RHCP

RURAL HEALTH CARE PROVIDERS IN INDIA

(THE CONTEXT AND RELEVANCE, REGULATION AND RESEARCH)

(Learning & sharing meeting organised by Liver Foundation, West Bengal & Bristol Myers' Squibb Foundation)

Approach Paper

18th November, 2012, Kolkata

Executive Summary

Liver Foundation, West Bengal (LFWB) proposes to hold a one day brain storming workshop on "Rural Health care Providers in India – the context and relevance, regulation and research" on 18th November, 10 am to 4pm with support of Bristol- Myers Squibb Foundation (BMSF). The venue is the top floor conference hall of the Alipur Campus of Calcutta University. The meeting is planned to discuss issues such as relevance of this clan of providers in the existing and emerging rural health care paradigms in India based on available descriptive and analytical research on the subject , the ethics , need and the ways of regulation , system – integration of the providers and to network research workers from different centres for more impacting co ordinate action and planning .

This brainstorming and learning – sharing meeting has been felt necessary at a time when the provision of minimum curative care services of "acceptable" quality still intrigues the planners and organisers of rural health care in India – as it does in many developing countries where a large segment of the population lives in the economic fringes and are in social vulnerability. While trained health care human resources for every habitation is a coveted goal for meaningful human development, it is only prudent to recognise that the lifesaving and minimum curative care in vast rural areas of the country is provided by the untrained RHCPs whose mere presence in need make their "poor"/ doubtful quality care the "only" source for the rural poor. While not denying their harm potential, the strength and the weaknesses of the RHCPs need in depth analysis for planning rural health care delivery system in India. While there are several groups of workers in different parts of the country working individually /in groups – a sharing may be of mutual benefit and provide new ways of thinking and work plan.

Meeting Flow

10-10.10am: Welcome addresses Abhijit Chowdhury.

10-15 am- Chairpersons take over reins –Abhijit Vinayak Banerjee
Barun Kanjilal

Session 1- Views and Perceptions

10.20am to 10.30am: The pleasure, agony and Expectations of a Rural Health care provider- Sukumar Goswami.

10.30 am to 10.40am– The health-system perspective – Mr. Amarjeet Sinha

10.40 am to 10.50 am- The Academicians dilemma – Achin Chakraborty

10.50 am to 11.00 am– Media view points on the issue – Swati Bhattacharya

11.00 am to 11.10 am– Medical Professionals concerns– Sanjiv Mukherjee

11.10 am to 11.20am: A social activists viewpoints-cutting corners – Kumar Rana

11.20 am to 11.45 am- Tea Break and interactions

Session 2: Anecdotes and Evidence – RHCPS in PERSPECTIVE

11.45 am to 12noon - Meenakshi Gautham

12noon to 12.15 pm – Institute of Health management research

12.15 to 12.30 pm – Liver Foundation experience and engagements- Abhijit Chowdhury

12.30pm to 12.45 pm– Institute of development studies, Kolkata Research- Subrata Mukherjee

12.45 pm to 1pm – Bangladesh Experience– Sikdar Zakir

1.00pm to 1-15 pm – J Pal, IFMR work - Sharon Bernhardt

1 15 pm to 1.30pm – interactions

LUNCH: 1-30pm TO 2 PM

Session 3: ETHICS AND IMPACT

Should they be there at all - philosophy and realities put together?

2.00 pm to 2.15 pm		Anirban Chattopadhyay
2.15 pm to 2.30 pm	-	Krishnendu Mukhopadhyay
2.30 pm to 2.45 pm	-	Kabir Sheikh
2.45 pm to 3 pm		Arijita Dutta

Session 4: 3 pm to 4 30 pm (video and Round table Conference)

The Evidence and Implications-health care market and government planning

Gerry Bloom- Institute of Development studies, Sussex, UK

Jishnu Das- World Bank, New York, USA

Barun Kanjilal- IHMR, Jaipur

Abhijit Vinayak Banerjee – MIT and J Pal, Global

Phangisile Mtshali Manciya- BMSF, New York
(Perspective of Bristol Myers' Squibb Foundation)

