every alternate day rather than expecting the patients to visit the health facility. Other innovations include involvement of 'all relevant health-care providers' through public-public mix approaches, involvement of non-governmental organizations and community based volunteers.

Systemic Changes Needed

Together, intra-state rural and inter-state urban migrants form a very large proportion of the population today. Despite difficulties in establishing their credentials, becoming familiar with new health personnel, and transferring their health records, rural intra-state migrants have the possibility to access existing rural health systems.

Urban migrants pose particular problems and require a different treatment. The urban migrant struggles to decipher the urban landscape, cope with local biases and stigma, and develop the negotiating skills to access health services. These migrants most often live in the most underserved areas of the cities and towns. They usually work in the unorganized sectors of the economy and as such are not privy to the benefits that systems such as the Employees State Insurance Scheme provide.

Not only are they poor, but they also rely on ill-trained, expensive private practitioners for their health care needs. Co-optation of private practitioners, who are the first point of contact in a majority of patients, is essential. Incentives for their time may need to be considered in order to have their sustainable involvement for a successful program.

Enforcement of labor laws and ensuring safe working conditions with necessary healthcare to the migrant worker by the employers need to be pursued. Best practices already existing in the system and internationally can be utilized to inform the programs and new efforts.

With women forming the larger proportion of migrant populations, portability of health records in programs such as the Reproductive and Child Health Services acquire a particular salience. Health workers have been found to be very useful to bring people and services closer. In contrast with the rural areas, urban areas sorely lack this resource which adversely affects the reach of health services to the migrant. Standardization of health services across rural and urban areas alike generates familiarity and could encourage better utilization of services.

The Revised National TB Control Program has also provided for the possibility of transferring patient records between locations, but is struggling to implement this in a systematic way. Use of a smart card or an identification card along with technologically supported monitoring mechanisms can be greatly useful. Initiatives and social schemes like the Rashtriya Swastha Bima Yojana and the National AIDS Control Program have demonstrated the feasibility and success of using new technology to make portability of services possible.

For public health systems to embrace migrant health within their agenda appears to be both an urgent necessity and a responsibility.

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The Research Group Working Paper 10 Dec 2012

Nation on the Move

The Health of Migrant Populations

Public Delivery Systems

India's long tradition of public provision of health has its beginnings in the pre-Independence era. The public health system is rooted in a powerful influence - the Health Survey and Development Committee, set up in 1943 and commonly referred to as the Bhore Committee after its chairperson Sir Joseph Bhore. The Committee submitted its report in 1946. So comprehensive were its recommendations, that the post-independence National Planning Committee endorsed and recommended the report of the Bhore Committee as the blueprint for India's public health system. The report of the Bhore Committee detailed the condition of health of the time - infectious diseases such as malaria, smallpox, plague and cholera were rampant, life expectancy was less than 30 years, and maternal mortality was over 2000 per 100,000 live-births. The Committee was aware that populations were overwhelmingly agrarian, tied to the land and difficult to reach. Accordingly, its recommendations were based around the creation of a geographically organized public health system which would be designed to deliver services at the doorsteps of the people. The report noted that both public and private systems exist side by side. Indeed, India has a large and thriving private sector which has continued to grow after Independence; not only in the then traditional fields of Ayurveda, Unani, Siddha and Homeopathy, but also in Allopathy as doctors trained in the modern medicine began to become available to the Indian population.

Development has led to a changing demography and pattern of livelihoods. In the years following Independence, exploding populations and burgeoning urbanization gave rise to internal migration in search for livelihood and better living conditions. The reality of high rates of joblessness, poverty, low wages, and diminishing landholdings in rural areas were in sharp contrast to the attractive images of urban areas. Rural migrants arrived in urban centers in search of jobs, housing, education and health care. In the process, migration has reached numbers that ought not to be ignored and have acquired an importance because of its impact on socio-economic conditions.

