

# Fragile health policy of India: discussion on maternal health

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## Abstract

Since 2005, India has been relying on National Rural Health Mission—a flagship program under the Ministry of Health and Family Welfare to reduce country's high maternal mortality. The main strategy has been recruitment of female health volunteer in villages, Accredited Social Health Activist, and expansion of infrastructure, mainly buildings, transport, and digitization. However, in comparison to this huge investment, the outcome improvement is very less. The transformation of policy to program needs suitable political and technical interventions. The marginalized groups are neglected due to both their ignorance and state apathy. This article attempts to touch upon these issues to show that the strategies are not competent enough unless the human resource and infrastructure expansion complement each other.

**KEY WORDS:** Maternal health, health policy, National Rural Health Mission, health reform

## Introduction

Health policy can be defined as the “decisions, plans, and actions that are undertaken to achieve specific health care goals within a society.”<sup>[1]</sup> WHO (World Health Organization) further emphasizes health policy to have its clear vision for the future. The policy must have an outline in which the roles and responsibilities of different groups are well defined. The health policy mostly focuses public health, personal health care, pharmaceutical, health finance, quality of care, and health equity. The health gain mostly depends on how vibrant the policy is and its implementation in any part of the world. Way back in the nineteenth century, some of the policy measures in public health were initiated by the colonial rulers.

## Historical Perspectives in Pre-Independence

In the beginning of nineteenth century, Indian health system was dominated by the following cadres of medical professionals: (a) the Indian Medical Service officers, who served both military and certain civil appointments; (b) the military assistant surgeons; (c) the military hospital assistants; (d) civil assistant surgeons; and (e) the hospital assistants,

later designated as subassistant surgeons. A large number of indigenous medical practitioners, *vaidyas*, and *hakims* were also spread throughout country to take care of the public health and curative health care. The availability of already minimal public health care was hit hard by the Great Depression of 1929–33 in rural areas. The subsidized rural health care took a back step by 1931, which necessitated the prohibition of opening such dispensaries till end of the 1930s. The honorary medical scheme was adopted, in which private practitioners were appointed as unpaid honorary medical officers in the place of paid full-time government medical officers in government hospitals. The main aim was to save money for the government and to improve the skills of the private practitioners by means of experience.<sup>[2]</sup> Though the responsibility of health care rests in the hands of government, according to Bhore committee report, still there is no major attempt to act as per recommendation. The government spending on health is abysmal.<sup>[3]</sup> This decelerates the growth of system both qualitatively and quantitatively.

## Government Spending on Health Care

Since independence, India has spent a smaller proportion of its resources on public health in comparison to other governments in the world. In fact, India is lacking the idea of being responsible for the provision of public health care. This very ideology is not the one that has rooted itself in Indian political culture. Public health has been “one of the most neglected aspects of development in India.”<sup>[4]</sup> The perpetual Government apathy in provision of health services facilitates growth of private sector. The lax monitoring system has no strong action against the absenteeism of both clinical and

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nonclinical staffs in public health facilities. In spite of Government regulations and audit system, there is regular fraud in the procurement of drugs and consumables. The salary usually consists of more than 90% of the budget of Indian health facilities. Nearly half of the public health budget goes waste because 30%–65% of the money goes to absent health care workers.<sup>[5]</sup> The dysfunctional health structure has a detrimental effect on the maternal and child mortality of the country.

### **Difference of Maternal and Child Health Indicators: Six Decade of Independence**

The infant mortality rate fell from 146 per 1,000 in 1951 to 50 per 1,000 in 2009. The total fertility rate is reduced from 6 in 1951 to 3.1 in 2009 (SRS, 2009).<sup>[6]</sup> The Bhole Committee report<sup>[3]</sup> concludes that the maternal mortality rate in the country was approximately 2,000 deaths per 100,000 live births at that time, which has been reduced to 212 (SRS, 2009). Yet, it is clear that these gains are highly unequal distributions across rural–urban continuum, states, and across social groups. This is contrary to the vision of Indian statesmen's in formulating the public health policy of the nation during 1947. The poor and marginalized people are the worst suffers in the system as they have no capability to gain anything from the existing system.

From the National Family Health Survey rounds of survey it is evident that there is a reduction in maternal mortality with subsequent increase in institutional deliveries. Moreover, another area to be verified is whether this improvement is uniform across urban and rural lands. We discuss this in the following section.<sup>[7]</sup>

### **Poverty and Marginalized Groups in Health Care**

The majority of poor people are agglomerated in rural areas in the north, where they are predominantly engaged in agricultural activities. The poor are having lower levels of education than other masses, which is the cause of higher disease prevalence among them. Indian society is biased against women, making them more disadvantaged than their male counterparts in socioeconomic status. Women are less literate and succumb to poor health care leading to a high rate of maternal mortality. In general, the poor have less access to health facilities than the general masses. Further, access to clean water, sanitation and health care is very low. According to the yardstick of Planning Commission, the Government of India concern that scheduled castes and scheduled tribes (SC/ST) are overrepresented in below poverty line households. The number of SC/ST households living below the poverty line is more than 65%. Various studies found that the poor strata of population in India those are worst affected by diseases have minimal access to comprehensive medical services. Although in recent years there a significant

achievement has been attained in controlling and minimizing some of the diseases, still there are unmet needs for demand for basic health services for masses. There is a need of reform in health care policy addressing the problems of marginalized.