5 pm: Vote of thanks

Abhijit Chowdhury (LFWB)

Brief Overview

RURAL HEALTH CARE PROVIDERS IN INDIA–THE CONTEXT AND RELEVANCE, REGULATION AND RESEARCH

Health care delivery system in India is in a transition and turmoil. Economic development and social prosperity has its health care counterpart – a technically savvy, globally challenging chain of "most modern" hospitals, privately financed and managed, that are shining as edifices of an India moving forward. Side by side, provision of minimum curative care services of "acceptable" quality still intrigues the planners and organisers of rural health care in India – as it does in many developing countries where large segments of the population lives in the economic fringes and are in social vulnerability. In general , Indian people have been increasing accessing private health care establishments with consequences of spiralling out of pocket expenditure for both outpatients (for quite some time now) and in hospital care (emerging trend) . While a sub optimally sensitive and responsive public sector gives way to an ambitiously expanding private health care market – there are significant divergence in the system priorities and brush ups in the rural and urban India. Urban India had been the seat of most of the abovementioned "forward" moves. On the other hand, despite an initial seven years of stint with national rural health mission, we are still striving hard to find ways and means to arrange lifesaving care to our villagers. The priority in rural health care even today is not "good or bad" care – the issue is existent care in whatever form or its' non existence . Just like the frequently found wide "know-do" gaps between declared competence and actual performance amongst health care workers – "ghost" and "dead -space" infrastructure and health care workforce epitomises rural health care delivery in the country.

Availability of trained health care human resources who deliver services when needed , at a cost that is affordable by the consumers , at a quality that is considered "safe", "adequate", "appropriate" and "effective" had been a perennial concern in rural health care . The philosophical direction of health care system in the country have also changed from a focus on provision of "primary health care" to "universal health care", which aims to address the emerging health care priorities, with a new set of approaches that include creation of trained health care personnel and larger presence of individual insurances – instead of a near total age-old dependence on only "government assurances". While all these are happening – an intriguing issue that the planners of the rural health care delivery system had been handling with a "strategic ambivalence" and "informed ignorance" are the rural health care providers (RHCP) of the informal sector.

The rural health care providers are **self-employed and entrepreneurial health workers** who have **not undergone any formal training** to do so. There is **no regulatory or registration system** in any country for them – although there had been some proposals at some time point. The primary driver of the supply- demand balance is unemployment and poverty as well as lack of availability of trained health care resources in periods of need for all human habitations. The RHCPs operate usually in small and geographically defined localities, in close geographical proximity to people that are their clients. Such localized operations are based on their rapport with the community. They have a flexible, often forgiving payment policy that can be deferred or put on a sliding scale based on the financial condition of the

client. Such an option for payment buttresses their position in the community and places them in a quassi-voluntary health worker role, increasing their acceptance and reliance of people on them. These untrained rural health care providers (RHCPs) present a critical niche segment in considerations of human resources of developing nations of South Asia, south East Asia and Sub Saharan Africa. The RHCPs function in the rural private health care market in a freestyle manner, **unregulated** but "called for" by their clients. **Their primary strength is their number and the dependence of their consumers on them.** The concern arise from the fact that people use their service more frequently than what a "modern", forward looking, quality conscientious health care system would like to visualize. *They form a linkage between culture, craftsmanship and "modern" medicine, form a bridge between necessity, availability, access and are relics of the age old ethos of medical service delivery i.e. be by the side of the an ailing person with whatever means and knowledge you have, while they earn their livelihood based on this relationship and related service provisions* .

Estimates of the number of informal providers' nation-wide vary widely from 500,000 (based on surveys in Andhra Pradesh and Utter Pradesh) to 1.27 million assuming that that each village has on average two such informal providers. A survey indicated that each see between 20-50 patients per day for which they would receive anywhere between Rs10- 50 per consultation, depending on the ailment and the state. Higher consultation fees are charged in richer states. Despite their lack of knowledge and frequent involvement in potentially harmful practices they continue to hold the public's trust and earn a comfortable living from consultation fees and commissions for referrals to local private hospitals.