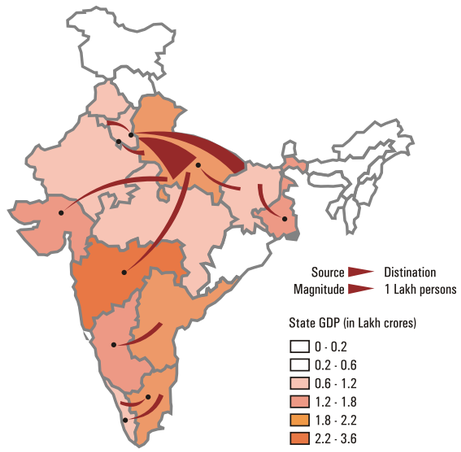
Yet various committees instated by the Government of India such as those led by Mudaliar, Kartar Singh, Jungalwalla, Bajaj etc. continued to assume a static situation of the population while providing recommendations to fine-tune the public health system. The National Health Policy of 2002 noted that migration is growing, but made no effort to define a system that responds to the needs of this growing segment of India's population. The report by the National Commission on Macroeconomics and Health (2008) also does not address migration - a major issue being thrown up by the changing socio-economic climate. But the sheer scale at which migration occurs has made it a public health problem that poses a significant challenge to India's public health systems.

Migration in India

A staggering third of the total population of the country or 309 million persons were classified as migrants in the 2001 census, which is the most recent published data on migration in India. In the decade 1991-2001, the growth in the number of migrants in India was 32.9%, compared to the rate of growth of the population of 21.5%. In 2008, a World Health Organization report noted that forces such as profound disparities, skill shortages, economic and demographic imbalances, and economic and political crises make migration omnipresent; and it has been projected by the United Nations that if

urbanization continues at the present rate in India, then 46% of the total population will reside in urban areas by 2030.

Migration in India 2001-2011



Source: http://www.iihs.co.in/wp-content/themes/education/resources/Migration.pdf

Intra-state migration takes place mostly from one rural area to another, while inter-state migrants usually move from rural to urban areas. Cities such as Delhi, Maharashtra, Kolkata, Chennai and Hyderabad are the most favored destinations of migrants. A considerable proportion of poor urban settlements are occupied by migrants as contract laborers, workers, small business traders, domestic workers (women) etc. Interestingly, female migration is of a higher magnitude than the male migration, and much of this in both rural and urban areas is for marriage. A large proportion of the Indian migrant workforce such as truckers and contract laborers come from families that have limited or no education, constrained economic resources and inferior political and social status. The poor migrant who moves to an urban area in the lure of a better life often finds himself in squalid living conditions in overcrowded settlements, unsanitary environments, and poor or no access to health services. Although their contribution to the economy is large, they remain neglected.

Health Access of the Migrant

The sheer numbers of migrants and the wide differences in their origins challenges public health systems. Diversity in social backgrounds, language and culture create barriers to access of health services in unfamiliar settings. Migrants are often invisible to health systems, forcing them to delay health seeking till the condition mandates emergency attention. State health systems in rural areas are not geared to deal with migrants and exclude them as they are seen to be an added burden. Excuses such as 'they are the ones who bring disease' are commonplace.

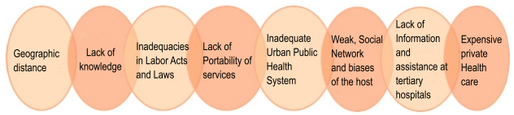
For the migrant to urban centers, this is only made worse by a lack of economic resources, weak social networks and lack of information.

> "In most urban areas, public health services are very meager. To the extent that such services exist, there is no uniform organizational structure. The urban population in the country is presently as high as 30 per cent and is likely to go up to around 33 per cent by 2010. The bulk of the increase is likely to take place through migration, resulting in slums without any infrastructure support. Even the meagre public health services which are available do not percolate to such unplanned habitations, forcing people to avail of private health care through out-of-pocket expenditure". GOI, National Health Policy- 2002.

