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Indira Gandhi National Open University
School of Health Sciences

NOS 1 – IGNOU/N0101
Version – 1.0 – Level 5.5

Introduction to Health and Hospital Management

MODULE

3

PLANNING AND MANAGEMENT OF HEALTH CARE SERVICES

Unit 1 National Health Planning And Health Financing In India

Unit 2 Health Care Delivery System In India

Unit 3 Health Scenario Of India And National Health Programmes

Unit 4 History And Future Of Nursing In India

Unit 5 Role Of Nursing Councils Commission And Associations

Module 3 is on Planning and Management of Healthcare Services. This module will cover National Health Planning and Health Financing in India – Health Committees in India, Five Year plans, National Health Policies, political economy of health, national health mission, health financing in India and national health accounts; Healthcare Delivery System in India – Health system at centre, state and district level, health care delivery and services; health Scenario in India and National Health Programmes – Health status and health problems in India, various national health programmes and programmes for systems strengthening; History and Future of Nursing in India – History of Nursing in USA, UK and India, recommendations of various committees, nursing structure at centre, state and district level, future of nursing in India, issues and challenges related to nursing in India and Role of Nursing Councils and Associations in India – International Council of Nursing, Indian Nursing Council, National Nursing and Midwifery Commission and professional associations of nursing in the world and in India.

Concept Map

Module	Learning Outcomes/ Graduate Attributes	Competencies: Discipline, Occupational, Social and Life Skills	Media and Resource	Activities / practicum / Internship	Assessment Rubric
Block 3 – Planning and Management of Healthcare Services Unit 1 – National Health Planning and Health Financing in India Unit 2 – Health Care Delivery System in India Unit 3 – Health Scenario of India and National Health Programmes Unit 4 – History and Future of Nursing in India Unit 5 - Role of Nursing Councils, Commission and Associations	• review national health planning and health financing; • compare health care delivery system at Centre and State level as recommended by MOHFW, GOI; • analyse health data and health problems in India; • review history of nursing in India; • review nursing trends and future need of nursing in India; • critically analyse the role of nursing councils and nursing associations. Discipline Knowledge regarding changing trends in health care planning, financing, health care delivery system, trends in nursing, role of councils and analyse need for nursing and midwifery commission	Discipline and Occupational Skills	Print - SLM, e-gyankosh; links - website, OER, PPT; Audio-Video - You Tube, Audio Books; Goggle Page/ Blog; Social Media; gyan darshan	Attending gyan darshan, watching video, listening to audio, reading, participate in discussion forum, assignment	Assignment evaluation Discussion forum evaluation Term End Examination - Model Answers

MODULE INTRODUCTION

Module 3 – Planning and Management of Healthcare Services

Unit 1 – National Health Planning and Health Financing in India

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Unit 5 – Role of Nursing Councils, Commission and Associations

	Module and Units	**Theory Hours**	**Practical Hours**	**Total Hours**
	Module 3 – Planning and Management of Healthcare Services	Theory	Practical	Total
1	National health Planning and Health Financing in India	04	00	04
2	National health Care Delivery System	02	00	02
3	Health Scenario of India and National Health Programmes	02	00	02
4	History and Future of Nursing in India	02	00	02
5	Role of Nursing Councils, Commission and Associations	02	00	02
	Total	12	00	12

Note: Theory counselling includes online compulsory contact sessions, watching gyan darshan and you tube sessions, OER and links, discussion, quiz, tutorial etc. Self study 3 hours. Total 15 hours.

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UNIT 1 NATIONAL HEALTH PLANNING AND HEALTH FINANCING IN INDIA

Structure

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1.4 Health Financing in India
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1.7 Answers to Check Your Progress
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1.0 INTRODUCTION

In module 1 and 2 you have learnt about basics concepts, elements and principles of management; these units have given you vision about basics of management and help you to apply these in understanding health, hospital and nursing management. In this unit you will learn about national health planning and health financing in India; because all the states and health institutions draft their plans based on policies and plans at national level. You will learn in brief about various committees in India, Five Year Plans, National Health Policies, National Health Mission and Health Financing in India. You will also learn the about national health accounts. You must have learnt about various committees, five year plans, national health policy, national health mission during your basic nursing programme; therefore we will review all these concepts in brief.