SOME PROPOSALS FOR DEALING WITH RHCPS

Thoughts and plans about RHCPs have mostly been academic. The government had not been able to engage with this category of health workers existing outside the boundaries of mainstream – in view of the sensitivity of the issue – primarily arising from an unexplained "intolerance" of the medical professional establishments. The following are some of the available suggestions:

1. **Mainstream some RMPs:**

Some stakeholders have suggested that some informal providers could be mainstreamed and trained as general health workers. The average PHC covers around 30-35 villages and would therefore be likely to include an area in which up to 80 informal providers are operating. They could be brought under the control and supervision of a qualified doctor at the PHC. Although this idea seems appealing at first, it might prove unworkable in practice. Firstly, qualified doctors at the PHC are not effectively supervising the PHC staff much less a large number of unqualified practitioners in remote rural areas. An improvement in PHC operations have to take place before this option could become a reality. Secondly as many RMPs are well paid making between Rs. 5-10,000 per month in consultations and reportedly several times that amount in referral commissions, they would be unwilling to be mainstreamed if it resulted in a reduction in their incomes.

2. Training and Accreditation:

A brief review of the operations of the RHCPs illustrates that the vast majority are unqualified to practice allopathy. In giving injections and/or prescribing medicines to almost all their patients they are potentially exposing themselves and their patients to HIV/AIDS and other diseases. Research has shown that those that are provided with an intensive package of support including INFECTOM and observed case studies dramatically improve the quality of the care they provide to sick children. Government could consider offering advice, information and possibly accreditation to the RMPs. This will ensure that they have the required information to offer safe injections and hopefully will move some way to replacing irrational treatments with evidence based medicine. Some RHCPs currently pay for and attend training. If trained RHCPs could charge higher prices or attract more clients there would be a greater incentive for them to attend training. However, this would require (i) training to be accompanied with some recognized form of certification or accreditation (which would help users' select better quality care), (ii) government oversight of the training course material and provision and (iii) public demand for accredited providers, which could be stimulated through education and awareness campaigns.

3. Public Health Education Campaigns there is a huge need for government to acquire better knowledge for patients and their health care providers. In addition to training RHCPs, a public health education campaign would play a useful role in health care delivery. A health awareness campaign could cover the potential hazards of visiting RHCPs as well as general information on illnesses that the rural poor are likely to experience and their successful treatments. Such a program, if successful, could create a demand for improved needle protocols and reduced use of drips, steroids and antibiotics etc. Community mobilization and public education components could easily be built into PHC contracting out arrangements and indeed have been an integral part of the successful pilots in Andhra Pradesh.

4. Social Franchising: Franchising is traditionally used in the private sector to expand outreach of a certain product, and capture economies of scale whilst also ensuring a high product quality. These characteristics make it particularly suitable for improving access to health care especially health care that can be packaged as a product. Involving RHCPs in a franchise scheme has a number of advantages. It can train the RHCPs to provide useful services such as family planning products and advice. It can build on an existing grass roots network that is already well established and respected in rural areas. The Janani experience in India illustrates that outreach through an RMP franchise scheme can be rapid and effective. However, the current model also illustrates that such a program faces greater difficulties in trying to reduce the inappropriate responses of RHCPs. Government's role in such a scheme could be to support the public good elements such as an awareness campaign or through a subsidy to the franchisors.

LIVER FOUNDATION, WEST BENGAL (LFWB) ENDEVOR and ENGAGEMENTS IN RHCP RESEARCH

Supported by Bristol Myers' Squibb Foundation (BMSF) and NRHM, department of health and family welfare, government of West Bengal **– LFWB**- had been engaged in a capacity

building intervention involving some selected RHCPs in Birbhum, Purulia, Nadia and Sundarban areas of West Bengal. This had been a structured program where the RHCPs are taught through classroom and demonstration classes – focussing on **WHAT NOT TO DO and WHAT TO DO** to save lives, improve referrals to mainstream system in time and also to use them for public health campaigns**. One of the driving intents of the program also had been to convert a group of self proclaimed doctors into a clan of enriched health care workers.** The intervention has undergone an impact assessment that indicates some learning's – which we are going to use for our subsequent modification of the program as we move on. Another research with J-PAL Asia in the context of the intervention is underway in Birbhum.

