



ORIGINAL RESEARCH PAPER

Public Health

IMPACT OF NATIONAL RURAL HEALTH MISSION – A KERALA HEALTH MODEL

KEY WORDS: Public health policy, Rural health, Kerala health model

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ABSTRACT

The present paper attempts to analyse the impacts of National Rural Health Mission (NRHM) on the people of Kerala. Kerala Health Model which is discussed and impressed world-wide with its sophistication and classiness and with established and satisfactory health outcomes undoubtedly materialised and upgraded with operation of this policy. This paper tries to investigate the present day challenges for the NRHM and ways to go through to improve the Kerala Health Model by synthesising the core aspects of the policy and needs of the community.

Introduction

India is currently the second most populated country in the world with nearly one fifth of the world's population. The population figure crossed the billion mark way back in 1998 and is projected to be the world's most populous country by 2022, exceeding the population of China. The population growth has a great bearing on the prevailing as well as emerging health profile, political, economic and social transformation and the changing socio-political, demographic and morbidity patterns of India are constantly under the global scanner. In India, about 75% of the health infrastructure, professional manpower and health resources are concentrated in urban areas where only 27% of the population live. The health status of Indians is still a cause of great concern especially that of rural population. The Govt. of India took cognizance of the current problem in its seriousness and realised that to improve the prevailing situation, the problem of rural health is to be addressed both at macro level- national and state level and at micro level-district and regional. While providing a broad framework of operationalization, Govt. of India introduced various strategies and policies to combat with the current perspective of declining rural health. The latest of them and the most beneficial one to the rural sector is National Rural Health Mission (NRHM) which started as a mission in the year 2005. NRHM was passing through its 10th year of implementation in 2015. A study on it in this period can gather and evaluate all the positive impacts over the people and their level of satisfaction in the study area selected. Analysis of the weak factors over these years and the corrective measures done so far can definitely contribute to valuable suggestions for the better implementation of the programme further in the ensuing years. Kerala is the most literate state of the country which is well known for its far advancement over other states in education, health, health facilities and well living standards. National Health mission has also contributed towards making it worthy of the success of overall growth. The Constitution of India makes health in India as the responsibility of state governments and makes every state responsible for "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and restructured in 2002 and 2017. The National Health Policy of 1983 and the National Health Policy of 2002 have served us well, in formulating the approach for the health sector in the Five-Year Plans and for different schemes. Now 13 years after the second health policy, the context has changed in four major ways. Health Priorities are changing and as a result of focused action over the last decade, we are projected to attain Millennium Development Goals with respect to maternal and child mortality. Maternal mortality, infectious diseases, non-communicable disease burden, health care costs, economic growth and increased fiscal capacity, inaccessibility of health care, lack of preventive approach and unfulfilled expectation of much other health needs serve as the wedge factors against satisfactory health of the people. The primary objective of the National Health Policy 2015, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions, investment in health, organizing and financing of healthcare services, prevention of diseases and promotion of good health

through cross-functional action, access to technologies, developing human resources, encouraging medical pluralism, building the knowledge base required for better health care, financial protection strategies and regulation and legislation for health.

National Rural Health Mission (NRHM)

Due to a fiscal crisis during the nineties, the public expenditure in health care was declining significantly and led to an overall deterioration of the availability of public healthcare system and skilled health professionals. The private medical sector undergone an uneven growth and contributed to a subsequent decline in access to health care facilities, especially in rural areas and hence the rising costs of health care had become a major public health issue. Moreover, healthcare outlay of about 1.3% of GDP had fuelled the out of pocket expenditure, accounted for nearly 80% of total health expenditure in India. This in turn resulted an estimated 3.2% of the population (approximately 39 million people) slipping below the poverty line every year, due to health care costs alone. So it became necessary for the government to go for the architectural correction in the public healthcare system in India, adopting a synergistic approach and led to the birth of NRHM. The 'National rural health mission' has been launched with a view to bring about dramatic improvement in the health system and the health status of the people. It is run by the Ministry of health. The mission was initially envisaged for 7 years from 2005-2012 and the programme is implemented mainly in two aspects: High focus and Non high focus. Eighteen states fall under the category of high focus. Kerala comes under the non-high focus large states group