1.1 OBJECTIVES

After completion of this unit you will be able to:

1. explain the planning cycle;
2. critically analyze the recommendations of various committees in India;
3. review the five-year plans especially actions and plan for health sector;
4. compare the recommendations by national health policies over time;
5. analyse the concept of political economy of health;
6. plan participation in implementing initiatives under national health mission;

7. analyse the health financing system in India; and
8. describe the national health accounts.

1.2 HEALTH PLANNING IN INDIA

In module 2 unit 1, you have learnt about basic concepts related to planning; where it was emphasized that planning is mainly for future to achieve the objectives, to use limited resources available and avoid wastage. Especially in the health sector day by day needs of people are increasing and health sector is forced to work under constraints due to limited resources to provide quality health care services. Health planning is a part of national development planning. Various management techniques are used by health managers for improving the efficiency of health care delivery system. In module 1 you have also learnt about management techniques which can be applied in hospital management.

Before we precede forward let us try to understand the meaning of various terms.

Health Needs and Demands: Needs and demands by people living in community/society. Health needs can be for medical care, sanitation, hygienic food, safe water etc. Needs perceived by people are known as health demands.

Resources: Hope all of remember 3 Ms i.e. man, money material and additional resources can be time, knowledge, skills etc. Limited available resources should be used carefully to avoid wastage and provide cost effective quality care.

Objectives, Goals and Targets: Objectives are end points of all activities. Goals are written in broad terms; e.g. one of the health outcome goal is - Reduction of Infant Mortality Rate (IMR) to 25 per 1,000 live births by 2017. Target means something to be achieved e.g. Increase facilities equipped for perinatal care (designated as 'delivery points') by 100%. As per RNMCH+A document, India aims to set one collective goal towards reducing preventable maternal, newborn and child deaths by 2017, it is increasingly becoming apparent that there is varied and unequal rate of progress within the states and districts. Therefore state specific coverage targets should be established against existing baselines.

Plan: Blue print for taking action. You can go through any Five Year Plan or Yearly plan to have an idea what are the elements of plan. Under National Health Mission you can go through PIP (Programme Implementation Plan) of your State.

Programme: It includes series of activities to achieve the objectives.

Let us now define the term health planning and identify steps of planning.

National Health Planning definition: It is an orderly process of defining community health problems, identifying needs and demands of people, available resources to meet these needs, establishing priorities, set goals and identify various actions to achieve the objectives.

Steps of Planning

1. Plan Formulation
2. Plan Execution
3. Plan Evaluation

Pre-planning process – It is a period for preparation for planning and there are certain pre-conditions which needs to be considered before finalizing plan i.e. government interest (political will), legislation i.e. various Acts, organization for planning i.e. planning commission (now NITI Ayog) and administrative capacity i.e. Centre and State Ministers of Health.

Planning Cycle

Steps of planning cycle are:

1. **Analysis of the health situation** – Collect data, information, analyse and interpret it. This will help to identify needs and demands and to set priorities.
2. **Establishment of objectives and goals** – Set goals and objectives. Specify measureable, realist objectives. Long term and short term objectives needs to be specified.
3. **Assessment of resources** – Resources means manpower, money, material equipment, supplies, machines etc), knowledge and skills.
4. **Fixing priorities** – Set priorities as per magnitude of the problem, political will and community needs and demands.
5. **Plan formulation** – The plan should be realistic, feasible to implement. All the programmes/institutions should specify targets, resources, budget and timeline to implement the activities and in-build system of monitoring. Approving authority can modify or reject plan activities. Before implementing plan it should be approved by the competent authority.
6. **Plan implementation** – Effective organization structure is required to implement the plan keeping in mind the principles and elements of management. Human resource or manpower planning is very crucial, selection, recruitment, placement, training, retaining, on the job training and their roles and responsibilities, communication, motivation, supervision are crucial elements.
7. **Monitoring** – Day to day supervision and follow-up during implementation of plan. Managers observe record and report; find deviations and take corrective actions if required.
8. **Plan evaluation** – Assess the achievements as per objective cost effectiveness, reallocation of resources and priorities are again set as per changing needs and demands.

