DISCUSSION

In this chapter a discussion on the main findings, converging and conflicting evidences, general limitations and assumptions would be made in order to draw conclusions and put forward key suggestions and recommendations. Further under those premises research scholar would also like to establish the findings of research answering how different questions and problems answered by the research and how those findings could be appropriate. The general aim of the research scholar would be definitely to defend the findings.

It was already outlined that there were two broader components of this research firstly the execution and secondly the achievements. Both components though interdependent despite required measuring through varied approach. Further achievements were parted in two categories such as performance and attainment. Attainment was taken as positive changes in the health indicators. According to the research scholar the performance in terms of medical services was different from attainment and therefore not necessarily required to get reflected in terms of net achievements as outlined in mission documents.

The performance under this research was considered as readiness or preparedness of the public health system to deliver. Ideally, a good performance required reflected in terms of achievements however in health sector the situation sometimes used to get different spheres as it could be apparent through this research. Research scholar came across numerous situations during the case studies that the performance was good despite they were not reflected in terms of achievements. Research scholar wanted to make a point here that in certain situations if achievements were not good or as expected so just on this basis the performance of National Rural Health Mission could not be discarded. It could be understood by an example- suppose a health facility was having work force, logistics and infrastructure in place and was fully capable and ready to deliver despite no patients visited and thus their performance could not be termed null. In such cases, the attainment could be null, not the performance. Thus, research scholar could say on this basis that achievements might inclusive of performance however, performance not necessarily required reflected in terms of attainments. Performance was definitely an indicative of the overall public health preparedness. This point was also substantiated and turned real during the
case studies and interviews. A public health system was required to keep its capacity to deliver the entire clock however it not was required always measuring the *performance* in terms of *attainment*. For example in a year if there was no use of any *anti venom* then it could not be assumed that a health facility would not require *anti venoms* in future because *attainment* was nil.

Research scholar had found that there were health facilities in remote area having minored catchment area which were able to cater their services to a small population in comparison of facilities having large catchment area able to render services to a larger population. In such situation, *attainment* could be termed low or high, not the *performance* because *performance* could be measured in terms of capacity of the health system to deliver. The *performance* under this research was rightly related to deployment of work force, creation of infrastructure and logistics.

Attainments of *National Rural Health Mission* was also rightly measured by the research scholar since the year 2005-06 onwards under the research with the help of secondary data sources, literatures and documents such as *Sample registration system bulletins, MIS on NRHM or Executive summary on NRHM, RHS Bulletins, Times series data, World health organization’s statistics for countries*. All those data for two point of time i.e. during the year 2005-06 and 2011-12 were compared to calculate the progress. Likewise inferences were drawn from the census reports for the year 2001 and 2011 were significant to confirm those *attainments*.

The research scholar would like to discuss one of the key problem under this research that how the achievements of *National Rural Health Mission* could be measured? It would be obvious from targets set at the onset of the *National Rural Health Mission* that the achievements would be measured by changes in health indicators (MOHFW 2005). However research scholar did not find it logical because it did not differentiate how much contribution came from *National Rural Health Mission* and private health sector respectively. Research scholar was aware that private health sector had almost 80 percent of stake in total health care expenditure and almost 45 percent population hardly visited any public health facilities (Chatterzee S., 2009). In addition, research scholar had also not found any clear data therefore it was difficult for him to accept this fact that every bit of change in the health indicators of the country was due to *National Rural Health Mission*. Therefore this issue highlighted by this research that how much contribution in improving health indicators made by private sector and public sector respectively and comparatively, required measured in this country? Also the data presented by *Sample registration system, Rural
Health Survey, District level household survey and National Family Health
Survey required taking up such respective issues in future. In the meantime it
would be opinion of the research scholar to avoid crediting only to National
Rural Health Mission for all positive changes in the health indicators. Therefore
achievements which partitioned by research scholar in two categories
performance and attainment was further proved logically correct as it would be
absolutely wrong to present achievements in terms of positive changes in the
health indicators. Research scholar did not find substantial basis to do so.
Research scholar had conducted several interviews on those issues and put
straight questions to several key functionaries such as state mission directors
and central mission directorates. The summary of their answer was just that
since there was no growth in private health sector therefore every growth would
be considered due to National Rural Health Mission. This was considered
illogical by the research scholar as it definitely required a well measured
outcome validated by a data. Certainly this issue was able to draw adequate
attention of functionaries and it expected that at some stage some action would
be done to ensure appropriate provisions in this regard.

