# NRHM AND HEALTH SECTOR DEVELOPMENT: AN INTERSTATE ANALYSIS OF KERALA AND BIHAR

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NRHM is a biggest health project in India's health sector over the last 50 years, classifies states in to high- focused and non- focused states and giving freedom to each state to implement their own programmes for achieving the targets. The mission accepts a synergistic approach by relating health to determinants of good health viz, segments of nutrition, sanitation, hygienic and safe drinking water. Review of NRHM studies clear that NRHM is a sincere effort to craft plausible public health system in India, which lead to reach out health services to the vulnerable sections of the society. The mission targeted to full fill their objective of health sector development within 2005-12 period, and the mid- term appraisal of NRHM has found that there has been a significant improvement in health indicators even in the short period. In this context there is a scope to evaluate the performance of the mission and its impact on the health sector. The present study is a comparative study focusing on NRHM in two states of India namely Kerala and Bihar in order to understand the utilization of NRHM funds and its impact on health sector. Compare to Bihar (high- focused state), the state Kerala (non- focused state) has the dominance in the success of the mission in health indicators and infrastructure development. But the trend of NRHM expenditure is not at all satisfactory in both states.

***Key Words:*** *Maternal Mortality Rate, Total Fertility Rate, Infant Mortality Rate, Health infrastructure*

## INTRODUCTION

The Constitution of WHO (1946) states that good health is a state of complete physical, social and mental well-being, and Universal Declaration of Fundamental Right (1948) considered health is a Human Fundamental Right and an important determinant of well being. It is source of energy and an essential component of development. So the protection of health is important for an individual at the micro level and for society at the macro level. Recognizing the importance of health in the process of economic and social development and the role of Government for the protection of the health of the people, the Government of India has resolved to launch NRHM in 2005, a biggest health project by giving more importance to decentralized management of health sector. It is a right based and flagship programme seeks to provide universal access to equitable, affordable and quality health care to rural population, especially the women and children.

While the National Rural Health Mission covers the entire country, it classifies states as High Focus Sates- Non- North East, High Focus States- North- East, Non- High Focus State- Large, Non- High Focus States- Small and Union Territories. The mission has identified 18 States as High Focused States due to their weak health set up and give more considerations. The mid- term appraisal of NRHM has found that there has been a significant improvement in health indicators even in the short period. In this context there is a scope to evaluate the performance of the mission and its impact on the health sector of high focused and non- high focused states. The studies carried out yet are focused only to single state or nation as a whole. As NRHM classifies states in to different categories and permitted each state to formulate their own programmes, a comparative study is

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relevant. In this context the present study tries to analyze NRHM in two states, namely Kerala and Bihar by understanding the trend of fund utilization, health infrastructure development and changes in health indicators- especially the IMR, MMR, TFR as one of the objectives of the mission is to reduce it.

The objectives of present study are;

- To compare the expenditure pattern of NRHM Fund in two states, namely Bihar and Kerala
- To evaluate the health infrastructure development in Kerala and Bihar.
- To understand how far both states succeeded in reducing IMR, MMR and TFR

## DATA AND METHODOLGY

The present study is based on secondary data compiled from Ministry of Health and Family Welfare, State Health Mission of Kerala and Bihar, NRHM report of Kerala and Bihar, SRS Bulletin, Kerala Economic Review and Rural Health Statistics. To make the study most fruitful one, the annual data on IMR, MMR, and TFR of Kerala and Bihar from 1990 to 2012, the health infrastructure statistics for the year 2005 and 2012 and the expenditure of NRHM fund in Kerala and Bihar from 2005 to 2014 were collected.

## REVIEW OF LITERATURE

There are so many studies related to National Rural Health Mission. Most of them are National Level, studied the scope, performance and failures of the mission.

Gayathri (2012) remarked that the issue of small and declining health sector financing by the central and state governments in India is addressed by the launching of National Rural Health Mission in 2005-06. Analyzing the district level NRHM funds flow and expenditure in Karnataka, the paper argues that the district wise allocations are wrought with poor expenditure planning. Utilization of the allocated resources is poor and there is absolute mismatch between the planned estimates for important components of NRHM like RCH, NRHM additionalities, Disease control program and Immunization and actual expenditure.

Hussain (2011) critically evaluates the success of the intervention strategies under NRHM scheme based on rapid appraisal surveys in selected districts, three common review missions by the Ministry of Health and Family Welfare, and data reported on the NRHM website. The study concluded that actual delivery of the NRHM has fallen far short of its targets. However, within this limited period, the NRHM has succeeded in putting back the issue of public health at the top of the government agenda. Outdoor patient visits had increased at all three levels (SC, PHC and CHC). The maximum improvement was found at the PHC level (129%) followed by an almost similar increase at the district and CHC level (86%). The paper argues that the NRHM did not adequately take into account the complexities of Indian rural societies in which the health system is situated and which ultimately determines the success of policies and measures.

