GOVERNMENT OF INDIA
HEALTH AND FAMILY WELFARE
LOK SABHA

UNSTARRED QUESTION NO:4683
ANSWERED ON:21.02.2014
HEALTHCARE SECTOR IN RURAL INDIA
Singh Shri Prabhunath

Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether healthcare is a major concern in the rural areas of the country;

(b) if so, the details thereof and the reasons therefor;

(c) the details of availability of healthcare infrastructure including manpower and affordability of facilities by the rural people;

(d) the details of steps taken to address the problems of rural health both at macro and micro levels and to improve the healthcare sector in rural areas of the country; and

(e) whether there is any proposal to revise National Health Policy and a longterm perspective plan to address prevailing inequalities in rural health sector and if so, the details thereof?

Answer

THE MINISTER OF HEATH AND FAMILY WELFARE (SHRI GHULAM NABI AZAD)

(a) to(b): Healthcare for all particularly for the rural areas has been a priority for the government. The health indicators like Infant Mortality Rate (IMR), Total Fertility Rate (TFR), nutritional status of children under 3 years including prevalence of anemia amongst them and pregnant women in rural area are considerably poor as compared to urban areas. The key health indicators are as under:

Indicator	Total	Rural	Urban
Total Fertility Rate (TFR) (SRS 2012)	2.4	2.6	1.8
Infant Mortality Rate (IMR) (SRS 2012)	44	48	29

Nutritional Status

Children aged 6-35 months who are anemic (NFHS 3)	78.9	80.9	72.2
Pregnant women aged 15-49years who are anemic (NFHS 3)	57.9	59.0	54.6

(c): A State/UT wise statement regarding the health facilities and human resource as per Rural Health Statistics Bulletin, 2012 is placed at Annexure I to XI.

(d): Public Health is a state subject. However, Central Government launched NRHM in 2005 to provide financial support to the States/UTs to strengthen their health systems particularly to cater to the healthcare needs of rural areas. Key steps taken to improve health care in rural areas include the following:

i. Support is provided to States/UTs under NRHM, to strengthen the health system including establishment/up-gradation/renovation of health infrastructure, engagement of Nurses, doctors and specialist on contractual basis based on the appraisal of requirements proposed by the States in their Programme Implementation Plans (PIP),

ii. Support under NRHM is also provided by way of additional incentives to serve in remote underserved areas, so that health professionals find it attractive to join public health facilities in such areas. In order to encourage the States to fill up existing vacancies in remote rural areas, the states are being incentivized to ensure rational deployment of health human resource. Manpower deployment is also to be put on the web in public domain,

iii. To increase the availability of doctors, several initiatives have been taken to rationalize the norms in medical education, such as, relaxation in land requirements, bed strength, increase in ceiling for maximum intake for undergraduates, enhancement of teacher-student ratio in Post Graduate Courses, etc., which has resulted in substantial increase in number of undergraduate and post graduate seats. Government has also approved setting up of ANM/GNM Schools in different States besides setting up of Institutes of Paramedical Sciences at National and regional levels,

iv. States/UTs are being impressed upon from time to time to make available improved health facilities including free essential medicines in all public health facilities. Accordingly, financial support is being provided for ensuring uninterrupted supply of free essential medicines in public health facilities based on the requirement proposed by the States in their PIPs.

An incentive of upto 5% of the NRHM outlay has also been introduced in 2012-13 for states for establishing policy framework and systems for providing free generic medicines to those who access public health facilities.

v. States/UTs are being provided support for focused attention and greater resources per capita to high priority districts with relatively poor composite health index.

vi. Financial assistance is provided to the States/UTs for selection and training of Accredited Social Health Activists (ASHA), who act as a link between community and healthcare facilities.

vii. States/UTs are supported with Mobile Medical Units for improved service delivery especially in hard to reach areas. There are over 2000 MMUs that are being supported under NRHM. Support is also provided for Emergency Referral Transport services to ensure in-interrupted referral services. There are over 20000 ambulances that are being supported under NRHM.

viii. States/UTs are assisted to constitute Village Health, Sanitation and Nutrition Committees so as to ensure community participation and village level planning and monitoring of health activities.

ix. New initiatives such as JananiShishuSurakshaKaryakram (JSSK), RashtriyaBalSwashthyaKaryrakram (RBSK), Rashtriya Kishore SwashthyaKaryakram (RKSK), 'National Health Mission Free Drugs Service Initiative' etc., have also been introduced to inter-alia make health care affordable by reducing out of pocket expenditure.

(e): Presently, there is no proposal to revise the existing National Health Policy (NHP) - 2002. The Twelfth Plan seeks to strengthen initiatives taken in the Eleventh Plan to expand the reach of health care and work towards the long term objective of establishing a system of Universal Health Coverage (UHC) in the country. This means that each individual would have assured access to a defined essential range of medicines and treatment at an affordable price, which should be entirely free for large percentage of the population. Inevitably, the list of assured services will have to be limited by budgetary constraints.

Further, to ensure equitable health care to bring about sharper improvements in health outcomes, at least 25% of all districts in each state have been identified as high priority districts based on a composite health index.

These also include all tribal and LWE affected districts which are below the State's average of composite health index. These districts would receive higher per capita funding, enhanced monitoring, focused supportive supervision and have differential planning norms. These measures would help reduce prevailing health inequalities in rural areas.