In next sub-section we will learn about some of the important committees.

1.2.1 Health Committees in India

In 1943 before independence first committee was set up i.e. Health Survey and Development Committee under Sir Bhore Joseph, commonly known as Bhore Committee 1946. It studied the health situation and health organizations and recommended future actions. It is a major document for national health planning in India.

Various other Committees set up by Government of India (GOI) are given below which were set up from time to time and their important recommendations:

1. **Health Survey and Development Committee also known as Bhore Committee -** Committee recommended that preventive and curative medical care services should be integrated at all levels; changes in medical education i.e. 3 months training in preventive and social medicine; and establishment of Primary Health Centres (PHC) in 2 stages:

   a. **Short Term -** 1 PHC for 40,000 population with 2 doctors, 1 nurse, 4 public health nurses, 4 midwives, 4 trained dais, 2 sanitary inspectors, 2 health assistants, 1 pharmacist and 15 other class IV employees. Secondary health care delivery institution to provide support and carry out supervision and monitoring.

   b. **Long Term -** Setting up PHC with 75 bedded hospital for 10,000-20,000 population. Secondary level health care unit to have 650 bedded hospital and setting up district hospital with 2500 beds in the region.

2. **Health Survey and Planning Committee also known as Mudaliar Committee. 1962 -** Main aim was to assess the performance of healthcare delivery system since recommendations of Bhore Committee. It was highlighted that PHC conditions was not good and they need to be strengthened first before opening new PHCs and PHC to cover 40,000 population, provide comprehensive preventive, promotive and curative services; it was also recommended to strengthen sub-district and district hospitals. Also recommended to create All India Services to replace old Indian Medical service.

3. **Chadha Committee, 1963 -** Aim of the committee was to suggest measures for the maintenance phase of National Malaria Eradication Programme and suggested that vigilance activities related to malaria programme to be carried out by the basic health workers to be designated as multi-purpose worker (1 per 10,000 population), and will also carry out family planning, collect vital statistics under supervision of family planning health assistants.

4. **Mukerji Committee, 1965 -** It was observed that basic health worker is not able to perform activities under malaria and family planning programmes due to heavy load. Therefore, this committee was constituted to review the national family planning programme. Committee recommended delink malaria and family planning programmes and to have separate staff i.e. family planning assistant to work for family planning. Basic health worker will carry out other activities under other programmes except family planning.

5. **Mukerji Committee, 1966** - During this time various national health programmes were implemented but most of the States in India were finding difficult to implement activities under various programmes like family planning, small pox, leprosy, trachoma, malaria (maintenance phase), etc. due to budget and other issues.. Mukerji committee was set up to look into these matters. It recommended that basic health care services should be provided at the Block level and District level. The committee worked out the details of the Basic Health Service which should be provided at the Block level and District level and services needs strengthening.

6. **Jungulwalla Committee, 1967 also known as "Committee on Integration of Health Services"** - Committee was appointed to look into issues related to integration of healthcare services, services condition of doctors and private practice by doctors in government job. Committee defined "integrated health services" as: A service with a unified approach for all problems instead of a segmented approach for different problems. Medical healthcare services and public health services should be under one administrative head at all levels.

   Committee also recommended to have unified cadre in the country with common seniority, recognise additional qualification, equal pay for equal work, special pay for special work, improve the service condition of the doctors and it also recommended that the doctors in government service cannot practice.

7. **Kartar Singh Committee, 1973 also known as "Committee on multipurpose workers under Health and Family Planning"** - Committee was constituted to recommend a framework for integration of health and medical services at all levels. This committee recommended to integrate all the cadres of community health workers into one i.e. Multipurpose Health Workers Female and Male. Auxiliary Nurse Midwife (ANM) to be designated as Multipurpose Health Worker (MPHW Female) and Basic Health Worker to be designated as Multipurpose Health Worker (Male). Lady Health Visitor to be designated as Health Supervisor (Female or Male) and will supervise 3-4 MPHWs.

