सत्यमेव जयते

Government of Rajasthan

Speech of Shri Aimaduddin Ahmad Khan- Health Minister Rajasthan at the10th Conference of the Central Council of Health & Family Welfare (CCH&FW)

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन
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Hon'ble Union Minister for Health and Family Welfare, Deputy Chairman Planning Commission, Ministers of Government of India, Ministers of Health and Family Welfare from the States of the Union and friends,

1. It gives me immense pleasure to participate in this 10th Central Council Conference to review the implementation of the policies and programs of Government relating to medical and health sectors and to recommend ways and means for better implementation of these policies and programs.

2. The flagship program of the Union Government in the Health Sector is the National Rural Health Mission. A lot has been achieved in the rural health sector since the launch of the NRHM. That said, the challenges of improvements in rural health sector are enormous and would necessitate substantial absorption and spending capacities by States. As a high focus State, Rajasthan's allocations under the XIth Five Year Plan have been projected at Rs. 6200 crores. At the end March 2009, the State would have utilized Rs. 1400 crores of the XIth Plan allocations. We have successfully scaled up utilization in the current year to Rs. 980 crores by end March 09, from Rs. 335 crores in 2007-08, an increase of nearly 300 percent. Despite this fiscal expansion, there is an urgent need to further scale up absorption and spending capacities so that XIth Plan allocations are fully utilized. In pursuance of this objective, Rajasthan has formulated an NRHM Program Implementation Plan for 2009-10 amounting to Rs. 1280 crores.

3. However a burgeoning size of NRHM PIP in the coming years, imposes tremendous strain on State resources given that States have to contribute 15 percent matching share. The State share for NRHM has increased in the past 3 years from Rs. 45 crores in 2007-08 to Rs. 126 crores in 2009-10. By 2011-12 the size of the NRHM Program Implementation Plan would be Rs. 2100 crores and this would necessitate a State share of Rs. 210 crores imposing substantial burden on an already crowded State Plan. It is therefore imperative to introduce a lesser resource burden on the States in the coming years, particularly as NRHM is likely to continue in the XIIth Five Year Plan period.

4. Besides NRHM allocations come with considerable rigidity of guidelines which are in the nature of structural conditionality. Health department, Rajasthan has been grappling with the issue of creation of additional ANMs in the Sub Centers as laid down by the Union Health Ministry. Government of India prescribes that unless the 2nd ANM is created under the State Plan resources, Union Government will not be financing creation of a 3rd post of ANM to be deployed at Sub Centre level. Despite a multitude of meetings with our Finance department, we have not succeeded in getting a sanction for putting in place 10000, 2nd ANMs and as a result could not put in place 3rd ANMs. This has affected our routine immunization program substantially. The State's Program Implementation Plan has a provision for creation of 5800 3rd ANMs in 2008-09 but we

will be re-appropriating the entire allocation, due to our inability to find resources for creation of the 2nd ANM position and inter alia no 3rd ANM is being created.

5. May I request you Sir, to relax this rigid conditionality and allow creation of an Additional ANM from Union Ministry's resources in our State so that Health indicators under routine immunization and home deliveries through skill birth attendants can improve. This will provide an immediate breakthrough in High Focus States like Rajasthan.

6. The strength of NRHM is in creation of Accredited Social Health Workers at Village Level to provide household visits to motivate and counsel every pregnant mother to come to the nearest Health Institution for delivery. DLHS-3 has pointed out that Asha performance has considerable scope for improvement. As per DLHS 3, in most of the high focus States, Asha involvement with Institutional Deliveries, ANC, and Sterilization cases remains less than 5 percent. An architectural correction is urgently needed for enhanced monitoring and phasing out of non functional Ashas. A national evaluation of Asha performance is needed so that this large mass of health workers is effectively mainstreamed to adopt the Union Health Ministry's agenda. I would congratulate you, Sir, for the decision to provide Ashas with a fixed remuneration of Rs. 500 per month taken in the National Health Mission meeting on January 29, 2009. It will help improve Asha performance on specific

indicators that could be firmed up in the evaluation study that I am proposing.

7. Effective implementation of the *Janani Suraksha Yojana* has resulted in substantial increases in workloads at District Hospitals and CHCs. It is important to recognize that Public Health Institutions at District Hospital and CHC level in Rajasthan are among the most stressed public health institutions in the country. Average OPD at District Hospitals (300 beds) is 25000 cases/ month, at District Hospitals (150 beds) is 20000 cases/ month, at District Hospitals (100 beds) is 12000 cases/ month, at CHCs (50 beds) is 8000 cases/ month and CHCs (30 beds) is 5000 cases/ month. With institutional deliveries increasing from 28 percent in 2005-06 to 70 percent in 2008-09, Rajasthan is grappling with a need to rapidly scale up infrastructure and manpower resources for to cope up with these enhanced workloads. May I request you Sir, to increase the allocations for the construction program from the current 33 percent of Additionalities PIP to 40 percent of Additionalities PIP so that institutional infrastructure can be adequately created.

8. Amongst the most successful models of ambulance care developed under NRHM is the collaboration with EMRI. However, such collaboration while being efficient and patient friendly comes at a huge financial cost to the NRHM program. Ways must be designed to make the EMRI model of ambulance care more cost effective and I would seek your

guidance in this regard. A Rs. 2000 crore corpus for operational costs in the long term could be considered.