As a final point it could be said that execution was rightly measured through
qualitative form of research involving the Case studies and Interviews and there
could not be any alternative way of doing this and according to the research
scholar the methodological process and selection of literature and data was fully
competent and what the research scholar had further found them beyond any
reasonable doubt. Performance of the National Rural Health Mission was also
rightly measured by the research scholar in terms of institutional arrangements
and their functioning, expansion of health facilities to the tune of Indian public
health standards, creation of adequate infrastructure, logistics, and deployment
of adequate number of medical and paramedical staff. In addition funds supply
and utilization was also included in performance.

Research scholar would now like to discuss the HR Management under NRHM.
HR Management under National Rural Health Mission might appear logical or
workable for the time being however it had the potential to give rise to several
constraints in long run. The rapid migration of health work force had emerged
as a key set back under National Rural Health Mission. It would definitely harm
the public health sector which could not develop eternally. Under National
Rural Health Mission HR Management was also found suffering due to rapid
migration of workforce (Makan 2010). Many analysts had doubted that with
such HR and personnel practices the country’s public health system would not
benefit in long run, as it required qualitative and skilled work force to run the
public health system. There were also apparent tensions reported among the permanent and contractual staff in the public health sector (Shrestha 2011). Demands were also raised from several contractual staff associations for equal salary and terms of service with those permanent staff and considering the fact that they both implemented similar kind of job, the demand was appeared logical and more so due to some constitutional provisions in India which were there to protect the interests of work force. It was further evident that one person were posted simultaneously at different locations and made to perform multiple jobs including highly skilful jobs which required specialized work force. Transfer-posting and private practice by government doctors were a major issue for concern in several states. Cadre conflicts among contractual and permanent staff were reported from several parts of the country and it required some urgent attention. Appointments were not impartial and transparent. Several doctors and paramedics were found employed without any valid degree or diploma making the overall recruitment process doubtful.

Research scholar had got evidence that more and more persons were posted at districts or locations near to any town, as they were not willing to go to remote areas. Under case studies, those issues were raised repeatedly. Transfer posting in health sector might be a lucrative trade in some states. Government doctors were found largely engaged in private nursing homes and clinics could be another major area of concern for HR Management as they might a case of dual salary or income as it could have the possibility to damage the public health sector. It was quite usual sight at several places that doctors were running private clinics and nursing homes adjacent to any government hospital. Sometimes they motivated patients to come at their private clinics and also made machines out of order. Break down in services in this fashion were more than usual. Also all doctors were not so competent and not able to draw the respects of patients as a very handful of doctors were able to draw patients in their OPDs. That had resulted in such doctors getting engaged in clerical or supervisory jobs. Thus some performance based incentives must be associated to keep reputed doctors engaged with public health system. Therefore overall HR policy under National Rural Health Mission considering the situation described as above could say deficient.

Research scholar would further like to discuss the issue of private practice by the government doctors considering the fact that a government employee or even a private employee could not be allowed to get double benefit. It was definitely a case of double employment simultaneously which was illegal as per rules of the land. However when research scholar asked this question to IMA
secretary Dr. SNP Singh he replied that since government was unable in paying a non practicing allowances or NPA therefore there could not be any ban on private practice by the government doctors. When this question was raised by the research scholar before some central officials they termed it as state subject and made states authority responsible for this. Although private practice by government doctors was definitely harming the public health sector despite no ban could be imposed. When research scholar asked this question to Dr. C.P.Thakur a Padma awardees and well known physician of the country also functioned as Union Health Minister, he replied in affirmation that it required to ban the private practice by the doctors. However research scholar had found that it was never so that only non payment of none practicing allowance was the only issue. In fact a high ranked official who did not want his name being disclosed remarked that due to ban on private practice by government doctors more and more good doctors would not be available as they expected to desert the government job because their private practice was so prospered. It was also observed that there were few good and reputed doctors who were able to draw patients in government hospitals as their OPDs were full of patients whereas there were several other doctors who had virtually no patient or very marginal patients in their OPDs and IPDs. Therefore the government was also apprehensive that due to ban on private practice it would be required to pay non practicing allowances to all doctors what would only benefit poor performing doctors and yet good doctors would desert the government facilities and there would be decline in number of patients in government hospitals.