Dhingra and Dutta (2011) in their article concluded that for the mission (NRHM) to be a success it needs strong political commitment, financial resources, adequate and quality infrastructure and a scientific background. The guidelines need to be strictly adhered to, commitments fulfilled and national interests given priority over individual aspirations. The community needs to be empowered in the planning and utilization of these systems in a Rights based framework. By bringing about a

sea change in the health care system, NRHM can help build a health system of the people, for the people and by the people of the biggest democracy in the world.

Asthekar (2008) concluded that the three years of NRHM have made only marginal impact on health system; apart from rise in institutional deliveries. The failure of decentralization, the lack of inter sectoral coordination and the under mining of traditional health support are the reason why the NRHM has not delivered what it had set out to achieve.

## RESULTS AND DISCUSSION

### NRHM Fund Utilization in Bihar and Kerala

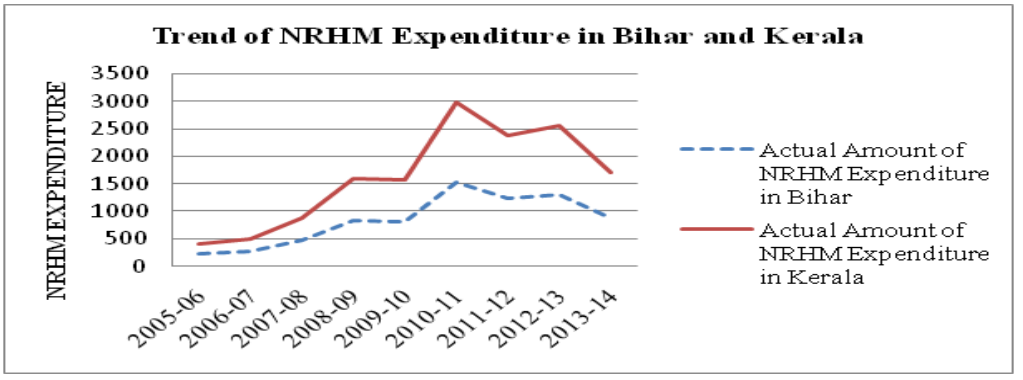
Financial allocations under the National Rural Health Mission are based on Programme Implementation Plans (PIPs), which are prepared by State Governments and are subject to approval by the Union Government. Though the first two installments are released unconditionally, subsequent ones are released subject to expenditure of at least 50-60 per cent. States that fail to spend their previous installments do not receive subsequent. In fact, the unspent balance of the previous year is incorporated into the next year's allocation, i.e. States that are able to spend their funds more efficiently get more funds in subsequent rounds. Thus, instead of financial allocations under the National Rural Health Mission being needs based, the state's ability to spend becomes the criterion to decide the flow of funds.

**Table 1.1 : NRHM Expenditure in Bihar and Kerala (2005-14) (Rs. In Crore)**

| YEAR | Actual Amount of NRHM Expenditure in Bihar | Actual Amount of NRHM Expenditure in Kerala |
|---|---|---|
| 2005-06 | 224.42 | 411.11 |
| 2006-07 | 273.27 | 508.91 |
| 2007-08 | 463 | 886.25 |
| 2008-09 | 823.88 | 1607.07 |
| 2009-10 | 816.26 | 1569.47 |
| 2010-11 | 1528.31 | 2983.29 |
| 2011-12 | 1227.25 | 2374.99 |
| 2012-13 | 1295.62 | 2567.41 |
| 2013-14 | 867.07 | 1709.35 |

Source : NRHM- HMIS REPORT

The funds under NRHM are classified differently as National Rural Health Mission-A ( known as Reproductive and Child Health Flexible pool, funds that flows from the state to the districts for strengthening reproductive health, ie fund for mothers and children), National Rural Health Mission-B ( known as Mission Flexible pool, include NRHM Additionalities, fund for other important activities to strengthen the health system, including health worker training, health facility upgrades and maintenance, planning, and other funds untied to any particular health area), and National Rural Health Mission-C ( fund for Strengthening Immunisation system of the society). Pool for Infrastructure and National Disease Control Programmes are also established. Besides Union Government allocation, State Governments too contribute to health funding, including funding for safe motherhood initiatives.