### **Factors Responsible for Changes in Health Indicators after the 1980s**

Various factors are responsible for the changes in the health indicators in the country. Some are directly related to health and family welfare and others are related to an intersectoral coordination among the departments.<sup>[4]</sup> These factors are the following:

- The improved network of primary health care institutions supported by improved skills of staff, cutting edge technology, efficient supply chain management of drugs.
- Effective management of vertical health programs such as tuberculosis (TB), malaria, leprosy, polio, and cataract blindness.
- Emphasis on improvement and management of facilities at secondary and tertiary care centers.
- Improvement in information, education, and communication (IEC) activities resulting in increasing awareness of issues such as safe drinking water, oral rehydration therapy, contraception, prevention and control of diarrhea, and early treatment of leprosy and TB.
- Health reforms to enforce the vision of national and multilateral agencies and international conventions.

Improvements by other departments and organizations

- The availability of donor funding for various health activities, primarily from United Kingdom Department for International Development (DFID), US Agency for International Development (USAID), Danish International Development Agency (DANIDA), National Institute on Drug Abuse (NIDA), Norway–India Partnership (NIPI), WHO, and United Nations Children's Fund (UNICEF) to perform activities to promote health. The resources available are used for various promotive and curative health care services. These organizations also support technical and administrative work.
- Improvements by intersectoral coordination are undertaken by converging Government departments.
- The focus on improved literacy levels in the country creates an informed citizenry. This campaign helps in understanding and improving the health care seeking behavior of people especially at rural area and among the marginalized groups of the society.
- The provision of safe drinking water and sanitation for masses helps in improving the health conditions.
- The rural infrastructure in terms of better road communication linking villages to blocks and towns makes the patient

avail health services as per need. This helps in the accessibility of people to the health centers.

- The development of mass media plays a great role in promoting awareness of general public about health issues. The increased geographical coverage of radio and television along with print news has exerted an influence on the people to know the plans of Government.
- Extensive network of *anganwadi* centers under the Integrated Child Development Services program, with provision of service for pregnant and lactating mothers, preschool children, including growth monitoring and supplementary feeding for the children as required.

### Gaps in the Health Infrastructure: Lack of Continuity

At the very primary level, we find that public health centers (PHCs) are dysfunctional. The onus of ill health is therefore on secondary and tertiary care providers. The following problems have a strong bearing on the delivery of health care:

- There are administrative delays, such as delay in payment of cash incentives, delay in receiving medicines, and cases of mishandling Janani Suraksha Yojana (JSY), that demotivate families.
- Lack of guidelines for the health practitioners and auxiliary nurse midwife (ANM) to follow.
- Frequent cases of administrative ambiguities regarding recruitment and employment of Accredited Social Health Activists (ASHA).
- Logistic failures for vaccine storage and procurement.
- Ancillary health services such as cleanliness, laundry services functional toilets, and emergency responses are overlooked.

Besides, there are systemic constraints at the macro level, which are discussed in the following section:

- Inadequacy in retaining skilled human resources such as nurses and doctors
- Lack of monitoring mechanism (grievance redressal mechanism)
- No provision to make community participate in health care delivery

### Safe Motherhood Programs in India

During the 1970s, the programs such as Child Survival and Safe Motherhood (CSSM) and Reproductive and Child Health in which immunization received high priority were given utmost importance. The task of vaccination was assigned to the ANMs. CSSM program emerged as an effective immunization program in India during the mid-1990s. This program was

supported by World Bank and UNICEF and designed to provide child survival by improving immunization, diarrhea, and acute respiratory infection control. The safe motherhood services were provided by setting up First Referral Units (FRUs); encouraging tetanus immunization, prevention of anemia, antenatal care, delivery by trained personnel including trained traditional birth attendants; and promoting institutional deliveries and birth-spacing through the PHC system. In spite of the ANM's duty as a community midwife finds mention in the policy documents, it was not implemented in the field. ANMs are overburdened by priority to routine preventive services, such as immunization and antenatal care, compared to emergency services, such as delivery care. The Reproductive and Child Health (RCH) program focuses more on reproductive health by establishment of blood storage units, provision of referral transport, and access to safe abortion.

### Reproductive and Child Health-2 (RCH-2) and National Rural Health Mission

In 2005, with the assistance of World Bank and other donors, RCH-2 program was started as a follow on to the RCH 1 program and placed under a new government initiative. The NRHM (2005–2012) provides high priority to revamping rural health systems. It focuses on bringing all health and family welfare and allied sector programs under one umbrella with special emphasis on reduction of child and maternal mortality. The RCH-2 program has led to decentralization, flexibility in programming, and increased financial allocations to field-level workers.