8. **Shrivastav Committee, 1975": Group on Medical Education and Support Manpower"** - Committee was constituted to recommend reorientation of medical education and design curriculum for health assistant. Committee recommended to have 3 cadres of health workers i.e. MPHWs, Health Assistants (community level workers) this will help to have good inter-personal relationship with the community and Medical Officers (at PHC) and development of referral complex which will provide referral services. It also recommended a establish a Medical and Health Education Commission for planning and implementing the changes in health and medical education on the lines of University Grants Commission.

9. **Bajaj Committee, 1986: "Expert Committee for Health Manpower Planning, Production and Management"** - Committee recommended to formulate National Medical and Health Education policy and Health

Manpower policy, establish health manpower cells in States and UTs; establishment of an Educational Commission for Health Sciences (ECHS) on the lines of UGC and establishment of Health Science Universities at State and UT level and vocational education in relation to health field at 10+2 level for para-medical manpower.

1.2.2 Five Year Plans

Though the planned economic development in India began in 1951 with the inception of First Five Year Plan, theoretical efforts had begun much earlier, even prior to the independence. That is setting up of National Planning Committee by Indian National Congress in 1938, The Bombay Plan and Gandhian Plan in 1944, Peoples Plan in 1945 (by post war reconstruction Committee of Indian Trade Union), Sarvodaya Plan in 1950 by Jaiprakash Narayan were steps in this direction.

Health planning in India is a part of socio-economic planning for the country and is based on the recommendations of various committees, set by Government of India. The Planning Commission was set up in 1950 by Government of India to draft five year plans for the country; review the progress there after and recommend future action to the Government. In 2015, Planning Commission was replaced by National Institution for Transforming India (NITI) Aayog and the Thirteen Five Year Plan was in the process of implementation. Objectives of NITI Aayog are given below in the Box. 1.1.

Box 1.1: Objectives of NITI Aayog

Objectives of NITI Aayog are to:

1. evolve a shared vision of national development priorities, sectors and strategies.
2. foster cooperative federalism through structured support initiatives and mechanisms.
3. develop mechanisms to formulate credible plans at the village level and at higher levels.
4. ensure, on areas that are specifically, that the interests of national security.
5. pay special attention to the sections of our society that may be at risk of not benefiting from economic progress.
6. design strategic and long-term policy and programme frameworks and initiatives, and monitor their progress and their efficacy and take corrective measures

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7. provide advice and encourage partnerships between key stakeholders, national and international, educational and policy research institutions.
8. create a knowledge, innovation and entrepreneurial support system through a collaboration.
9. offer a platform for the resolution of inter-sectoral and inter departmental issues.
10. maintain a state-of-the-art resource centre, be a repository of research on good governance and best practices.
11. actively monitor and evaluate the implementation of programmes and initiatives.
12. focus on technology upgradation and capacity building for implementation of programmes and initiatives.
13. undertake other activities as may be necessary for national development.

National Institution for Transforming India - https://niti.gov.in/

https://www.nhp.gov.in/miscellaneous/committees-and-commissions

https://www.niti.gov.in/verticals/health-and-family-welfare

https://www.niti.gov.in/sites/default/files/2021-02/Annual-Report2020-2021-English_0.pdf

https://www.niti.gov.in/

Check Your Progress 1

1. List the steps of planning cycle.

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2. Describe recommendations of Bhore Committee.

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3. List any 6 objectives of NITI Ayog.

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1.2.3 National Health Policy (NHP)

In 1983, first health policy was adopted by Government of India, prior to that health activities of the states were formulated through Five Year Plans and recommendations of various committees and it was revised in 2002. Later National Health Policy was revised in 2017.

National Health Policy 2017 – Aim

National Health Policy, 2017, emphasizes on providing good quality healthcare services in an assured manner to all the people, keeping in view the changes due to socio-economic, epidemiological and technological factors. Key principles are, equity, affordability, accountability, partnerships and decentralisation.

