale for public-private partnerships or to suggest other ways of delivering healthcare such as cooperatives, insurance, etc. The rationale for the poor performance of government health sector needs some close examination before we suggest privatising services. This will help in understanding the 'evidence base' of the privatisation logic.

A few studies on the health services system in the country, and especially on primary care institutions, reveal the overwhelming preference of people for government healthcare. Some of these studies show that accessibility and availability of healthcare are mediated by structural issues such as institutional inadequacies and inefficiencies in the system and influenced by various social, political and economic factors. The Planning Commission's study on community health centres (CHC) is another which *finds incompleteness in the availability of services as the main reason for the under-utilisation.* The logic of completeness in the package of services, which was responsible for the differential utilisation of CHCs could also be applied to PHCs.

The government has also ***given in to the pressure of international donor*** agencies to adopt what can be called as the ***'one by one approach'*** or the categorical approach that takes up disease eradication programmes concentrating on one disease at a time. The *Mudaliar* committee had noted that the method of dealing with diseases individually, through mass campaigns is not conducive to the organisation of unified efforts needed for the promotion of total healthcare. These costly drives are undertaken by mobilising the entire health service system leading to a neglect of all other programmes, including other immunisations. Implicitly it means that India is not capable of eradicating diseases through an integrated and complete

package of primary health services. The community is also made to believe that this is the programme that is going to save the lives of their children.

It is time to recognise that the utter neglect of primary care and primary healthcare institutions has influenced the utilisation of health services and contributed to the worsening epidemiological profile in the country in recent years. In the present form, the proposed mission adds to the confusion about the approach to healthcare in the country. Cost-effective interventions such as the rational distribution of financial and medical resources, including drugs, effective manpower distribution and primary healthcare approaches, should be part of the vision. These are often brushed aside for ushering in the privatisation logic.

What is also needed at present is a vision that gives primacy or rather credibility to the vast network of health institutions that the country has built over years. Strengthening the sub-centres and equipping the government's own health workers (instead of adding posts) would be epidemiologically and economically more effective. States should be allowed to define their own priorities and plan programmes. At present the public health scenario is extremely nebulous and the differential pattern across states is so glaring that it does not allow the imposition of pan-Indian solutions.

Apart from this, there is also a **need to equip and enable elected representatives at the village and block level for handling health**

issues. Presently, health programmes are beyond the reach of people who are supposed to govern under the decentralised form of government as these are often considered technical subjects. There is a need to remove the confusion among representatives and officials at the *panchayat* level about the roles and responsibilities around health services.

The government is still busy with macro-economics while the World Health Organisation (WHO) has moved forward to the Millennium Development Goals. The WHO is all set to establish a commission on the social determinants of health, which gives us a tremendous opportunity to define and delimit actions on the social front from a public health perspective. The government should think of establishing its own commission on the social determinants of health, considering the complexity, extent and diversity of public health problems in the social context.

There should be a rethinking on highly intensive drives, technocentric packages, vertical efforts and costly building activities that are being carried out by using the external assistance received under the safety net programmes. From a scientific point of view, such a logic does not have an 'evidence base', a term which is often used by the so-called protagonists of techno-managerial packages. The rural health mission would greatly benefit if it follows the vision of those that scripted India's health service system based on ***an integrated and unified approach as against the selective interventions*** **being proposed in recent years.**

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