Source : NRHM- HMIS REPORT

Fig. 1.2 Health Infrastructure in Bihar and Kerala (2005 and 2012)

The Table 1 and Figure 1 reveals that, the NRHM expenditure (including all heads) in Kerala and Bihar has growing tendency up to 2010. A high jump in the expenditure was seen in 2009-10 periods and after that it falls and started to decline. Even though Bihar is a high- focused state, Government allocating more funds, the amount of expenditure in every year seems to be less as compared to Kerala.

**Table 1.2 : IMR and TFR of Kerala and Bihar (1990-2012)**

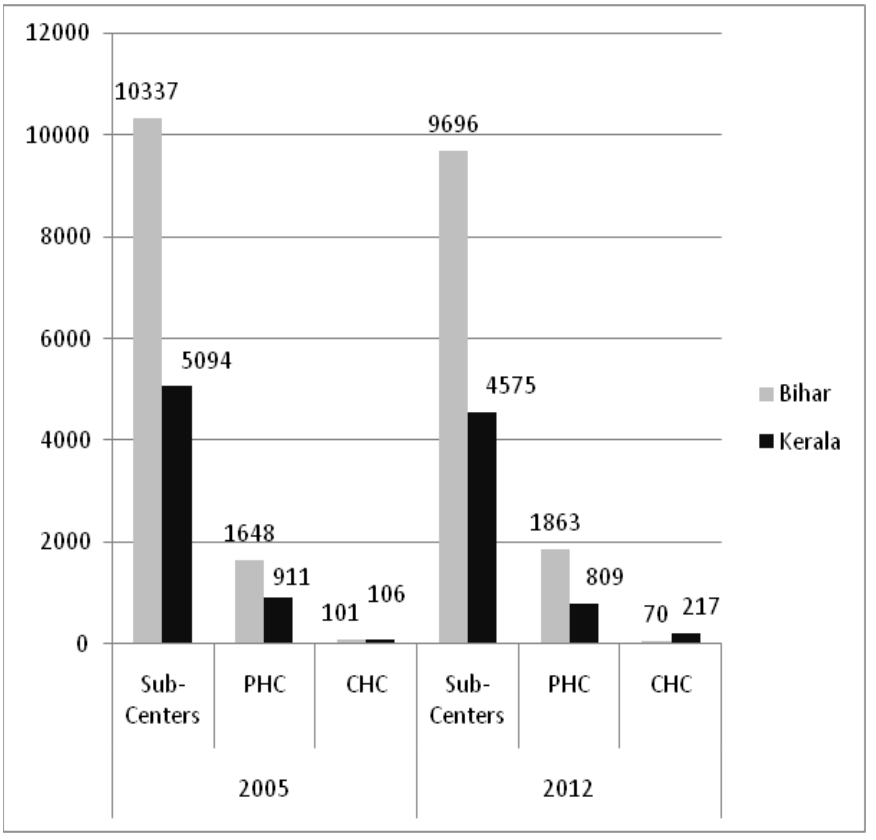
| Year | Kerala | | | | Bihar | | | |
|---|---|---|---|---|---|---|---|---|
| | IMR | Annual rate of reduction in IMR | TFR | Annual rate of reduction in TFR | IMR | Annual rate of reduction in IMR | TFR | Annual rate of reduction in TFR |
| 1990 | 17 | 0 | 1.9 | 0 | 75 | 0 | 4.8 | 0 |
| 2000 | 14 | 0.3 | 1.7 | 0.02 | 62 | 0.7 | 4.3 | 0.05 |
| 2004 | 12 | -1 | 1.7 | 0.1 | 61 | -1 | 4.3 | 0.0 |
| 2005 | 14 | -2 | 1.7 | 0 | 61 | 0 | 4.3 | 0.0 |
| 2006 | 15 | -1 | 1.7 | 0 | 60 | 1 | 4.2 | 0.1 |
| 2007 | 13 | 2 | 1.7 | 0 | 58 | 2 | 3.9 | 0.3 |
| 2008 | 12 | 1 | 1.7 | 0 | 56 | 2 | 3.9 | 0 |
| 2009 | 12 | 0 | 1.7 | 0 | 52 | 4 | 3.9 | 0 |

| Year | Kerala | | | | Bihar | | | |
|---|---|---|---|---|---|---|---|---|
| | IMR | Annual rate of reduction in IMR | TFR | Annual rate of reduction in TFR | IMR | Annual rate of reduction in IMR | TFR | Annual rate of reduction in TFR |
| 2010 | 12 | 0 | 1.8 | -0.1 | 52 | 0 | 3.7 | 0.2 |
| 2011 | 12 | 0 | 1.8 | -0.1 | 44 | 8 | 3.6 | 0.1 |
| 2012 | 12 | 0 | 1.8 | 0.0 | 43 | 1 | 3.5 | 0.0 |

Source : SRS Bulletin, office of Registrar General of India, census report, NRHM Report various years