NHP-2017 also identifies seven priority areas, they are:

1. Swachh Bharat Abhiyan
2. Balanced, healthy diets and regular exercises.
3. Addressing tobacco, alcohol and substance abuse

4. Yatri Suraksha - preventing deaths due to rail and road traffic accidents
5. Nirbhaya Nari -action against gender violence
6. Reduced stress and improved safety in the work place
7. Reducing indoor and outdoor air pollution

To achieve Universal Health Coverage by 2025, NHP-2017 assures a comprehensive primary care to one and all. Both the quantifiable and measurable goals have been laid down. It has been proposed to set up health and wellness centres which would provide full range of preventive and promotive services to prevent diseases and enhance well-being.

To address the serious shortage of human resources, the policy has proposed: i) reviving the multipurpose male worker cadre ii) empowerment of ASHA's to undertake preventive education at the community level and iii) training AYUSH doctors, nurses and para-medics for six months on public health so as to position them in the Health and Wellness centres. From the current spending of 1.15% on public health, the policy envisages raising the spending to 2.5% of GDP by 2025.

Major features of the policy that aims to transform healthcare in India:

- The policy aims for attainment of highest possible level of health and well-being for every citizen through a preventive and promotive healthcare orientation.
- It seeks to provide and deliver healthcare services, particularly to underprivileged and socially vulnerable groups of people in the country.
- Under the policy, every family will have a health card for access to primary care facility as well as to defined package of services nationwide.
- Health and hygiene to become part of school curriculum – Yoga would be introduced much more widely in schools and work places as part of promotion of good health.
- The policy envisages a three-dimensional integration of AYUSH systems by promoting cross referrals, co-location and integrative practices across systems of medicines.
- The policy also seeks to address health security and promotes Make in India for drugs and devices.
- It seeks to establish a Public Health Management Cadre (PHMC) in all states.
- It also proposes rising public health expenditure to 2.5% of the GDP in a time bound manner.

Targets set under the NHP 2017

1. Increasing life expectancy to 70 years from 67.5
2. Reduce fertility rate to 2.1 (Replacement levels) by 2025.
3. Reduce infant mortality rate to 28 by 2019.

4. Reduce Under Five Mortality to 23 by 2025.
5. Reducing premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.
6. The policy seeks to achieve'90:90:90′ global target by 2020 – implying that 90% of all people living with HIV know their HIV status, 90% of those diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of those receiving antiretroviral therapy will have viral suppression.
7. Reducing the prevalence of blindness to 0.25 per 1000 persons by 2025 and
8. The disease burden to be reduced by one third from the current levels.
9. Elimination of leprosy by 2018, kala-azar by 2017 and lymphatic filariasis in endemic pockets by 2017.

Sustainable Development Goals

In September 2015, the post 2015 UN Development Agenda, comprising of 17 Sustainable Development Goals (SDGs) will be adopted, replacing the Millennium Development Goals (MDGs). These ambitious and aspirational SDGs call for significant rethinking in development processes across the world. They also call for significant resources to be dedicated and invested in priority areas as identified in the framework of Goals and Targets for each member state.

The Sustainable Development Goals are commitment by world leaders which sets out a universal agenda which includes economic, environmental and social aspects of the well being of societies. SDGs for 2030 evolved from the Millennium Development Goals (MDGs) for 2015. MDGs were set with 8 international development goals and 18 targets for 2015 set by the Millennium Submit of the United Nations in 2000. NITI Aayog is given the task of coordinating work on SDGs by involving central ministries, states, union territories, civil society organizations, academia and business sector to achieve SDG targets.

Sustainable Development Goals are the collection of 17 global goals set by the United Nations General Assembly in 2015. SDGs also known as global goals, as a universal call to action to end poverty, protect the planet and ensure that all people peace and prosperity. They came into effect in 2016 and will guide policy and funding till 2030. SDGs comprises of 17 goals and169 targets. Goal 3 of SDGs with 13 targets is dedicated to health and other 16 goals are directly or indirectly related to health.