Some recognition of the needs of migrants is evident in the framing of Labor Acts notably the Inter-State Migrant Workmen Act 1979. The Act makes provisions for some medical facilities for workers, free of charge. Others such as the Contract Labor (Regulation and Abolition) Act, 1970 mention the provision of first-aid facility, but make absolutely no reference to facilities for major health conditions. Yet many employers hire migrants in unregulated and informal ways to remain exempt from providing any health care facilities to the migrants. The Acts are in place; however their enforcement is weak because of the low ratio of enforcement officers to the industrial establishment. This situation has been reflected in the report of The Working Group on 'Labor Laws & Other Regulations' for the Twelfth Five Year Plan (2012-17). It elucidates the views of State Governments that there is no adequate law governing the migrant laborers and it also underscores the need for revising 'The Inter-State Migrant Workmen Act 1979' to make it implementable.

Nevertheless, health conditions requiring long term treatment have brought internal migration sharply into focus in public health care provisioning. Programs such as the National AIDS Control Program

Issues faced by Migrants in Accessing Health Care



are directed precisely to migrants who constitute a major risk group for contracting HIV infection. The Revised National Tuberculosis Control Program makes room to accommodate treatment defaulters and transfer of drug boxes; but still faces the problem of tracking patients when they move. Other health programs such as the Reproductive and Child Health Program lack a dedicated plan and resources that specifically address the migrant's health care needs and their distinct vulnerabilities.

Out of the Box Thinking

The health systems were originally designed with the underlying assumption that populations were static. Universal access to health, both domiciliary and institutional was emphasized but without accounting for specific ways of ensuring this for the migrant. With time however, the displacement of people across states and countries has become a reality which cannot be ignored. Health systems and policies have not kept pace with the pressures and consequences of modern migration, disregarding the emerging contemporary needs of migrant populations. Various strategies have been adopted by various health schemes and programs in India.

Countrywide service provision: The *Employees' State Insurance Scheme* is a social security measure devised by the central government, tailored to provide full medical care to worker populations in the organized sector and their dependents. Insured persons are also entitled to a variety of cash benefits in times of physical distress due to sickness, temporary or permanent disablement etc. The scheme uses biometric smart cards named 'Pehchan cards' given to the employee. Another smart card is provided to his/her family who may be residing in another state. So the worker and his family both can avail the services at any ESIC hospitals/dispensary throughout the country.

Insurance: The *Rashtriya Swastha Bima Yojana* is a unique public health insurance scheme developed for low-income workers (those below the poverty line) by Government of India. One of the key features of the scheme is that it allows portability of the services if the beneficiary migrates from one place to another. This is made possible by the use of a biometric enabled smart card which allows the beneficiary to avail services in empanelled hospitals anywhere in India. Cards can also be split for migrant workers to carry a share of the coverage with them separately. The strategy uses robust information technology applications to implement this feature and the biometric enabled card makes it tamper proof and safe.

Purchased health care: The *Indian Railways* have a dedicated health care system to provide primary level and most secondary level health care to all the employees. But some secondary health care needs are purchased from other hospitals' recognized' by the Railways. Tertiary level health care is mostly provided through arrangements with government hospitals and private hospitals' recognized' by the Railways. In this way, railway employees can access health services throughout the country, irrespective of residence or location.

Migration kits and passports: Targeted intervention projects to interrupt HIV transmission among highly vulnerable populations including truckers and migrants has been one of the most important components of the *National AIDS Control Program*. The program has mechanisms to cater to the mobile population for example, interventions at transit locations, at worker destination sites and for the family of the migrant. Migration kits are distributed in transit areas. The truckers' component is provided through a set of dedicated truckers clinics called Khushi clinics on national and state highways. The trucker is provided with a 'passport' to enable them to access continued treatment for ailments at any Khushi clinic.

Adaptation of program guidelines: The *Revised National Tuberculosis Control Program* does not presently have a national level strategy and guidelines for migrants. Nevertheless, in order to deal with migrants' issues, various programmatic approaches have been adapted in different sites. In metro cities such as Delhi, tracking pavement dwellers was a challenge. Government staff has adapted their approach by visiting pavement dwellings before patients leave their shelters on the pavement on