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Revamping Policies and Strategies of Public Health Management in India: A Critique

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Even after more than 60 years of Independence and so many health sector reforms, the rural India is still unable to access the services of the allopathic doctors as 74% of these doctors live in urban areas, serving only 28% of the national population, while the rural population, which is 72%, still gets no benefit of their services. Also, even the doctors in urban area prefer to work in private setup, thereby leaving the public healthcare delivery system in a dismantled state. Now, in a country where most of the population can afford treatment only in public hospitals, a shortage in the number of doctors/specialists in Govt. setup can be disastrous. This explains the trend of high MMR and IMR in India. Even after implementing many strategies, this situation has not changed much since the last many years. So, now the Govt. has decided to change its strategy. Now, along with focus on retention of specialists in public hospitals, Govt. has also collaborated with private sector in different ways to improve the situation, as the ultimate goal is 'Health for all', irrespective of the provider of Healthcare. This paper gives a brief account of these strategies and schemes and salient features of these schemes. Also, the significance of these strategies in improving the situation has been discussed. It also shows how the situation in healthcare industry can be improved by using fundamentals of public health management and Human Resource Management.

Keywords: MMR, IMR, NRHM, IPHS, RSBY

Introduction

According to RHS 2011, more than 65% of the posts of specialists are lying vacant at CHC level. It also elaborates that out of the total vacancy, there is a shortage of 75% surgeons, 80.1% physicians, 65.9% obstetricians, and 74.4% paediatricians. It means that every 2 out of 3 post of obstetrician and paediatrician is vacant at CHC. This itself explains that why we have a high value of the critical indicators like, MMR (Maternal Mortality Rate, per 100000 live births), IMR (Infant Mortality Rate, per 1000 live births), etc.

Infant Mortality Rate in India is 47 (as per SRS-2010) and MMR is 212 (SRS- 2007-09), which is quite high as per International standards.

To cater to this issue and other similar issues, National Rural Health Mission (NRHM) was launched in the year 2005 for a period of 7 years (2005-2012).

Goals of NRHM (relevant to this study)

- **Reduction in Infant Mortality Rate (IMR)**
- **Reduction in Maternal Mortality Ratio (MMR)**

Now, in order to achieve these goals, there is a requirement of Paediatricians and Obs & Gyn specialists. The posting of these specialists starts from the level of CHC, where there is 1 post each of Paediatrician and Obs & Gyn specialist. A look at the following figures explains the gravity of this situation:

Figure 1: Average Rural Population (2011-Provisional) covered by a CHC

(Rural Health Care System in India, IPHS)

