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National Rural Health Mission: a failing mission

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While India today is in the forefront of healthcare, and we often hear of health tourism being a great revenue generator, the vast majority of Indians, especially in the rural areas, today lack even the basic health amenities.

Even today "quacks" or "Docsaab", who are former compounders of doctors or even the compounder's assistants, rule the roost in such areas. Those in the government setup largely ignore such "quacks" as they are regularly paid off to turn a blind eye to their activities. It is common to have a person walking into a clinic and asking for a drip because of "weakness". In a matter of 30-45 minutes, dextrose is pumped into that person alongwith injections of Avil and dexamethasone, he or she ends up paying some Rs 250 to 300 and leaves satisfied at having been treated well. Even the auxiliary nurse midwives (ANMs) and "dais" who are the "Doctorani" have well educated persons utilising their services for ante-natal services and deliveries.

Against this background of grassroots realities, the National Rural Health Mission may have been launched to remove the dichotomy in healthcare. As it stands even today, the NRHM could have revolutionised healthcare delivery in India and been a role model for all the Third World to emulate. But this is not the case.

The NRHM mission document states that "The goal of the mission is to improve the availability of and access to quality health care by people, especially for those residing in rural area, the poor, women and children." (1) It primarily aims to improve the following parameters: health, sanitation and hygiene, nutrition and safe drinking water. It seeks to provide to rural people equitable, affordable, accountable and effective primary healthcare.

Along with other national programmes like the Janani Suraksha Yojana, the NRHM can go a long way to improve the mother and child welfare parameters in the country. While the concept is utopian, given the ground realities in the country, it has become a milch cow for many to siphon off funds.

The NRHM workforce comprises accredited social health activists (ASHAs), auxiliary nurse midwives (ANMs), and multipurpose workers (MPWs) along with contract or "samvida" staff nurses, AYUSH (ayurveda, yoga, unani, siddha and homoeopathy) and allopathic doctors. There is a great emphasis on reviving the AYUSH system of medical treatment for which various measures have been incorporated into the mission.

The ASHAs form the backbone of the NRHM and are meant to be selected by and be accountable to the panchayat. There is no fixed remuneration provided for the ASHAs but it is assumed that they will be suitably compensated for their work through various schemes. They are to act as a bridge between ANMs and the village. They are to be provided with a drug kit including Ayush drugs for common ailments, worth Rs 1,000, which are to be replenished from time to time. The government has also allocated "total support of up to Rs 10,000 per ASHA for initial training, monthly orientation, drug kit, support material, travel expenses, etc. Rs 5,000 permanent advance may be made available to every gram panchayat as a permanent advance for performance based incentive for ASHAs and anganwadi workers(2).

In fact the ASHAs were selected by the government's provincial medical service doctors for a consideration and legalised later by getting the panchayats to appoint them. Yet, even today no ASHA has a drug kit and so there is no question of these kits being replenished. Finally, funds are provided to the panchayats to transport patients to primary health centres (PHCs) but again these are siphoned off as most of the population is not aware of this and other facilities under the NRHM.

Bringing AYUSH into the mainstream is a major thrust area of the NRHM. AYUSH doctors were to be appointed at PHCs and sub centres, and pharmacists and drugs were to be made available to them(1). However, on appointment they are being posted to allopathic hospitals. They are not provided with AYUSH drugs and pharmacists. They are prescribing allopathic drugs to patients and the unfortunate patient does not know that the treating physician is a homeopath or hakim or vaidya prescribing allopathic medicines. As the salary of

AYUSH doctors is on par with that of the allopathic doctors, and unemployment levels are high in these streams due to mushrooming of colleges, there is a huge rush for appointment as samvida or ad hoc medical officers. The office of the chief medical officer (CMO) demands two to four months' salary (Rs 50,000 to Rs one lakh) to appoint a samvida medical officer. Although the guidelines call for local persons to be appointed, doctors from other, far-off districts are being appointed after providing a proper "consideration". Not too long ago, interviews for the post had to be cancelled when the office was filled with a large number of AYUSH doctors willing to pay upto Rs 1 lakh for the appointment as "samvida chikitsa adhikari". The office was also inundated with letters and calls from ministers, local members of the legislative assembly and the bureaucracy.