Vision of NRHM:

1. NRHM seeks to provide effective health care to rural population throughout the country with special focus on 18 states which have weak public health. The mission is an articulation of the commitment of the government to raise public spending from 0.9 % to 2-3 % of GDP.
2. It aims to undertake architectural correction of the health system to enable it to effectively handle increased allocations as promised under the National Common Minimum Programme and promote policies that strengthen the public health management and service delivery in the country.
3. It envisages the provision of a female health activist in each village; a village health plan prepared through a local team headed by the health & sanitation committee of the panchayat; strengthening of the rural hospital for effective and curative care; maintenance of Public Health Standards and integration of vertical health & family welfare programmes and funds for optimal utilization of infrastructure and strengthening primary healthcare delivery.
4. It seeks to revitalize local health traditions and mainstream AYUSH (Ayurveda, Yoga, Unani, Sidha and Homeopathy) into the public health system.
5. It aims at effective integration of health concerns with determinants of health like sanitation & hygiene, nutrition, and safe drinking water through a District Plan for Health.
6. It seeks decentralization of programmes for district

management of health.

7. It seeks to address the inter-State and inter-district disparities, especially among the 18 high focus States, including un-met needs for public health infrastructure.
8. It shall define time-bound goals and report on their progress in public domain.
9. It seeks to improve access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary healthcare.

In Kerala, the programme is implemented by the state unit of NRHM – Arogyakeralam. The state would be funded for interventions like Accredited Social Health Activist (ASHA), Programme Management Unit (PMU), and up-gradation of Sub centre (SC)/Primary health centre (PHC)/Community health centre (CHC) through better grants. Kerala has its own operational modalities in health action plan which is made in consultation with the Mission Steering Group of NRHM. Like other States Kerala also signed a Memorandum of Understanding with Government of India, indicating their commitment to increase contribution to Public Health Budget (preferably by 10% each year), increased devolution to Panchayati Raj Institutions as per 73rd Constitution (Amendment) Act and performance benchmarks for release of funds. Major areas of policy implementation in Kerala are establishing referral system of protocol – strengthening the 3rd tier and activating the 2nd tier, promoting preventive and promotional aspects of primary health care in the community, strengthening the training programs and capacity building measures, establishing health management information system, strengthening nursing education department, improving & sustaining health indicators, putting up a system of referral transport, launching special programs for non-communicable diseases, piloting remedial measures for 2nd generation problems like pain and palliation, malignancies, geriatric problems, suicides and mental health problems, tackling the re-emergence of infectious diseases, combined behaviour change communication strategy, optimizing the use of all systems of medicine and convergence of various activities of health department.

Kerala Health Model

Kerala state has achieved improvements in material living standard as reflected in the indicators of social development and it is comparable to those of many developed countries even though the state per capita income is low. Kerala model has been defined as a set of high material quality of life indicators coinciding with low per-capita income, both distributed evenly across nearly the entire population of Kerala; a set of wealth and resource redistribution programmes that have largely brought about the high material quality-of-life indicators and high levels of political participation and activism among ordinary people along with substantial numbers of dedicated leaders at all levels.

Model High lights

1. Amended changes in the health care delivery objectives at par with states health development. They include

- Improve the health status and clinical outcomes of health care
- Improve social justice and equity in the health status of population
- Ensure transactional quality and management
- Reduce total economic burden of care and illness
- Deliver evidence based or research based care
- Better decision making
- Promote interdependence
- Coordinate and integrate multidisciplinary approach

2. Equal distribution of health

Disparity in Urban and Rural population health and health care is very minimal in Kerala with respect to gauges like ratio of hospital beds to population in rural areas, ratio of doctors to population in rural areas, per capita expenditure on public health, infrastructure of health system, female to male ratios for children and health improvement in tribal areas.

3. Better access to health care

It is seen that the access difficulties related to geographical distance, urban versus rural, socio-economic distance and gender distance is nominal in Kerala

4. Economic Equality

All over India the poor suffer disproportionately because of double burden of traditional diseases as well as modern diseases but it is less prevalent in Kerala. Even though it is against K .K. Dewette's modern economic theory Kerala state has achieved the high living standard from a 'developing' country which has arisen mostly from the Kerala model of Health prospective.