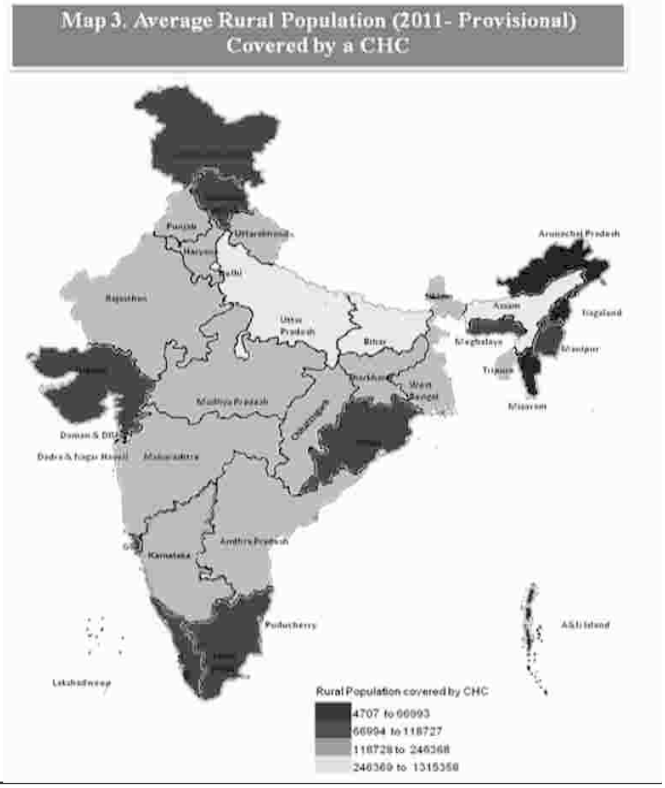

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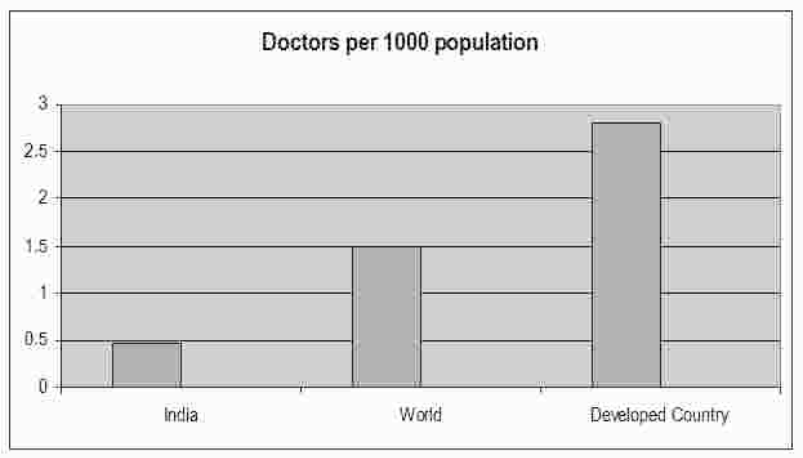
Figure 2: Doctors per 1000 population



(Source: www.indiaonline.in/health/Health-Statistics.aspx)

Table 1: Total no. of specialists in India at CHC level:

	2011				
Specialists	**Required**	**Sanctioned**	**In position**	**Vacant**	**Shortfall**
Surgeons	**4809**	**2182**	**1018**	**1220**	**3052**
Obs & Gyn	**4809**	**1958**	**1389**	**915**	**2682**
Physicians	**4809**	**1437**	**819**	**847**	**3252**
Paediatricians	**4809**	**1731**	**1041**	**849**	**3029**
Total (Physicians, Surgeons, OB&GY, & Paediatrician)	**19236**	**9831**	**6935**	**3880**	**12301**

(Source: RHS 2011)

In a country, where there is a huge shortfall of healthcare providers, is bound to suffer in the field of Healthcare. To manage this delicate situation, Govt. of India has taken few steps and some of the strategies have proven to be very successful like:

NRHM (National Rural health Mission):

The Govt. of India has realized the importance of Health and in the development of the country. Keeping this view in mind, the Govt. had launched the National Rural health Mission (NRHM) in 2005. Its initial time frame was 2005-12. The main aim was to improve the basic structure and delivery of Healthcare services especially in rural parts of the country. Special focus and consideration has been given to states with poor health indicators/infrastructure. This Mission has a very clear vision of improving the health through the improvement in significant health Indicators. In addition, basic amenities like safe drinking water, nutrition, hygienic conditions have directly been linked with good health. Further, it intends to lay the foundation stone of improving healthcare infrastructure as well as Human Resource by fundamentals like Optimum utilization of available resources, Main streaming of AYUSH,

utilizing the management and financial expertise in Healthcare. To quantify and measure the improvements Indian Public Health Standards (IPHS) have been developed for all categories of Healthcare Organizations. The ultimate goal is to improve the accessibility, availability, and affordability of Healthcare services in this country along with accountability.

NRHM suggested that if the specialists cannot be appointed on a permanent basis, then they could be offered contractual appointment. This strategy proved fruitful and under NRHM, 1589 specialists have been appointed on contractual basis.