Research scholar would also like to discuss the ASHA program because it appeared that ASHA program neither was nor properly regulated as all the seven module training not provided to them. The public health situation could not build on the basis of such a huge institutionalized voluntarism. After all in several states ASHA were on roads demanding several illogical demands including permanent jobs and promotion to the job of an ANM. Research scholar never felt comfortable with such a scene on roads and their confidence in public health facilities further gets reduced. Research scholar would further like to comment that future of ASHA program would depend on how it regulated in future as it was not regulated properly. There were several discrepancies and inconsistencies persisted in their selection, training and payment of allowances-incentives. Most of time they appeared a play doll for respective ANMs and AWWs. Definitely ASHA program was not regulated well in the country and it appeared a great burden on the public health management system.
It was also planned at the onset of National Rural Health Mission that a new cadre of rural doctor would be introduced in the country however it appeared that the idea was put on back burner due to resistance from Indian Medical Association which was so against this move. However research scholar could see no harm in introduction of new cadre which could be done on the basis of engineering pattern where the cadres of junior engineers and bachelor engineers existed simultaneously with provisions of junior engineers able to complete bachelor degrees. Such arrangement could be also done in the field of medicine although it required massive research and development of appropriate curriculum across the country. This was most needed considering the fact the lack of doctors in the country.

Likewise number of institutional deliveries as mentioned in MIS on NRHM also appeared not fully justified to the research scholar that every individual which provided cash benefits under Janani Suraksha Yojna were mentioned in that figure which was definitely not the case. In addition, increase in immunization coverage and polio eradication could be not fully credited to National Rural Health Mission. However research scholar would definitely like to give credit to National Rural Health Mission for rapid increase in number of OPD and IPD cases and ambulatory services at public health facilities across the country. Nevertheless research scholar was not able to retain the accurate numbers of OPD and IPD cases at public health facilities in the country as the same was not included in the MIS on NRHM.

Research scholar had also find several discrepancies in gap analysis as only rural population were considered by the functionaries however it was required including the population of urban areas also because National Urban Health Mission not started as proposed earlier? Thus the apprehension of research scholar proved correct that urban poor population not adequately covered under National Rural Health Mission. Now research scholar had come to know from a news paper reporting that National Urban Health Mission would be started in almost 800 towns of the country having population at least 50000 or more. The report also said that National Urban Health Mission would start during 12th five year plan or it could start from April 2012 and on later stage both Urban and Rural health missions would be merged together (Times 2012). Therefore on the basis of aforesaid deliberation research scholar could say that certain discrepancies in setting targets, pronouncing achievements, and maintenance of public health data were also due to lack of awareness or non application of mind by the respective authorities collectively and individually.
Some critics had opinioned that pace of achievement was more visible in early years than the concluding years (Shukla 2011). However, research scholar not found any such indication and so much so that it was found that *National Rural Health Mission* progressed almost evenly throughout, though different states and union territories also found performing differently. Also such reports did not matter because net outcome under this research was considered as a whole and no divisions was made on the basis of periods such as initial, medial or final years. In fact the net outcome was measured at national level including every state and union territories involving the period 2005-06 to 2011-12.

Some reports had also opinioned that performance of EAG states or high focused states had shown better results (R. Sinha 2012). The research scholar had also find that the rate of progress were more visible in States like Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Rajasthan and Uttarakhand, all those states were categorized in high focus states. In addition some north eastern states including Assam had performed much better. However, it was also found that despite laudable progress their overall achievements could not match to other states and perhaps it would consume time in this process. One of the working hypotheses built by the research scholar that positive transformation in the public health sector was more perceivable after implementation of *National Rural Health Mission*, and this hypothesis proved correct. There were most valid evidences that situation had changed significantly since commencement of *National Rural Health Mission* in the year 2005. However it could be also said by the research scholar that the overall performance of high focused states were relatively better, which was a most welcome sign.

For common people, considering the fact that set targets as mentioned in mission documents that achievement of *National Rural Health Mission* was not same or somehow fall short of as targeted because it was utmost clear that *National Rural Health Mission* not able to achieve all the targets what aimed at its onset and reflected through mission documents. Also some targets were expected to be achieved during coming years. Nevertheless, according to this research this could not be a substantial basis to discard the overall achievements of *National Rural Health Mission*. The gains on the front of improvements in health indicators was expected to consolidate further as the reports of SRS and RHS what would be published in the year 2013-14 taking into the account the period 2011-12.

The mission document on *National Rural Health Mission* had clearly articulated the mandate of *National Rural Health Mission and it was very clear that National Rural Health Mission* planned to address primarily population
stabilization. In fact, National Rural Health Mission had adopted very flexible approach and provisioned ample space and scope of adjusting varied issues despite public health not emerged so strong. The programs like Reproductive and child health or RCH-II, Janani Suraksha Yojna were more oriented towards population stabilization and little towards public health. It could be evident from the goals set at the onset of National Rural Health Mission.