5. Political Will

Successive governments provide systematic state investments in health and education in Kerala and attempt to reduce the gaps in health policy formulation and its execution

6. Emergence of Private Health Care

The private health care system in Kerala has grown enormously over the years and is well established and flourishing. At the time of Independence, the private health sector accounted for only 5 to 10 per cent of total patient care. Kerala spent eight times more on private hospitals and twice as much on transporting patients compared to costs in government hospitals according to National Health Accounts (NHA) estimates (2013-14). Instrumental factors for these could be improved access, quality, capacity building, better norms for accreditation and established standards and guidelines.

7. Safe health behaviour

People of Kerala mostly from its literate behaviour does not show any poor health behaviours such as refusals towards vaccinations and too early, too many or too close pregnancies. People try to anticipate with preventive health aspects, positive attitude towards health care facilities including compulsory pre natal check-ups, institutional deliveries which altogether contribute towards strengthening of present care system, reduction of maternal deaths, perinatal mortality rate and ultimately led to the one digit infant mortality rate (IMR) of Kerala state. Institutional deliveries or facility-based births are promoted for reducing maternal and neo-natal mortality all over India especially under National Rural Health Mission. Yet, many women in low- and middle-income countries, including India, continue to deliver babies at home. To lessen the financial barrier, the government of India launched the Janani Suraksha Yojana (JSY) in 2005. JSY is a conditional cash transfer programme that provides a cash incentive to women who give birth at public health facilities

8. Better programme implementation

Health model and National Health Mission is glowingly executed in Kerala with intensive thrust on lessening challenges. It is seen that administrative causes, effects of population growth and other factors do not impede with the programme implementation. Programme is better executed in Kerala with convergence of activities of health determinants. High functioning three tier referral system, capacity building, behaviour change communication, health management information system and in service programmes for of health workers and ASHAs are the major high spots in Kerala

9. Population Attributes

India is the second most populous country in the world and it again lead to defaults in health care delivery. Poor financial structure and unemployment contribute towards the problem. Kerala is home to 2.76% of India's people and at 859 persons per square-km; its land is three times as densely settled as the rest of India. However, Kerala's population growth rate is far lower than the national average. According to economic review (2015) by Kerala State planning board population growth trend shows that the state is moving towards zero population growth or negative growth.

9. Efficient Medical practitioners

About 75% of medical facilities are concentrated in urban area where only 40 % of population lives resulting in gross unavailability of health care in rural areas. The doctor ratio and

nurse ratio to population is very low in India compared to developed nations. Number of nurses for 10000 populations in India is only 8 whereas the world ratio is 33. But Kerala with the creation of large number of trained doctors and nurses and extensive network of hospitals with efficient referral system has achieved a standard health status. Even though supply and demand for private care is large and rising in Kerala more sophisticated patient care involving support services and holistic care team of skilled professionals are evolving through government institutions.

10. Wages and duty timings of health professionals

More relaxed work atmosphere and better pay is always demanded in Kerala's health sector. A number of strikes were organised that generated public interest and resulted in some potential long-term changes in the perspectives on health care professionals' recruitment and terms of work.

NRHM – New fangled Challenges in Kerala Model

Present health care scenario calls for the NRHM to participate in the competitive situation of public versus private, more over its impacts should have a long term or sustained goal for the better health outcome of the rural people. It can be analysed as below

Immunisation coverage

There has been a sudden rise in mistrust for vaccinations in some parts of Kerala especially where there is Muslim domination. Confirmed cases of diphtheria were reported from the Malappuram district and it pointed towards the huge gaps in immunisation. In spite of the various aggressive campaign programmes MR vaccination movement faced many opposition issues and even attacks on medical staff. This could be because of there is a powerful lobby working against such initiatives. It's a challenge to be addressed by the NRHM by coordinating the health education and converging the various health care fields like modern medicine and naturalistic views points.