Chiranjeevi Yojana

Chiranjeevi Yojna initially implemented in Gujarat is one such strategy. It was observed by the Govt. of Gujarat that out of total about 18000 registered doctors (including 2000 gynaecologists) more than 13000 were working in the private sector. As a result, there were 65% positions in CHC and 30% in District Hospitals for gynaecologists lying vacant. This shortage was 67% for specialists in paediatrics. Now, the ironical part is that, most of the patients can afford treatment in the sector in which most of the specialists are not interested to work. Therefore, the Govt. decided to utilize the resources available in the private sector. In this scheme, the Govt. had a tie-up with private doctors to provide obstetric care to needy patients at predefined charges, to be paid by Govt. This scheme resulted in an increase in Institutional deliveries.

Table 2: Outcome of Chiranjeevi Scheme

Outcome of Chiranj eevi Scheme: Mothers & New Born babies saved (Up to March-12)	
Total Deliveries under Chiranjeevi scheme	7,69,418
Maternal death reported under Chiranjeevi scheme	105
Early Neo -Natal death reported under Chiranjeevi scheme	2537
Normal Deliveries	6,82,972
C-Section	47,946 (6.2%)
Complicated Deliveries	38,496 (5.0%)
Private specialist enrolled	646

(http://www.gujhealth.gov.in)

Table 3: District wise performance of Chiranjeevi Yojana in Gujarat:

Chiranjeevi Yojana Report Upto March-2012 (21 District)

Sr #	District Name	Normal	LSCS	Compli cated	Total	% LSCS	# of Doctors Enrolled
1	Gandhinagar	7519	1364	1237	10120	13.48	24
2	Mehsana	36256	3068	2048	41372	7.42	47
3	Patan	56050	4808	1276	62134	7.74	31
4	Ahmedabad	54237	2576	16	56829	4.53	88
5	Kheda	14666	1518	248	16432	9.24	27
6	Anand	23687	3680	1071	28438	12.94	27
7	Surendranagar	18531	607	150	19288	3.15	20
8	Vadodara	27125	1522	1028	29675	5.13	19
9	Bharuch	6728	892	1444	9064	9.84	11
10	Narmada	7983	411	423	8817	4.66	5
11	Surat	15321	1340	164	16825	7.96	21
12	Tapi	2359	294	484	3137	9.37	4
13	Navsari	13080	1643	422	15145	10.85	11

Chiranjeevi Yojana Report Upto March-2012 (21 District)

Sr #	District Name	Normal	LSCS	Complicated	Total	% LSCS	# of Doctors Enrolled
14	Valsad	12417	1235	208	13860	8.91	17
15	Ahwa-Dang	1593	40	281	1914	2.09	1
16	Rajkot	30792	2550	843	34185	7.46	51
17	Jamnagar	5377	93	17	5487	1.69	27
18	Bhavnagar	12571	846	638	14055	6.02	18
19	Amreli	5341	529	561	6431	8.23	14
20	Junagadh	20761	2245	465	23471	9.56	22
21	Porbandar	1896	500	38	2434	20.54	6
22	**21 District Total**	**374290**	**31761**	**13062**	**419113**	**7.58**	**491**
23	**5 District Total**	**308686**	**16185**	**25434**	**350305**	**4.62**	**155**
24	**26 District Total**	**682976**	**47946**	**38496**	**769418**	**6.23**	**646**

(http://www.gujhealth.gov.in)

RSBY (Rashtriya Swasthya Bima Yojana)

Not being able to appoint and retain sufficient number of doctors and specialists in public sector hospitals, Govt. of India has launched one very ambitious scheme on the fundamentals of Insurance system. This scheme is known as Rashtriya Swasthya Bima Yojana or RSBY. The idea of this scheme is because, if Govt. cannot retain specialists in its system, then the Govt. should arrange to enable the patients to receive healthcare in private sector at the same cost with which Govt. hospitals are providing care. This scheme is meant for the patients belonging to the class, which can be assumed most needy in terms of healthcare, because of their socio-economic status, i.e. Below Poverty Line (BPL) population. Therefore, it gives an impression that the Govt. has taken this issue seriously that the Indian public should not suffer, because of the shortage or non-availability of doctors and specialists in public hospitals. Therefore, the ultimate goal has been to ensure adequate healthcare facility irrespective of the provider.