Similarly, allopathic doctors are also being asked to pay for appointments, though a large number of their posts lie vacant. As all appointments are being made for a year at a time, with a gap of 15 days before re-appointment, money is being demanded on an annual basis. The NRHM scheme is to be functional from 2005 to 2012. The appointments for the scheme are on an annual basis, with a gap in service of 15 days. So large amounts of money change hands annually. This will lead to a window period of four months in the whole scheme with no 'Samvida' staff at the PHCs.

Samvida staff receives their salary only after they submit an attendance register every month at the CMO's office. This must be submitted personally after being counter-signed by the medical officer in charge and the deputy CMO. In the process, two to three working days are wasted. Earlier, before they started transferring salaries directly to the staff member's bank account, the office staff would demand money to release the same; otherwise, payments would be delayed, or amounts deducted on flimsy grounds. Even now, if a proper "consideration" is not paid to the office staff, you can land up receiving your salary after six months or more. As the amount involved is large, the demands too are higher. The attitude is that they are doing you a favour by giving you a salary and you are a new and easy source of profit.

While the NRHM envisages three staff nurses in every PHC with residences(2), it provides for only one 'samvida' doctor with no provision for residence. If the 'samvida' doctor does night duty, then there will be no one for the OPD services and vice versa. So there is a lack of vision in the provision of basic services.

All contract doctors and staff are supposed to work for eight hours a day, but permanent staff doctors try to exploit them by making them do their own work. At times, they make them work during non-duty hours. They push the 'samvida' staff around according to their whims and fancies, threatening termination on the flimsiest of grounds under a contract which is biased towards the office of the CMO.

The Janani Suraksha Yojana, being a major thrust area for safe deliveries in hospitals under the NRHM, is the biggest source of corruption. A mother from a rural area is to be paid Rs 1,400 and one from an urban area is to be paid Rs 1,200 for delivery expenses. ASHAs are also compensated for bringing mothers to the PHCs. But the mother and her attendants are made to cough up Rs 500 before the delivery. Around Rs 150 is taken for medicines that are provided to the centres free of cost under the NRHM. The unfortunate patient is told that she is going to get around Rs 700 for the delivery, so the lure of the money makes her pay as they would under normal circumstances have had to pay for the delivery to the dais or the doctor. The vast majority of deliveries are done by ANMs who pose as doctors and share their booty with the system, so the whole thing works flawlessly. Of late, a new practice has emerged: even home deliveries are shown as having been done at the PHCs to siphon off funds and skew the data to show a higher number of deliveries in the government setup.

Samvida doctors under the NRHM are an exploited lot of daily wagers who have no casual or earned leave and must work even on gazetted holidays, failing which their salary will be deducted by an amount which is a few hundred rupees more than what they would be paid for that day. The PMS doctors look down upon them as lesser beings who are disturbing their well oiled system of "gratification" for doing no work. Due to the undefined "hanging sword of termination" in their contracts samvida staff is forced to work as bonded labourers.

The most unfortunate fact about this utopian scheme of the NRHM is that the delivering agency assigned to it is the very one that failed to provide these services in the first place. Now they are being paid a second time to do the very job for which they were appointed by the government. To give one example, if you hear Provincial Medical Services doctors talking about a PHC and mentioning figures like Rs 1 or 2 lakh, they are talking about the revenue in bribes that the PHC generates per month. Based on this amount, the CMO and other senior officers demand their share of the booty.

To expect these people to deliver under any scheme or mission would be like asking for the sun.

Looking for a mechanism that may make the NRHM succeed, at least in Uttar Pradesh today, is a nightmare to my mind. A government set up will always find ways to make money out of the scheme, as is already being done with Pulse Polio. It is also difficult, if not impossible, to find an honest NGO to deliver; even they have to grease palms to get their dues and once they clear that hurdle, the lure of easy money is difficult to resist and the bureaucracy will keep demanding its pound of flesh.

The NRHM is yet another failed dream.

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