Effective referral

Despite having an extensive medical infrastructure, the existing facilities are not being used effectively to ease on referral system of Kerala. Even though the proper guidelines and referral card system has been issued by Directorate of Medical Education (DME) and Directorate of Health Services (DHS) of Kerala, it fails to work at times due to lack of expertise or devices.

Public Versus private care

There is a preference for private health care compared to public health care in Kerala. A study conducted by IMS Institute for health care informatics (2016), there is dissatisfaction with the quality standards of state run or public hospitals and 90% of patients are willing to shift from private to public sector if the situation improved in public health care facilities. As one of the goals of NRHM is up-gradation of institutions and after these 10 years of functioning of this policy also it failed to get the quality acceptance from the public.

There is also an added problem on the part of medical practitioners as they get a moderately high payment from the private sector compared to public health job and there is facility for private practice.

Influence of foreign money

Undoubtedly the impact of gulf money in Kerala cannot be brushed away. Kerala contributes the NRI (Non Resident Indian) income inflow and hence the people naturally will have the tendency to go for private health care. And there are hospitals being established aiming at the NRIs and even NRI themselves start hospitals in Kerala. State wide medical insurance irrespective of income barrier may attract people to avail public health care facilities and there will be a novel trend of public health care over private health care and naturally the public system will take the challenge of improving from its roots and finally it will reduce the family or community burden on diseases.

Staff shortage

In Kerala there exists a gap between the sanctioned and deployed strength of medical staff. Some hospitals are working with a staff strength sanctioned 50 years ago. Many strikes are going on in the state for the creation of posts, retirement age issues and compulsory bond service for PG cadres. NRHM appoints staff under scheme on contract basis but the questions of making the staff regular and wage differences remain. Staff issues hit the patient as well as the administrative activities and it calls for the need of a realistic assessment of the staff strength and work load and its long term solutions.

Turnover of nursing staff

Even though recent strikes from the nursing staff have drawn social attention towards the work and wage aspects of the medical, para medical and nursing staff of Kerala. The working atmosphere and getting emoluments turn the staff to demotivated status and there is no wonder that 70 % of the nurses working in private sector of Kerala think it merely as a place for getting an experience on their way towards foreign entry and better job or government jobs. Majority of the Nurse educators working in self-financing colleges are also unsatisfied with the salary provided and other benefits earned and it naturally digress the outcome of education. In near future the best supplier of nurses tagline will be moved out of Kerala's nursing education sector.

Non developed pharmaceutical sector

Pharmaceutical sector in the country is not yet competent with other parts of the world. Regulations and rules pertaining to prelin and development in this sector is to be amended after progressive assessment and creating sustained outcome goals.

Underdeveloped medical device sector

Even though medical device sector in India is the fourth largest in Asia and in the list of top 20 among the world there is a need for initiation and upsurge based on global regulatory strategies to solve the under met clinical needs

Non communicable diseases burden

As per the 2017 WHO report, non-communicable diseases are the cause of 61 % of deaths in India. Its burden is rapidly increasing. The target to abolish or diminish the problem is changing of lifestyle and it is to be addressed from the community. NRHM should try for the flourishing of Behaviour change communication to tackle this problem.

Disease trend changes and lack of researches

The drift and the major threat to the human that is seen in this era are emerging diseases and re-emerging pathogens. There is a need from the health care sector to address this problem and establishment of research activities to curtail this danger. NRHM does not start an initiation step on research activities but it should do it at the earliest. Literally well going state like Kerala can contribute much towards this if proper motivation and state of affairs are granted.

Pollution and waste management

Though NRHM has its scheme of reducing pollution and waste management by various modes of operations at the periphery level like ward health and nutrition days, health education, dry days and monsoon days monitoring, an acceptable mode of management of waste and reduction of pollution is still not achieved. The core area addressed by the system is the domestic management considering only the communicable diseases burden but more wide attempts and strategies to be made considering non domestic, industrial and other areas.

Conclusion

NRHM has completed its 12th functional year in 2017. It started as a mission from 2005 to 2012. There is positive impact over the people of India. Earlier it considered the rural area as the aim, then National Urban Health Mission (NUHM) was added over it targeting urban areas but now it is an overall policy under the umbrella name of National Health mission (NHM).As

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