The research scholar was not so convinced that without making a formidable public health system how National Rural Health Mission could afford to embark upon health determinants such as nutrition, safe drinking water and sanitation. Research scholar was aware that good nutrition, safe drinking water, better sanitation could definitely improve health situation but how it could be said proper for Ministry of health and family welfare to put them fully or partly on agenda of National Rural Health Mission. Research scholar had found and could argue that in this fashion would a program like National Rural Health Mission tomorrow consider construction of roads and bridges as a part of public health intervention because connectivity with health facilities were also a key problem in rural areas. Research scholar had noticed that in Bihar, Chhattisgarh, and Jharkhand several primary and sub health centers not functioned partly or fully due to naxal threats then would any program like National Rural Health Mission also try to promote law and order in those areas on its own? Research scholar definitely wanted a program like National Rural Health Mission to focus on public health services. However research scholar also not found it tactical approach to divert failures on to other departments and say that it was not their fault as because of poor law and order, low connectivity, unsafe drinking water, poor sanitation and lack of nutrition situation not improved. Research scholar would ultimately like to say on this issue that a program like National Rural Health Mission with limited manpower must focus on its priority areas instead of expanding its horizon unnecessarily.

In addition, some related questions also required answering “considering the fact that health was a sustainable subject then what could be the need and urgency to opt for a mission oriented, time bound and project based approach in public health sector in form of National Rural Health Mission”? Now the research scholar could answer this question. The time bound approach was certainly taken for maximum use of the time and resources. Country required some urgent results and the resources were limited thus the time bound approach or special intervention could be justified. Research scholar had found that the time bound program with mission-oriented approach had helped the health sector largely but temporarily. It had created massive people awareness
on key public health issues in rural areas and promoted the movement for social activism. The time bound and project based approach provided a governmental set up exercising several flexibility in approach which would be rather difficult in a government sector which used to remain limited due to strict rules and regulations. Innovative HR Management was one such area, which witnessed tremendous innovation. It was also observed that more and more enterprises world over were converted to project based approach to enhance their performance as more and more government set up were adopting time bound and project based approaches in socio-developmental sector also to address their key objectives in short span of time. Similar approach was also adopted in the field of education namely Sarva Shikha Abhiyan also called Education for All. The research scholar not found any specific reason to term such approaches ineffective and redundant most importantly considering the fact that government used to suffer from deficiencies of finances to fund socio-developmental sector. However several reports had criticized HR policy of National Rural Health Mission and approaches it adopted and so much so that termed them against the laws of nation as several legal provisions such as equal wages for equal job (Biswas 2011). Nevertheless research scholar did not find it injustice as employees under National Rural Health Mission agreed to terms and signed contracts and thus personal liberty was exercised to select the job on specified terms.

Now, in India since health was a state subject therefore this problem could find an answer that why instead of funding the health department of respective states, the central government directly launched National Rural Health Mission on its own and almost imposed it on states. The research scholar could find an answer to this and put like in a manner to say that the capacity of states to tackle health issues and additional funds flow was considered not sufficient as it could evident from NRHM mission documents. National Rural Health Mission had definitely succeeded in enhancing the capacity of respective states to absorb additional funds flow by making appropriate institutional arrangements at state, district and sub district levels. Now it was believed that from 12th plan period onwards that states would be funded regularly on 75-25 percent basis. Therefore research scholar found institutional arrangements as a key tool to absorb additional funds under National Rural Health Mission which was not a case earlier. However due to improper functioning of health societies and institutions at different levels and unethical actions of functionaries some serious kind of malpractices reported from various states. Some states were not able to improve their performances accordingly and for this sake the Mission Steering Committee had decided to associate the release of funds with performance
indicators from financial year 2012-13 onwards (A, Ghosh 2012) however it would be better to see in future that how that arrangement would go well.

Research scholar would also like to make a point here that the public health preparedness was not a homely job; it required lot of specialization, skill devotion, and quality assurance. The confidence in the public health system could only reflect on ground and not in data or papers. After all a common people could not get satisfied by just hearing that National Rural Health Mission had performed better and able to correct several health indicators. A common people could not know the relevance of those health indicators and data as he would be just concerned about the care and facilities one could get at any public health centre. So far research scholar never able to search any valid data about quality of public health care in India. Also no data available about capacity of each health centers to provide a range of efficient and quality health care. Research scholar considered capacity of handling of any emergency cases as core to the public health preparedness. The case study had also revealed that still sizeable part of population preferred to visit any private nursing home instead of any public health facility for delivery of child. However, under JSY, money provided to deliver a child in private nursing homes also however, the amount paid was marginal and at that cost, not all nursing homes could offer to deliver child safely except some charitable or nonprofit making nursing homes and clinics. This was found that at some places MOUs signed with charitable hospitals or nonprofit making entities. It was required to make every PHC able to deliver child safely in real terms not just on paper and for this purpose every step must be taken at all costs. Even public health services required to take it more close to people and making a health centre able to delivery of child under full institutional care. If we could not do so then we should stop talking any betterment of the public health system, as we must think twice before claiming any such things. Research scholar had found that even several district hospitals were not able to deliver a child safely. The reason was obvious; a government set up lacked confidence due to stakes and lack of quality and integrity among work force to possess a degree of will power to perform (Bashistha, 2011).