9. Let me also highlight, Sir, some of the important achievements of the NRHM program in Rajasthan in the year 2008-09. As a high focus State, Rajasthan has witnessed an increase in institutional deliveries from 55 percent in 2007-08 to 70 percent in 2008-09. The period of stay has improved significantly with substantial institutional quality improvement measures of BCC training and Sulabh International deployment for clean toilets being introduced. To focus on child heath indicators Rajasthan has operationalized 33 Facility Based Neonatal Care units and Malnutrition Treatment Corners in 2008-09. 43 Urban RCH centers have been operationalized in collaboration with NGOs. The State is fully geared up to launch the National Urban Health Mission in 5 cities as soon as it is announced by the Union Government. 53 Mobile Medical Units have been operationalized. Diagnostic vans have been procured for taking high quality health care to "C" category villages. 100 CHC base ambulances have been procured for institutional emergencies, "102" services are being strengthened.

10. Human Resources have been the major thrust of the NRHM program. All positions of SPMU/ 33 DPMUs have been filled. Recruitment of 237 BPMs has been completed. 1084 Accountants have been recruited, as also 27

specialists and 3704 GNMs. Hard duty allowances have been sanctioned to 557 PHCs. Recruitment of Pharmacists, Laboratory Technicians and Ayush Doctors is in progress. Recruitment of 12000 Ashas has been completed. Against 46000 Ashas, Rajasthan has deployed 42000 Ashas; 28000 Ashas have been equipped with drug kits. The Asha incentive structure has been streamlined to ensure timely incentive payments.

11. All building less CHCs/ PHCs/ Sub Centers have been taken up for renovation/ construction. Rs. 150 crores construction program has been sanctioned in 2008-09. Keeping in view the larger vision of the Department to have 500 bedded district hospitals and 100 bedded CHCs by end of the 11th Five Year Plan, 30 bedded maternity wards have been sanctioned in all District Hospitals and CHCs with more than 200 deliveries/ month. I would also propose additional infrastructure build up at Medical Colleges keeping in view the vast in-patient care that JSY is bringing to the institutions.

12. Rajasthan has fully integrated the Village health planning process into the institutional framework and 41000 Village Health Committees have been constituted. They have been fully empowered and moneys have been transferred to all committees. The Village Health Plan is a physical plan and integration of the financial plans in health

sector is only to the block level. Health Ministry may like to take a fresh look if a health plan is needed upto the village level as a physical plan or whether we can operate a financial plan upto the block level. I would propose that we formulate Gram Panchayat wise plans so that institutional integration with Panchayati Raj institutions can be maintained.

13. Mainstreaming Ayush remains an important issue where further attention is needed. NRHM envisages convergence with Ayush to provide different health systems under one roof. However such convergence in a PHC and CHC has proved difficult as Ayush doctors are attending to a very small number of OPD patients. In several PHCs only Ayush doctors are available with acute shortages of manpower in Allopathic doctors. NRHM would have to build adequate training modules and integrate Ayush into the other activities like Alternate Vaccine Delivery, supervision of MCHN sessions etc so that this manpower is fully utilized.

14. Chronic shortages of specialists have been felt in many public health institutions in the State. Despite numerous efforts to recruit personnel, specialists have shown little interest in working in harsh rural conditions. The Rajasthan Rural Health Service constituted as a panacea for the chronic shortages of doctors in rural areas has helped the situation considerably. However we need to identify more Anaesthetists, Gynaecologists, Surgeons and Paediatricians

to ensure that all CHCs function as FRUs and all 24x7 PHCs are providing basic emergency obstetric care. For this purpose, post graduation seats need to be increased in medical colleges, and the amendments that this council is going to deliberate today under medical education are going to be enormously helpful steps in this direction.

15. Health Insurance has been tried out in Rajasthan under various forms. We have implemented the Rashtriya Swasthya Bima Yojana through the Labour Ministry; the Rajasthan Swasthya Bima Yojana through the NRHM and the Swasthya Bima Yojana through State Plan funds. Our experience has been that in the absence of adequate private accredited institutions, health insurance through a private insurer is likely to result in very poor number of claims against the premium transferred. We have now reconstituted the scheme as *Mukhya Mantri Jeevan Raksha Kosh* with direct funding to Medicare Relief Societies of Public Health Institutions.

16. I would like to turn to the issues of Financial Management of the NRHM program. Rajasthan, for the first time in 3 years is in a position to fully absorb and spend the PIP 2008-09 allocations of Rs. 980 crores. This is a significant achievement and a significant transformation in many public health institutions could be achieved. Given the large flows of moneys, liquidity management has posed considerable problems with nearly 80 percent of the RCH II PIP being spent at the institution level. A better banking

system to ensure timely electronic transfers upto block/ institution level is necessary. The Financial Management Group could be advised to work on putting in place better liquidity management practices that will reduce the age of advances and the amount of advances at the institutional level. Besides it is very difficult to collect utilization certificates from village level institutions where considerable moneys are flowing, and all such advances could be treated as booked expenditures once amounts are transferred to village institutions.

17. The National Health Bill 2008 represents progressive social legislation empowering citizens with 'right to health'. However, it could be premature legislation as considerable strengthening of health institutions is required before the law is enacted to make it justiciable. The following issues need further consideration:

a. Availability of funds to maintain IPHS standards, would these resources flow from Union Government.
b. Share of Union and State Governments in the Health reparation funds?
c. Can sub centers be excluded from government health care establishment?
d. Status of medico legal cases should be very clear in case of medical negligence.
e. What will be the position of the State governments in cases of insufficient manpower?

f. Liability of other concerned departments in cases of problems in sanitation, safe drinking water etc.
g. In the duties of users it is proposed to add the maintenance of clean user friendly institutions;
h. A District Health Board for district level monitoring is also recommended.

18. Rajasthan is short by atleast 15 Medical Colleges. In this regard, I welcome the proposed central scheme for strengthening and upgradation of Government medical colleges in the States. We look forward to early launch of the Scheme. The amendments to the MCI regulations and condition for land requirement for a Medical College are welcome initiatives and it is expected that these measures will enable establishment of additional medical colleges in the State.