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Commentary

The challenge of building rural health services

The challenge of building rural health services, State's responsibility in providing these and training paramedical personnel to carry out limited curative and preventive responsibilities were part of India's development thinking before and after independence. The Sub-Committee on Health of the National Planning Committee of the Indian National Congress set up in 1938[1], the Gandhian Plan[2], the Bombay Plan[3], and the People's Plan[4] of 1944 despite major differences in addressing the issue of economic growth and poverty, unanimously agreed on building rural health services. The Bhore Committee Report[5] called for an integrated 3-tier health infrastructure to provide basic services for the rural areas. Reviewing past achievements, the Mudaliar Committee Report[6] in 1962 offered financial options for building health services.

India's mixed economy attempted to accommodate a welfare policy that led to expansion of health service infrastructure, manpower and public sector drugs and instruments production units. The training of paramedics was a key activity through nursing, ANM and Basic Health Workers and Health Assistant's training schools. After the Third Plan this emphasis got diluted. Investments in health services continuously declined and urban hospital based services got priority over the rural 3-tier system proposed by Bhore Committee. To contain the emerging dissatisfaction in rural areas, the State introduced the Minimum Needs Programme in the Fifth Five Year Plan (1974)[7], the Community Health Workers Scheme in 1979, and expanded and restructured primary health Centre network adding Community Health Centres in the Sixth Five year Plan (1981)[8]. The acceptance of Alma Ata declaration of Comprehensive Primary Health Care in 1978[9], the National Rural Health Mission (NRHM) of 2005, training Accredited Social Health Activists (ASHAs) and now the proposal for a shorter training for rural practitioners, all were meant to strengthen rural infrastructure. The para-medics, however, remained neglected as a variety of male and female health workers were integrated into multi-purpose workers of both sexes in 1973[10] without much attention to improving the number and quality of training schools. Instead of an effective integrated manpower, capable of responding to the needs of rural areas the State created an army of ASHAs with limited skills to apparently provide full coverage.

Absence of an effective infrastructure in rural areas and a medical education based on colonial vision of medicine that divided clinical medicine and public health failed to inspire doctors to work in PHCs though their numbers continued to rise as private medical schools expanded and further undermined public health component of medical education. Concentration in cities and out migration characterized this set of personnel. This paucity of personnel in rural areas created a huge gap between needs and availability of public sector providers. People depended upon private providers from different systems of healing such as AYUSH and folk medicine, and the fastest growing among these were the informal allopathic practitioners. This trend was more in the well off areas as compared to other relatively poor areas where profits are difficult in private practice.

Was it wrong then to believe that adequate primary health care for all is possible? Or, did the system fail because the steps required by the policy for building rural health services were scuttled? The answer to this question lies not within the health service system, but in the larger developmental process. Since 1970s, the ongoing global collapse of the welfare States made them forego their political promises. They opted for structural adjustments that called for withdrawal of State investments in welfare, and its centrality in

provisioning of welfare services. The Indian State too succumbed to this pressure informally over 1980s and formally in 1992. The State itself accepted its institutional inefficiency and inability to deliver services; corruption within and lack of managerial proficiency was assumed as incurable and all these were used to cover up the structural distortions introduced over the years. Private sector as an alternative became the State favourite at its own cost, leading to significant shifts of subsidies from public to private sector. The evidence often showed their anti-poor inclination such as failure of subsidised private tertiary care institutions to provide free care to the poor in 10 per cent of their indoor beds and 25 per cent of the OPD patients[11].

Health Sector Reforms further transformed this sector into an industry which is expanding at 12 per cent CGPA (cumulative growth per annum) since 2008 and its market is poised to gross Rs.1.3 trillion in revenue by 2020[12]. According to investment Commission of India, the Confederation of India and the consultant firm Mc Kinsey, the main sources of this growth are hospitals, nursing homes, medical equipments, laboratories and upcoming specialities such as aesthetics and weight loss, health insurance, medical tourism and expanding private medical education[13]. In the process, the very nature of definitions of primary health care and public health changed. From 'comprehensive' primary health care the policy makers moved to 'selective', and then 'primary level' and latter 'essential' care thus, fragmenting content and delinking levels. The tertiary institutions were absolved of the responsibility to support the secondary institutions and were free to become a part of the global health market. Market forces and availability of technology and not epidemiological priorities regulated them. This led to a schism in services, urban hi-tech curative, and rural ill staffed, ill equipped institutions dependent on ASHAs and AWWs for community work. The focus of rural services narrowed down to population control, maternal and child health and a few disease control programmes[14] while the medical market penetrated it through first referral private institutions for curative care, private practice by government personnel and other forms of public private partnerships.

Today, the rural health service is characterized by its inadequacy and poor utilization. The NRHM, that was to change this reality, apart from provisioning of materials and finances, has actually delinked primary from the tertiary level, focused on private partners for first level and secondary referrals and use of contract workers[15] rather than developing manpower specially paramedics. The new cadre of ASHAs in absence of this support remains necessary but not sufficient as is evident from the current Annual Health Survey of the Office of the Registrar General of India[16]. ASHA under the "*Janani Suraksha Yojana*" can take the woman to the PHC but cannot impact maternal and infant mortality in majority of the high priority States. The rural elite are moving to urban medical markets and 65 per cent of rural population uses Indian systems of medicine[17]. An empiricist, a-historical analysis of the situation can at best show us the present pattern of preferences but it does not show us why these preferences are as they are. If people use private services because, these are 'close at hand, better or cheap for basic needs' then, should we be pragmatic and use their actions to accept the status quo or should we explore it further?

This is the dilemma for Gautham *et al*[18] in this issue. There are problems with their choice. Public health teaches us to minimise death and suffering not only as an end in itself but also as one of its various tools, that when used judiciously, changes the epidemiological history of diseases and becomes the experiential basis for mobilising people's participation in disease control strategies. A balanced curative and preventive strategy is then its essence and not only basic clinical services. Should it not be possible for trained paramedics, part of the public health team, to provide that basic care which the informal private practitioners are providing- many of whom are from the government health services? The notion of 'basic diseases of the poor' too needs to be shed off as they bear the brunt of common and uncommon diseases and their complications due to the delays in treatment and neglect and therefore, deserve more attention! One, therefore, needs to ask where do local practitioners send their patients when they cannot handle them?

The solution to the challenge of handling rural health needs lies in strengthening the public sector rural infrastructure as a whole including primary, secondary and tertiary referral facilities and integrating national disease control programmes and not in accepting the informal practitioners as permanent solution or equipping primary rural institutions without adequate support from secondary and tertiary levels. This calls for restructuring NRHM. To use people's health behaviour as justification of status quo in a context ridden with constraints, promotes the interests of the medical market ignoring the needs of the rural population. If the people in rural areas are not impressed by the NRHM and yet

seek modern medicine in private sector then, is it not our professional responsibility to search for the cause of this contradiction and examine the constraints of their context rather than accept the obvious structural and functional flaws?

In building a comprehensive rural health service, linking up private providers with primary institutions may be the first step in the alternative strategy but that strategy must evolve out of an analysis of the subverted policies and not pragmatism that overlooks the undermining of the principles of public health planning.

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