

Health Systems Strengthening for Manipur, India: A Critical Examination of Gaps and Contradictions

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Abstract: Fifteen years later, grounded evidence from Manipur, a state in the North-east region of India, indicates that infrastructure and human resources continue to languish and the state has one of the highest out of pocket expenditures in the country, fuelled by inter-state medical tourism. Even as these weaknesses remain entrenched, the state is now gearing up for medical tourism from Myanmar and neighbouring states from the region. **Background:** The National Health Mission (NHM) was intended to strengthen health systems, making it more responsive to the needs of rural and urban communities in India. **Material and Methods:** The secondary sources that were reviewed include data sources such as the National Sample Survey and newspaper archives to capture both quantitative data and local contexts. Primary data was collected using in-depth and semi-structured interviews to examine the utilisation of services amongst the users and providers of two districts viz. Churachandpur and Thoubal. **Results:** Considerable deficits in human resources and infrastructure even after one-and-a-half decades of the NHM are noted in the state of Manipur. Geographic challenges accentuate these inequities. **Conclusion:** Newer policy initiatives such as medical tourism expose the contradictions.

Keywords: Public Facilities, NHM, Healthcare, Health Disparities, Health Outcome

1. Background

The *Imphal Free Press* reported on 31st January 2023 that civil society organisations in Tamenglong shut down the district hospital in protest against acute shortage of doctors in the hospital. This hospital is amongst one of the oldest public hospitals in the state, serving an estimated 2 lakhs population. It reported massive shortages of specialists, paramedics, technicians and hospital administrators. The posts of District Malaria Officer and District AIDS Officer were also vacant; this is of particular concern as the country seeks to eliminate malaria by 2030 and Manipur is a top priority for the HIV/AIDS programme. Reports of disruptions of the state health services have become a regular feature in the local newspapers of Manipur, a small state in the North-East region (NER) of India. This raises a red flag that is a harbinger of structural and functional inadequacies that Manipur continues to experience after nearly three decades of health sector reforms in India including one-and-a-half decades of the National Rural Health Mission (NRHM)/ National Health Mission (NHM).

The 75th round of the National Sample Survey (NSS) reported that in Manipur 79.7% of hospitalised cases are treated in government facilities (NSS 2019), underscoring the primacy of the state as the principal provider of health services. Public facilities were accessed by 82% of rural and 83% of urban population for any spells of ailments.

The robustness and experience of a state health system is marked by its responsiveness. Responsive health systems are powered to anticipate and adapt to current health needs and respond to future shifts and demands; these translate to better health outcomes for the population that they serve. It is the lived experience of people's interaction with their health services that reinforces their initial expectations of needs being fulfilled. Experiences of interactions are outcomes of interaction between the beneficiary side and the provider side (Mirzoev and Kane 2017).

The risk of poor health outcomes and health disparities are accentuated by barriers that prevent or limit access to needed health care services (U.S. Department of Health and Human Services 2003). Social determinants of health comprise of non-medical determinants that influence health outcomes including contextual set of forces and systems that shape the conditions of daily life (WHO 2008). Two of these determinants, particularly relevant in the context of Manipur, are structural conflict and access to affordable health services of decent quality.

Drawing upon empirical evidence, this paper is a critical examination of the gaps and contradictions the health system and service delivery in Manipur. These assume relevance in the backdrop of the investments and inputs of the National Health Mission and the milestone of achieving Universal Health Coverage (UHC) by 2030. It needs to be reminded that Manipur is one of the four north-eastern high-focus states in the country of the NHM.

2. Material and Methods

The paper draws upon the doctoral research of the author. The paper unpacks some of critical determinants that continue to ail the public healthcare delivery system of the state. The secondary sources include government reports, documents, journals and articles. The news achieves were used as primary source 'to fill in gaps' as it complements or supplements on the 'information gap' on topics which are not widely researched and archival materials are consequently scanty (Allen and Siczekiewicz 2010). Secondary data such as the National Sample Survey (NSS) and National Family Health Survey (NFHS) were reviewed.