## Health Infrastructure Development in Bihar and Kerala

Health Infrastructure is prerequisite for health care utilization. As far as rural peoples are concerned, Government Health Centers are the most accessible facility for protecting their health. Inadequate financial resources and its inefficient utilization are basic hurdles in health sector development, especially in the case of infrastructure and human resources. Even though the Government set down norm for health care infrastructure it lacks the capacity to implement them on the ground level. There is lack of proper buildings, equipments, improper functioning, shortage of human resources such as trained doctors, health assistants, health workers, lab technicians and pharmacists. Through peoples participation, NRHM trying to ensure availability and accessibility of health infrastructure. Up-gradation and standardization of health centers kept as one of the strategy under NRHM for infrastructure development in order to provide quality health care services to rural people. From the figure 3, it is understood that the number of PHC, CHC, and Sub- centres are higher in Bihar than Kerala. But the implementation of Mission shows negative impact, as there is deterioration in the number of Health Centers in both states. As far as Kerala is concerned the numbers of PHC, CHC and sub- centres are surplus than required. Based on the Rural Health Statistics 2012, there are 4575 Sub- Centres are functioning (3525 are required), 809 PHC (586 required), 217 CHCs (146 are required). Compared to 2005 there is a decrease of 519 Sub- Centres, 102 PHCs while 111 CHCs are increased in 2012. The Kerala State Government reported that it is due to standardization of health institutions as a part of NRHM Programme. According to the ASSOCHAM report, Bihar lags behind other states on health front; therefore the report suggested the government to promote private sector participation in organized healthcare development, particularly in rural areas. Compare to 2005 there is a reduction in 641 of Sub- Centres and 31 CHCs while the 215 PHCs are increased in the state. When we considered all India level there is a great progress in the health centers after the mission was implemented. There is an increase in number of Sub- Centers, PHCs and CHCs.




Source : Rural Health Statistics in India, 2012

Reduction of Mortality and Fertility Rates: a Comparison of Pre and Post NRHM periods in Bihar and Kerala.

One of the important objective of NRHM was to reduce MMR as100 per 1,00,000 live births, IMR as 30 per 1000 live births and TFR as 2.1 percent. Table 1.2 and 1.3 shows the IMR, TFR and MMR of Kerala and Bihar during 1990-2012 and their annual rate of reduction. From the table it is understood that the state Kerala has achieved the targeted level of IMR, TFR and MMR before the mission was implemented, and it is the only state in India achieved this success. As far as Bihar is concerned, it is the most vulnerable and backward state in India. The implementation of mission shows high impact as there is a huge decline in IMR, TFR and MMR of Bihar during 2005-12 period. The annual rate of reduction in IMR, TFR, and MMR are higher in Bihar than Kerala. The average annual rate of reduction in IMR in Kerala is -0.64 whereas in Bihar it is 1.61, in TFR the average annual rate of reduction is -0.09 in Kerala and 0.59 in Bihar. And in the case of MMR it is 16.6 in Kerala and 36.2 in Bihar. As Kerala achieved the targeted level before 2005, the task of NRHM is to keep up that level. In almost all years the mission succeeded to maintain that level except some years, which seems to negative reduction in annual rate. Even though there is high reduction in IMR, TFR and MMR in Bihar, the state is still behind the targeted level.

**Table 1.3 : MMR of Kerala and Bihar (1991-2012)**

| Year | MMR (Kerala) | Rate of reduction | MMR of Bihar | Rate of reduction |
|---|---|---|---|---|
| 1991-01 | 149 | 0 | 400 | 0 |
| 2001-03 | 110 | 39 | 371 | 29 |
| 2004-06 | 95 | 15 | 312 | 59 |
| 2007-09 | 81 | 14 | 261 | 51 |
| 2010-12 | 66 | 15 | 219 | 42 |

Source: censusindia.gov.in/vital statistics/SRS Bulletin/MMR- release- 070711.pdf

## CONCLUSION

NRHM is a successful health venture in India during 2005. From the above analysis the state Kerala (non- focused state) has dominance in NRHM compare to Bihar (high- focused state). Kerala is the only state achieved the targeted level of reduction in health indicators by followed a different development path, like transferring of health department to local authorities. Even though the mission allocated more funds to Bihar, the state failed to effective utilization of it. Effective governance by Panchayaths and Municipal authorities can do a lot. On the basis of overall analysis it is understood that NRHM is a successful endeavor, the states are tried to achieve all most all norms, and implemented variety of programmes for health sector development. Some sort of deliberate intervention by the decentralized authorities for improving the Human Resources and infrastructure of Sub- Centres/ PHCs/ CHCs are needed.

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