Ministry of Labour & Employment, Govt. of India, has launched this health insurance scheme. In this scheme, up to 5 members of a BPL family are insured for their Health coverage of Rs. 30000 for 1 year. The beneficiary is supposed to pay only Rs. 30 as administrative charges, the premium is paid by Govt. and the registered family can avail healthcare facilities (free of cost up to Rs. 30000) in any of the enrolled hospital, which may be a Govt. or private hospital.

Maternity benefit Package under RSBY

This package has been specially designed and includes all the necessary charges for almost all the facilities which could be availed in the hospital by the expecting mother, as bed charges in general ward, charges for doctors including surgeon charges, Anaesthetist charges, nursing charges, consultant charges, charges for blood, oxygen, surgical materials, medicines, food, transport expenses, cost of investigations and diagnostic procedures. The unique feature is that the package includes charges for medicines and diagnostic procedures as long as five days after discharge and one day before admission.

RSBY Package charges for Normal Delivery: Rs. 2500/-

RSBY Package charges for Caesarean Section / Complicated delivery: Rs.4500/-

Active smart cards in India: 32963104 and total hospitalization cases: 4267338 (as on 9/11/2012)

However, the major drawback or shortcoming in this scheme is the non-inclusion of BPL population, because it is also true that a large majority of population does not come under BPL status but still cannot afford treatment in private hospitals/nursing homes. Therefore, this scheme may be good but is not serving the complete purpose of 'Health for all.'

Initiative by FOGSI

Federation of Obstetric and Gynaecological Societies of India (FOGSI) has given one more strategy. The salient feature of this strategy is to train the basic doctors through a certificate course (16 weeks) in Comprehensive Emergency Obstetric care. This has been a sponsored scheme implemented in 20 states by the Ministry of Health and Family Welfare in association with the Federation of Obstetric and Gynaecological Societies of India and Indian College of Obstetrics and Gynaecology.

Relaxation in IPHS norms:

Indian Public Health Standards were launched in the year 2007 under NRHM to provide guidelines for improving the quality of healthcare services provided by public hospitals. It

includes norms and specifications for Infrastructure, Human Resource and equipments in the public hospitals of India. It has also clearly defined the qualification norms for all categories of staff in Govt. hospitals. After observing the trend of shortage of specialists in public hospitals, throughout the country, IPHS came with an alternate arrangement. According to IPHS standards for Community Health Centre (2012)

"As a short term arrangement, MBBS doctors who have received short term training or having experience of at least two years in the particular speciality can be utilized against the specialty post. However, in such cases a specific order after posting such doctors must be issued."

Lessons to be learnt from Tamil Nadu

A First Referral Unit (FRU) with the facility of Comprehensive Emergency Obstetric care and provision for emergency transport was managed at about 30 km distance, in Tamilnadu.

Exemplary act by a Rural Hospital in Maharashtra

A study conducted at Sanjivan Hospital, Dindori, Nashik Maharashtra As it is evident that the hospital was able to manage increased caesarean section workload with the help of local hospital team (comprising of on-call specialists) and this team could manage more than 90% of the cases and abortions with only two maternal deaths. Therefore, this system of on-call specialist team can be an implemented at CHC level till the time regular staffs (specialists) are available in optimum number.

Conclusion:

Therefore, it is quite evident from the above points that the shortage of specialist doctors can pose a serious risk to the healthcare delivery system. This problem or risk can be minimized to some extent by adopting strategies as mentioned above, but these are just temporary arrangements as it has been seen that as these schemes have progressed, many issues have come up and doctors are not interested or motivated enough to be a part of these schemes. Therefore, a sustainable solution is the need of hour. Still, for the time being, these strategies are at least trying to fill the gap created by huge shortfall.

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