The list of the Sustainable Goals is given below:

GOAL 1: No Poverty

GOAL 2: Zero Hunger

GOAL 3: Good Health and Well-being

GOAL 4: Quality Education

GOAL 5: Gender Equality

GOAL 6: Clean Water and Sanitation

GOAL 7: Affordable and Clean Energy

GOAL 8: Decent Work and Economic Growth

GOAL 9: Industry, Innovation and Infrastructure

GOAL 10: Reduced Inequality

GOAL 11: Sustainable Cities and Communities

GOAL 12: Responsible Consumption and Production

GOAL 13: Climate Action

GOAL 14: Life Below Water

GOAL 15: Life on Land

GOAL 16: Peace and Justice Strong Institutions

GOAL 17: Partnerships to achieve the Goal

The **SDG 3 has direct involvement with health sector**. Thus SDG 3 is discussed below.

SDG 3: ENSURE HEALTHY LIVES AND PROMOTE WELL-BEING FOR ALL AT ALL AGES

Goal 3 aims to ensure that people enjoy a level of health that enables them to lead a socially and economically productive life.

It aims to end preventable deaths across all ages from communicable and non-communicable diseases and illnesses caused by air, water and soil pollution and contamination. It aims to achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality and affordable essential medicines and focus on mental health issues.

Ensure healthy lives and promote wellbeing for all at all ages India has made significant strides in improving various health indicators. The Infant Mortality Rate has declined from 57 in 2005-06 to 25 in 2024. Similarly, Under-5 Mortality Rate has fallen from 74 to 29/live births in 2024 over the same period. This has been enabled, at least partially, by a significant improvement in vaccination coverage for children between 12-23 months of age. Moreover, institutional deliveries have increased from 38.7% in 2005-06 to 88% in recent time and Maternal Mortality Ratio (MMR) 130 per 100,000 live births in 2014-16 to 97 per 100,000 live births in 2018-20. The country's strategy in health is focused on providing essential services to the entire population, with a special emphasis on the poor and vulnerable groups. The National Health Policy, 2017 has specified targets for universalising primary health care, achieving further reductions in infant and under-5 mortality, preventing premature deaths due to non-communicable diseases as well as increasing government expenditure on health.

A composite index is being used to monitor and incentivise improvements in health services delivery across states in the country. The government is aiming to immunize all unimmunized and partially immunized children against vaccine preventable diseases by 2020. In India, the National Full Immunization Coverage for FY 2023-24 is 93.5%. Towards achieving universal health coverage, a health insurance cover of INR 100,000 (USD 1,563) is being extended to all poor families.

Universal Health Coverage

Universal Coverage refers to where everyone is covered for basic healthcare services, regardless of their socio-economic cultural backgrounds, so that all will have the right to affordable, acceptable, accountable and appropriate health services of assured quality. They receive promotive, preventive, curative and rehabilitative services at primary, secondary and tertiary levels. The Primary level care is provided through the Health and Wellness Centres and PHC and the secondary level health care is rendered by the District health system, as mentioned the 1.2 earlier. as well as addressing the determinants of health like education, nutrition, water, agriculture etc;

Today the role of a government being as an enabler and guarantor of health care services therefore supplementary system of finance protection for people is also planned so that people are able to afford health care services.

Principles of UHC

- Universality→ caring all for all health problems
- Equity→ Equitable consideration for all
- Non-Exclusion and Non-Discrimination→ No one is spared irrespective of social or economic status
- Comprehensive Care of good quality→ A care that is care in totality and good in quality
- Financial protection→ at a low cost
- Protection of Patients Rights→ Survival of the patient is main motto and he gets all cares as a right to health
- Strengthening Public Health provisioning→ Making all the public health faculties functional with resources.
- Accountability and Transparency→ Putting everything clearly.
- Community Participation→ Taking everybody (community) along with the system
- Putting health in people's hand→ Making health care availability and utilization as a movement of the people not only the government.

UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

UHC enables everyone to access the services that address the most significant causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them.

Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015. Countries that progress towards UHC will make progress towards the other health-related targets, and towards the other goals. Good health allows children to learn and adults to earn, helps people escape from poverty, and provides the basis for long-term economic development.

There are many things that are not included in the scope of UHC:

- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.
- UHC is not just about health financing. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation.
- UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available.
- UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, and so on.
- UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.

Primary health care is an approach to health and wellbeing centered on the needs and circumstances of individuals, families and communities. It addresses comprehensive and interrelated physical, mental and social health and wellbeing.

It is about providing whole-person care for health needs throughout life, not just treating a set of specific diseases. Primary health care ensures people receive comprehensive care, ranging from promotion and prevention to treatment, rehabilitation and palliative care as close as feasible to people’s every day environment.

WHO has developed a cohesive definition of primary health care based on three components:

1. ensuring people's health problems are addressed through comprehensive promotive, protective, preventive, curative, rehabilitative, and palliative care throughout the life course, strategically prioritizing key system functions aimed at individuals and families and the population as the central elements of integrated service delivery across all levels of care;

2. systematically addressing the broader determinants of health (including social, economic, environmental, as well as people's characteristics and behaviours) through evidence-informed public policies and actions across all sectors; and

3. empowering individuals, families, and communities to optimize their health, as advocates for policies that promote and protect health and wellbeing, as co-developers of health and social services through their participation, and as self-carers and care-givers to others.

Primary health care is the most efficient and cost-effective way to achieve universal health coverage around the world.

To meet the health workforce requirements of the Sustainable Development Goals and universal health coverage targets, over 18 million additional health workers are needed by 2030. Gaps in the supply of and demand for health workers are concentrated in low- and lower-middle-income countries. The growing demand for health workers is projected to add an estimated 40 million health sector jobs to the global economy by 2030. Investments are needed from both public and private sectors in health worker education, as well as in the creation and filling of funded positions in the health sector and the health economy.

UHC emphasizes not only *what* services are covered, but also *how* they are funded, managed, and delivered. A fundamental shift in service delivery is needed such that services are integrated and focused on the needs of people and communities. This includes reorienting health services to ensure that care is provided in the most appropriate setting, with the right balance between out- and in-patient care and strengthening the coordination of care. Health services, including traditional and complementary medicine services, organized around the comprehensive needs and expectations of people and communities will help empower them to take a more active role in their health and health system.

National Health Policy, 1983 - https://www.nhp.gov.in/sites/default/files/pdf/nhp_1983.pdf

National Health Policy, 2002 - https://nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/national_nealth_policy_2002.pdf

National Health Policy, 2017 – https://mohfw.gov.in/sites/default/files/9147562941489753121.pdf

1.2.4 Political Economy of Health

It will be interesting to learn about political economy of health. As the word implies political and economy, these are derived from two subjects that is politics i.e. power, governance, authority to make decisions, the state and economy i.e. provision of material, contracts, market economy, resource generation and distribution, benefit distribution, role of government to improve services etc. As per Todaro, political economy goes beyond simple economics to include social and institutional processes through which economic and political elites choose to allocate resources for their own benefit and then to the wider population. It deals with ways in which politics determines or influences economic activities.

Political Economy doctrine from 1980 onwards is based on pro-market model. It is concerned with: - Market efficiency and maximization of economic welfare. - Market liberalization (right prices) - Trade liberalization (export oriented) - Privatisation (reduce state expenditure and control) - Private sector as a force for development - Free trade. The approach advocates for governments role to be limited in the economy due to its: - Ineffective planning and implementation. - Price distortion. - Prevention of private sector initiatives. - Inefficient public enterprises. - Rent seeking/corruption. Stiglitz, (2002). Emphasized that the market economic system appears to be collapsing under its own weight and predict that market capitalist system is no longer sustainable. That it will run its course over a few more decades and give way to another economic and political order

Ravi Duggal (1997), in his article highlighted that, 1980s saw the beginning of a process for economic change towards greater liberalisation and privatisation of the Indian economy, the 1990s have accelerated that pace under the umbrella of structural adjustment. This has also increase in borrowings with the debt burden and making interest payments by the State budget. This has impact on State spending, and social sectors are the first to get the axe. Under structural adjustment since 1991 there has been further compression in government spending in its efforts to bring down the fiscal deficit to the level as desired by the World Bank.