Primary data was collected using in-depth and semi-structured interviews to examine the utilisation of services amongst the users and providers of two district hospitals viz. Churachandpur and Thoubal in the state of Manipur, India. 09 Providers and 22 users of the hospital were interviewed Thoubal and 07 providers and 27 users in Churachandpur.

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The two hospitals were selected in order to include one hospital from the hill district viz. Churachandpur and another from the valley district i.e., Thoubal. The representation of a hill and valley hospital was done to understand and contrast the availability of health infrastructure on access and service utilisation. Additionally, to get insights on ethnic diversities, Churachandpur a Kuki (*Hmar and Paite*) dominated district and Thoubal a *Meitei* dominated district were studied.

3. Results

Has NHM Strengthened the Architecture of Primary Healthcare?

The 30th World Health Assembly resolved the “attainment by all citizens of the world by the year 2000 A.D. of a level of health that will permit them to lead a socially and economically productive life” through the primary health care approach (Singh and Singh 2004). Subsequently, the Astana Declaration 2018 reaffirmed the global commitment to primary health care in achieving universal health coverage and the Sustainable Development Goals (WHO 2019). The National Health (NHM) is committed to health systems strengthening in achieving these goals by strengthening primary healthcare.

Public health services are delivered in Manipur through the State Health Administrative Department and implemented by the Directorate of Health Services, which includes the National Health Mission (NHM) (Directorate of Economic and Statistics, Govt. of Manipur, 2017). These comprise of 2 tertiary level hospitals, 7 District Hospitals (DHs), 17 Community Health Centre (CHCs), 85 Primary Health Centres (PHCs) and 421 Sub Centres (SCs). Shortfalls in SCs worsened from 17% in 2015 to 23% in 2020 and from 15% to 19% for CHC level. The shortage of beds ranged from 24% in the State General Hospital to 34% in the DH and 28% in the CHCs in 2015.

Against the WHO’s recommendation of one doctor per 1000 population, the situation is distressing as there are only about 1400 doctors for approximately 30 lakhs population of the state when roughly 3000 doctors are needed (The Sangai Express 2023). The shortfall in the workforce is exemplified by the sanctioned posts of staff nurses being about 50% less than the requirement – 679 instead of 1412, and 562 being in actual position; the implication: only 40% nurses are available against the requirement by population level norms. Similarly, for specialist doctors, 50% of the posts are sanctioned and 38% posts are filled up against the population requirement.

The High Court of Manipur took note of the acute shortage of staff and disproportionate distribution of staff. It further asked the state government to fill the vacant posts; else, the purpose of establishing hospitals would be meaningless and the state shall be held liable (The Frontier Manipur 2021).

Delay in Construction of Health Facilities

The development of health infrastructure is not only deficient but slow as timely construction and building of infrastructure is interfered with and hindered. The factors include poor and untimely disbursement of funds and

monetary demands from various insurgency outfits. There are 33 insurgent groups in Manipur operating in both hills and valley districts. Many are involved in extortion, kidnapping and even killing when their demands are not met. Money is extorted through a wide range of networks from businessmen, commercial establishment, contractors, health centres and civilians. The contractors and builders who are involved in constructing health facilities are required to pay 15 to 20% of the project costs. Considerable time gap in the completion of sanctioned facilities and functioning of facilities contribute to the detrimental health outcomes. For example, the State TB and Leprosy Hospital was sanctioned in 2010 and was officially inaugurated in 2018 when the project deadline was in 2012. The delay was due to non-release of the requisite funds from the state government. A retired health official who did not want to be named shared that,

‘...they will ask you to give the money as if we owe them. It’s our hard-earned money. They asked for some percentage cut. If we comply also, our jobs get into trouble and if we don’t, our lives are at stake. The money sanctioned is not to be given to them but it’s for the health of the people’. IDI_State official

Inadequacy and unavailability of equipment

Inadequate facilities and lack of availability of critical medical equipment hinder service delivery, particularly for women and children – major beneficiaries of state-provided health services. PHC Komlathabi, a fully functioning 24x7 PHC in Chandel district reportedly lacked oxygen or ambulance facilities (The Sangai Express 2018).