A big part of the problem persisted in the public health could be also due to vast disparities in health spending between low and high income countries. While per capita health expenditure was about USD 32 in poor countries, including in India, it was around USD 4590 in rich countries which had 10 times more doctors, 12 times more nurses and midwifes and 30 times more dentists. In addition double burden of diseases due to spike in infectious diseases that caused maximum child and maternal mortality coupled with chronic non-
communicable diseases - such as diabetes, heart diseases, and cancers were not put on agenda under NRHM 2005-12 so strongly.

Despite all progress it was certain that stake of private health sector of the country in overall health system was still over 80 percent. This was almost in contrast of the education department where almost 80 percent student in country was educated in government schools or colleges (Dayal 2012).

The trust deficit still existed among people in respect to public health sector. Reports related to adverse effects of immunization and mishandling of cases at public health facilities across the country kept emerging from time to time. There were cases found by research scholar that quality being compromised or some exaggerate being created in public mind. In this situation, any public health authorities must stop to play any sort of hype, which may become extremely disastrous for the patients. Still surgical interventions either general or gynecological hardly performed in all district hospital of the country or those could be extremely rare. Gynecologists could not provide to almost 30 percent primary health centers.

The National Rural Health Mission documents had specified Public private partnership as one of the mission components (MOHFW 2005). However, given the fundamentally divergent objectives of the public health system a ‘partnership’ of such differing institutions needed clearly specified, to prevent its abuse. Any measures under the banner of ‘partnership’ which might lead to privatization of existing public health services should be strongly questioned and opposed, since the consequence of such privatization had often been introduction of steep user fees, barring the poor and lower middle class from accessing services.

Research scholar had found that the number of health facilities could not upgrade along the pattern of Indian public health standards population norms. Medical and paramedical institutions not opened at Regional, State and Sub State levels despite being fully aware that lack of medical and paramedical staff was crippling the system. PHCs were not linked with two-way communication for data transfer. Thus, country was failing to strike timing and timing was conceptualized by the research scholar to mark the occurrence of infrastructure, logistics and workforce simultaneously at all the places, all the time. Research scholar found that infrastructure, logistics and work force without each other at all time and every place were a waste then why not efforts were made to create work force and medical and paramedical colleges not opened in each and every district of the country on priority basis? The National Urban Health Mission
was also proposed but still not implemented. What was the specific need of a separate health mission for urban and rural areas and if a separate, urban mission was required then why not it implemented? Government was also so slow on the insurance sector and it failed to provide health insurance coverage to all below the poverty line families of the country. However, prior to provide insurance cover government must make its health facilities able to respect those liabilities otherwise due to non respect of insurance liabilities any insurance plan would be futile and would only promote the interests of insurance companies and other stake holders.

The research scholar also likes to put a comment about his observation about public health data in the country. The public health data maintained in India was largely formula driven or based upon sample surveys conducted by respective agencies excluding census reports. The data shown by SRS and DLHS could be categorized in this category. In addition targets calculated under National Rural Health Mission for various programs specially immunization were based upon a formula provided by the central agencies. This formula took into consideration the entire population of the area plus decadal growth rate for that area. Now it could found that in several states almost 30-40 percent rural population had migrated to other places in search of employment or due to other reasons. Therefore targets calculated based upon population becomes irrelevant and mostly tentative. It was required to have correct public health data in the country. It could be only ensured by mandatory registrations of each birth, death, illness and cause of illness and death in the country. This could be done through a web enabled services which could be further used to generate certificates. Unique ID number of citizens could be considered for this purpose. Every public and private health facilities in the country required implementing such mandatory registration through a single web enabled services. Only by doing so we could be able to get the most authentic public health data in the country.

To end with this chapter research scholar would like to say that though more and more reports and documentation would keep coming over the next few years nevertheless research scholar was certain that nothing-significant difference would emerge or evolve what highlighted under this research. Therefore the results would be largely acceptable and could not be set aside in totality or partiality through any other justifiable evaluations.

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