National Rural Health Mission (NRHM) focuses on recruiting a female health volunteer in each village in the name of ASHA. The main aim of NRHM is to reduce maternal mortality by institutional deliveries. The Government has recently changed its policy to allow staff nurses and ANMs to initiate treatment of pregnancy-related complications, including administration of intravenous fluids and injectables, antibiotics, and magnesium sulfate. Skilled birth attendant training has been imparted to ANMs to improve their skills to conduct normal deliveries. The community health centers (CHCs) are being upgraded to FRUs for providing referral services to mothers for obstetric emergencies, complications, and safe abortion services. NRHM has tapped the benefit of the so far underutilized services of the Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) doctors in both preventive and curative care. But still there are many places having no AYUSH health services for want of fund and willingness of the administration.<sup>[8]</sup>

### Mainstreaming of "AYUSH"

The core strategy of NRHM is to promote colocation of AYUSH services with other mainstream health facilities. This ensures that people have a better access to AYUSH. Moreover, it provides a choice between different systems. The

human resource and infrastructure can be shared and synergized for better reaching NRHM goals. Under this scheme, 11,575 AYUSH doctors and 4,616 paramedical staff have been appointed. More than 60% of these doctors serve in high-focus states to provide both clinical services and management of national health programs. In 18,222 health care facilities, AYUSH services have been collocated. This includes 416 district hospitals, 2,942 CHCs, and 1,246 other subdistrict hospitals, 9,559 PHCs, and 4,059 equivalent primary care facilities. Apart from the described services, there is almost equal or more numbers of AYUSH stand-alone facilities at the primary- and secondary-level AYUSH hospitals (3,360) and dispensaries (21,769) as well as 7 national institutes that offer tertiary level care. These health facilities deliver the services of their own system. However, collection of information about their services through either health management information system or surveys is currently not being undertaken. The changes happening in the health sector depend on various socioeconomic factors and the implementation of programs.

Hence, despite the improvements by the health department in revamping the health infrastructure, such as blood bank, equipment, and medicine and consumables, the real change has not happened.

## Reform for Improvement of Quality

The reforms mostly focused on improving the access of common men to health care centers, and availability of equipment and medicines for their services. Efficiency in drug procurement and distribution can make the public health infrastructure vibrant to address the needs of the public. In the age of modern logistic system, the health sector can be benefited by maintaining a good inventory even in the remote part of the nation. The main objective of the government is to make sufficient and good quality drugs available to patients in all public health institutions. The procurement and maintenance of the equipment is a challenge in many parts. The technicalities in tender process, specification of the equipment, preventive maintenance, and its appropriate use put a lot of challenges in operationalization of the high-quality instruments.

The objective of introduction of user charges was to raise resources for the health institutions from people who are able to pay and use them for the improvement of the hospital and the benefit of the patients. The hospitals come under its ambit are tertiary, district-, and subdistrict-level government hospitals.

Privatization of various services started in Government health facilities to enhance services and ensure quality. Privatization of cleaning in hospitals was initiated to ensure the cleanliness in public hospitals.

There is a failed attempt for mandatory pre-PG rural service to curb the shortage of doctors. This ensures the presence of doctors in remote and difficult areas and provides better rural orientation to young doctors.

The establishment of State Health and Family Welfare Society has ushered a new era for independent management of recourses. The main aim is to create a simple, problem-free method for making funds available for health care activities as and when required.

The idea of efficient management of PHCs by non-government organizations (NGOs) came into effect on pilot basis. Then attempt was made to transfer more PHCs to the NGOs for enhancing efficiencies in services and keeping the cost factor into consideration. As the NGOs are weaker partners in the public-private partnership mode, it becomes difficult for them to comply with the standards of the agreement. The benefit in this arrangement is the management of remote PHCs.<sup>[4]</sup> The shortage of doctors is an ever-existing problem of the Indian health care delivery system.

## Physician Emigrations

Physicians in the developing and underdeveloped countries emigrate because of the poor incomes and inadequate resources available in their home countries and for the better professional prospects and higher standards of living available to them abroad. Among emigrating physicians, the graduates from higher-quality institutions account for a disproportionately large share in comparison to other institutions.<sup>[9]</sup> The emigration of physicians from numerous low- and middle-income countries drains skilled personnel from an already weak health system and reduces the chances of success of existing primary care and public health activities.<sup>[10]</sup> Government has no sound policy for retention of highly skilled manpower. Besides poor infrastructure, the lack of manpower affects the quality of maternal care especially in rural India. Reform in health sector is inevitable to tackle the emerging problems.

## Significance for Public Health

Maternal health could be improved by scientific assessment of the structures and processes of health care delivery. Program implementation depends on infrastructural component and functionality of key health workers. Compliance with Indian Public Health Standard (IPHS) needs serious attention to ensure safe delivery of public health services. The IPHS standard provides enough scope for availability of quality services in a public health care institution. The paper emphasizes the continuum of care in India, which acts as a learning opportunity for policy-makers.

## Conclusions

The article tries to bridge the gap at policy level for better outcome in the coming days. The role of government is paramount in formulating infrastructural, manpower, and administrative policies. Whatever gains we made in the past or going to make in near future in improving the maternal health should be maintained by strategic move and provision

of funds for the same purpose. Finally, we need a radical approach in provisioning of rural health care instead of a piecemeal approach in maternal public health.

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