THE PREMISES AND ISSUES FOR DISCUSSION IN THE MEETING

In an issue that has such wide social relevance, it is important that a dispassionate and reasoned analysis of the situation is done for futuristic planning. LFWB, supported by BMSF, is also planning to undertake a country wide networked research on the issue in a more focussed manner. The **brainstorming session** is planned to guide everybody on the issue. The primary objectives are-

1. To share experiences on RHCP research–descriptive and analytical – from different research groups and individual thinkers.

2. To discuss and dissect issues such as relevance, ethics, regulation, integration or decapitation of RHCPs- based on knowledge, understanding and wisdom from an academic and view point of planning effective, safe and available rural health care.

3. To plan the rationale and the course of future action and research- analytical and operational – involving RHCPs.

LIST OF PARTICIPANTS

1. **Abhijit Vinayak Banerjee** - Professor of Economics, MIT & Director , Abdul Latif Jameel Poverty Action Lab (J PAL)
2. **Barun Kanjilal-** Professor of Health Economics and Dean Institute of Health Management Research (IHMR), Jaipur, India
3. **Gerry Bloom** – Research Fellow, Institute of Development Studies, UK
4. **Jishnu Das –** Senior Economist, Development Research Group. World Bank
5. **Kabir Sheikh**- Research Scientist and Head , Health Governance Hub, Public Health Foundation , India
6. **Amarjeet Sinha-** Principal Secretary , Government of Bihar
7. **Anirban Chattopadhyay**- Editor, Ananda Bazar Patrika
8. **Meenakshi Gautham -** Country Co Ordinator, IDEAS, New Delhi.
9. **Zakir Sikdar** – Telemedicine Reference Centre , Bangladesh
10. **Pradeep Malhotra**- Consultant, Department of Health and Family Welfare, West Bengal.
11. **Achin Chakraborty-** Professor , Development Economics , Institute of Development Studies ,Kolkata
12. **Dilip Ghosh –** Advisor, Pratichi Institute, Kolkata**.**
13. **Kumar Rana-** Project Director, Pratichi Institute, Kolkata**.**
14. **Subrata Mukherjee-** Assistant Professor , - Institute of Development Studies, Kolkata
15. **Saswata Ghosh-** Assistant Professor , Institute of Development Studies ,Kolkata
16. **Arijita Datta**- Professor ,Department of Economics , University of Calcutta
17. **Swati Bhattacharya-** Chief Reporter , Ananda Bazar Patrika
18. **Sanjiv Mukherjee-** physician , Kolkata
19. **Sharon Bernhardt- Assistant** Professor, Economics. IFMR , Chennai and J – Pal , South Asia
20. **Urmi Bhattacharya-** Research Associate , J – Pal , South Asia

21. **Krishnendu Mukherjee**- Physician

22. Anupam Bhattacharya- Liver FOUNDATION, West Bengal

23. Sudip Barua- Liver FOUNDATION, West Bengal

24. **Saibal Majumdar**- Liver FOUNDATION, West Bengal

25. **Kajal Chatterjee** - Liver FOUNDATION, West Bengal

26. **Nayan Mukherjee** - Liver FOUNDATION, West Bengal

27. **Fuad Halim-**Physician, Kolkata Swasthya Sankalp

28. Nirmal Saha - Liver FOUNDATION, West Bengal

29. **Sukumar Goswami**- Rural Health care Provider, Kalyani - Liver Foundation, West Bengal trainee.

30. Dhiren Chatterjee- Rural Health Care Provider , Birbhum

31. Asokananda Konar - Liver Foundation ,West Bengal

32. **Amal Santra-** Liver Foundation , West Bengal

33. Abhijit Chowdhury- Liver Foundation, West Bengal

34. Partha Sarathi Mukherjee - Liver Foundation, West Bengal

35 .Phangisile Mtshali Manciya- Director, Bristol Myers' Squibb Foundation