In peripheral facilities, underutilisation of equipment and facilities were reported due to the absence of dedicated staff. Maintenance of existing medical equipment is an issue in such facilities. A news article reported Shri L. Jayantakumar Singh, Minister of Health & Family Welfare of the state expressed his concern on the under-utilisation of expensive medical equipment and machines in the DH, Senapati (IFP 2017).

‘Even though we have an OT in our hospital we don’t do any surgery. We refer them to Imphal. We are only two of us at present in the surgery ward. I just joined recently. We have not started taking up surgery cases as we need other support system as well.’ IDI_Doctor_Thoubal

Geographic Inequities: The Hills-Valley Divide Continues

Healthcare systems require and involve a complex process for allocation and division of the total resources into various sub-parts that include budget, physical buildings, human resources and equipment. The allocations are done to various administrative levels, geographical regions, target population and the institutions (Knox 1978). In India, health facilities are allocated on the basis of population and geographic norms. Geographically, Manipur is composed of two sets of landmasses, the hills and the valley. The hills are predominantly inhabited by the tribals and the valley by the *Meiteis*, a community with significant socio-economic and political dominance. Unlike conventional spatial health disparities in terms of rural-urban divide, the divide in

Manipur is between the hills and valley (Mishra et al 2021). The valleys have more concentration of health infrastructure both in public and private facilities, particularly in and around the state capital Imphal. In the hills, there are 232 SCs, 44 PHCs and 6 CHCs in place against the required 279 SCs, 41 PHCs and 10 CHCs (MoHFW 2022). This implies a shortfall of 17% of the required SCs and 40% of the required CHCs in the tribal areas. The only two tertiary health facilities, Regional Institute of Medical Sciences (RIMS) and Jawaharlal Nehru Institute of Medical Sciences (JNIMS) are located in Imphal. 11 of the 17 CHCs, about two-thirds, are located in the valley. The shortage pushed the people in the hills to utilize facilities at the higher levels and these facilities are mostly in the valley and are not easily accessible.

The Irony of Medical Tourism

The state government is eager to leverage India's Act East Policy and has committed itself to transform the state into a healthcare and medical tourism hub. The state government has initiated talks with the union government to provide visa-on-arrival for medical tourists from Myanmar.

This is even as an ever-increasing numbers of people from Manipur are accessing for secondary and tertiary care from outside the state. The preferred destinations are Guwahati, Chennai, Delhi, Mumbai, Vellore and Chandigarh. Guwahati is emerging strongly as hub of healthcare services for people in the state due to similarity in culture and geographical proximity. With improved connectivity facilitated by low-cost airlines made the phenomena of inter-state medical tourism on the rise.

'People who can afford to seek treatment in other states like Delhi, Mumbai will proceed...it is poor people who suffer. Worst case scenario, people have to sell property or borrow money from others to go outside (state/district) for treatment' IDI_KI

'If the doctors here cannot handle the patients, we also tell them to go to Guwahati..' IDI_KI
...the doctor told us to go to Guwahati as things cannot be handled in Manipur. We went there and consulted the doctors there. It didn't take much time. We stayed for a week and so...IDI_Thoubal

Distorted Referral Systems

The barriers and enablers of referral systems have a bearing on both the functionality of health services as well as beneficiary perceptions of care. Specialised and referral services are provided at facilities that are located at the district headquarters or Imphal. The facilities till the district level are fairly good and functions adequately. The challenges start with the facilities from CHC and below. The CHCs are the first referral unit and are supposed to provides comprehensive obstetric care services, emergency care of sick children, to name a few. However, health facilities below the CHCs level have shortages of beds, human resources and infrastructure in the state. Out of the 17 CHCs in the state, 15 CHCs are without all four specialist doctors, 12 CHCs are without functional operating theatres (O.T.) and 11 CHCs are without functional labour room, stabilization unit for new born and new born care corner.

Out of the 72 24X7 PHCs, 66 PHCs are without functional O.T. (RHS 2022). In the absence and lack of specialised care, the only option left is to refer to the upward level facilities.

'...It is more convenient and economical for us to go to District hospital (Thoubal) rather than going to Imphal if it is not very serious. But when the medicines and test are not available, they tell us to go and get it from Imphal' IDI_Thoubal

Of the 85 PHCs in Manipur 12 are without any referral transport facilities. Any patient who needs referral at upward level facilities has to use public transport or hire private vehicles. Read with the fact that 27.3 % of SCs in 2015 and 3.5 % of PHCs in 2022 are situated at locations without all-weather motorable approach road (RHS 2022). The consequences for out-of-pocket expenditure on this account are easily gauged. Under such conditions, the chances of patients either going for self-referral directly to upward level facilities and being referred to upward facilities than relying on the primary services in their respective block/village.

High Out of Pocket Expenditure

The financial brunt for seeking treatment and care is incurred from household income and savings 97.9 % both in rural and urban areas, and the rest from borrowing, selling assets and taking loans. The average out-of-pocket (OOPE) expenditure in the government facilities for institutional childbirth is the highest in the country, Rs. 6,452. The OOPE for IPD per hospitalisation is 7th highest in the country for both rural and urban areas, amounting to Rs. 5912 and Rs. 8712 respectively (NSS 2019).

The non-medical share of financial expenditure per treated spell of ailment is estimated at Rs. 824 in rural and Rs. 214 in urban areas. The state does not have any rail facilities and inter-district public bus services are limited. In case of non-availability of public transport and ambulance, the cost of hiring a private vehicle from any district town to the state capital range from Rs 3000 to Rs 5000. The lack of social support and expenses deter many patients, particularly from the hill districts, from seeking care at the higher-level facilities.

One medical officer shared that the cost of referral to RIMS or Imphal is very high for the hill communities.

'Some of them have to manage their own vehicle when the hospital ambulance are not available...It is the poor and the patient party that ultimately bear the brunt. IDI_Churachandpur

Absenteeism and Substitution Culture: A Double Whammy

Considering the already limited numbers and inequitable distribution of health workers in the state, absenteeism and lack motivation among the staff causes disruption of health care service delivery. It is reported more among health providers posted in far-flung areas and are from the non-concomitant ethnic community of the posting place. A regular feature in the local news items corroborates this: 'Bishnupur Hospital Locked Over Absence of Doctors' (IFP,

2016); or, 'Jessami PHC rendered worthless as deputed doctor hardly attends' (Hueiyen News Service 2014).

The demographic distribution in terms of ethnic variation gives a mixed picture in the state. Some blocks and districts are usually inhabited in majority by a certain ethnic community. Issues of mutual inter-ethnic mistrust come into play strongly as health workers are reluctant to be posted in areas where his or her ethnic brethren are not in majority. This is coupled with the fact that such facilities have poor infrastructural support for the health workers to carry out their services. Non-availability of infrastructural support is more in health facilities located in the hill districts. In a news article covered in the local media, the village chairman shared '*... (doctors) persistent absence in the centre has compelled the villagers to concede that the primary health centre no more exists*' As also shared by one of the managerial level health personnel,

'...doctors who are posted in the PHC and CHC are all the time in Imphal. When do they go to the posting place is the question. The young people are very ambitious. They want to sit in Imphal and prepare for PG and other exams...they lack dedication'. IDI_Churachandpur

Absenteeism is more among women, especially doctors at PHC and CHC levels and ANMs at the SCs. Along with absenteeism, the inter-ethnic mistrust due to the protracted nature of ethnic conflict in the state leads to another layer of complexity in service provisioning in difficult geographies. As shared by one of the health officials,

'Some of the nurses are from another ethnic group. The nurse (Meitei) had to carry immunization in a remote (tribal) village where they had to hold a night if needed. She was not comfortable. What do I do? Security is also a concern. In such a situation how do I force the nurses to be regular in their duty station? The infrastructure problem is also a major setback.' IDI_Churachandpur

Causing further stress to the already strained health system is the 'substitution-culture' amongst ANM and staff nurses posted in remote locations. Under this culture, a nurse that is supposed to provide service in the SCs/PHCs employs a nurse available locally by giving a paltry sum per month. Usually, the amount for substitution varies from Rs. 7000-9000 but with some weekly/monthly visits as per the arrangement. This compromises the quality of services provided as substitute nurses may lack required skill sets or are not performing her assigned task competently. The arrangement is seen mostly amongst the workforces who are from other ethnic communities posted in their non-concomitant community areas and peripheral facilities. According to an official, who did not want to be named,

'...in our tribal areas, you will find many Meitei sisters (nurses) substituted by our tribal sisters. It is a good arrangement as they also get to earn some amount. But it is against the rule, no doubt.' IDI_Churachandpur

Threats and Harassment Faced by Health Professionals

The protracted conflict in the state has taken an enormous toll on the well-being of the workforce. A sizeable number of health workers experience threats and witnessed it

amongst their friends and colleagues. Threats and violence perpetrated are not limited to workplaces but extends towards their personal residences as well, increasing the risk amongst the family members. Some of them are attacked physically and are under constant mental threats.

Exemption to medical facilities and personnel during civil and political unrest are usually given. However, the erratic behaviour of civilian supporters on days of bandhs discouraged the providers to move around for performing their duties.

Sometimes, they (bandh supporters) used foul languages and talk very rudely with us. We also know that there's a bandh. But then we have to go to the hospital. It's a pain since I am from Keishamthong (Imphal). IDI_Thoubal_M.O

Socio-Political Disruptions

In Manipur dissent of any form, social, political or civil, no matter how mundane or crucial are expressed through bandhs, boycotts, shutdowns and blockades. The increasing incidence of aggressive protest and dissent shifting from 'a few' to 'the masses' have caused innumerable destruction of institutions and public services. Public health care is worst hit in terms of availability of providers, suspension of services and, sometimes, compromise in the quality of health care provided. This is true for cases admitted in the facilities or patients coming to avail the OPD services in public facilities. Under such situation, emergency cases are referred directly to private clinics and hospitals. The routine OPD services are provided at the residence of the consulting doctor, a preferred alternative and trend in the state. A patient shared his experience

'I prefer to see the doctor on the day of the bandh as the doctor is available at his residence whole day' IDI_Thoubal

Disruptions are mostly localised, affecting the capital city or the district headquarters, or the crucial national highways in the state namely NH-2 (Imphal-Dimapur) and 37- (Imphal-Jiribam, Assam).

The hills are hardly affected during the bandhs. Most of the facilities are in the valley. We have to pass through the areas where we will have to confront the bandh supporters. They will throw stones and sometimes they will stop us. We also do not want to move around but it is our need to go there (valley area)' IDI_Churachandpur

4. Conclusion

The NHM envisages achievement of "universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs" (NHP 2017). The NHM is also committed to reducing existing disease burden and ensuring financial protection for households (MoHFW 2017). To achieve these goals, among other things, the NHM is required to implement integrated facility development planning which would include infrastructure and human resources. It is evident that significant gaps continue to be there for this high-focus state.

In order to achieve Sustainable Development Goals (SDG) India is committed to Universal Health Care (UHC) for all by 2030. UHC entails ensuring all people have access to quality health services and ensure financial protection (NITI Ayog). As the NSS data amply demonstrated this continues to be a daunting task. The fact that institutional childbirth is the highest in the country is a matter of particular concern since maternal and child health is a key focus area of the NHM. In specific, the National Health Policy (NHP) 2017 is committed to assuring availability of free, comprehensive primary health care services for (among other things) reproductive, maternal and child health (NHP 2017).

Even as these glaring inequities continue, Manipur's policy tilt towards medical tourism is a matter of grave concern as it is likely to further deplete quality human resource from the public system. The state makes a commitment for UHC as it is "key to the achievement of all the other targets and the development of strong resilient health systems" (Government of Manipur 2019). The WHO's Commission on Social Determinants of Health makes health equity a social justice imperative (WHO 2008). As has been demonstrated, the gaps and contradictions shall continue to haunt Manipur in its journey towards achieving SDGs, unless both central and state governments shift gears and accelerates the journey.

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