Sigamani (2010) thesis highlighted that, New Public Health Management brought in reform in the public sector; they can be observed m three main categories: (i) reform within the government departments - departmental changes, such as performance appraisal, including performance based promotion and perfornance based salary increments (the creation of semi-government organizations or autonomous bodies are a part of this category); (ii) the larger sphere of governance- efforts initiated by civil society, such as NGOs, national and multinational donor agencies; and (iii) collaborative ventures - across the globe and with different stakeholders. The reforms process was reflected in the form of budget cuts, separation of provision and production, contracting-out, introduction of user charges as part of the resource mobilization strategy, vouchers scheme, introduction of customer concept, promotion of competition strategy, separation of politics and administration dichotomy, decentralization for peoples participation, accountability, performance appraisal, improved accounting, financial

management, strategic planning and change management as part of systemic change in the public system management.

Political decision-making gives shape to health policies and planning of a country and on other hand politicians have benefit of getting recognition through these social services. Political parties' preferences about the distribution of resources within the population shapes the health planning. The major influences on population health include the political regime, what party is in office, the level of healthcare spending, and the type of welfare state.

Elected leaders are responsible for improving the health of the people and provide quality health care services, and for this they need a strong partnership with public health officials. There is evidence that the public expects politicians to engage in constructive pursuits i.e. the public supports broader public investment in prevention and public health. On the other hand, public health officials cannot simply ignore the political system because in reality all governmental public health activity is based on authority and funding that is provided through a political decision-making process. The ability of state and local public health officials to regulate, implement programmes, spend public money, or receive private funding through user fees or other means is derived through a political process.

The health sector can make better use of knowledge about politics, power and political analysis to improve the effectiveness of its policy process. Health policy-makers recognize the need for political economy analysis; however, they often lack a clear idea of how to do it.

Health Planning in India article - http://www.cehat.org/cehat/uploads/files/a168.pdf

Check Your Progress 2

1. List principles of UHC.

2. Briefly explain political economy of health.

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1.3 NATIONAL HEALTH MISSION

In this section you will learn about the components of national health mission. In 2005 National Rural Health Mission (NRHM) was launched, in 2013 National Urban Health Mission (NUHM) was launched and in 2013 both were combined as National health Mission (NHM). In this section we will learn in brief about NHM.

A. **The National Rural Health Mission (NRHM)** was launched on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups. NRHM seeks to provide equitable, affordable and quality health care to the rural population, especially the vulnerable groups. Under the NRHM, the Empowered Action Group (EAG) States as well as North Eastern States, Jammu and Kashmir and Himachal Pradesh have been given special focus. The thrust of the mission was on establishing a fully functional, community owned, decentralized health delivery system with inter-sectoral convergence at all levels, to ensure simultaneous action on a wide range of determinants of health such as water, sanitation, education, nutrition, social and gender equality. Institutional integration within the fragmented health sector was expected to provide a focus on outcomes, measured against Indian Public Health Standards for all health facilities.

B. **The National Urban Health Mission (NUHM)** as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013. NUHM envisages to meet health care needs of the urban population with the focus on urban poor, providing them essential primary health care services and reducing their out-of-pocket expenses for treatment. This to be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing and Urban Poverty Alleviation, Human Resource Development and Women and Child Development.

NUHM would cover all State capitals, district headquarters and cities/towns with a population of more than 50000. It would primarily focus on slum dwellers and other marginalized groups like rickshaw pullers, street vendors, railway and bus station coolies, homeless people, street children, construction site workers. The centre-state funding pattern will be 75:25 for all the States except North-Eastern states including Sikkim and other special category states of Jammu & Kashmir, Himachal Pradesh and Uttarakhand, for whom the centre-state funding pattern will be 90:10. The Programme Implementation Plans (PIPs) sent by the by the states are apprised and approved by the Ministry.

C. **The National Health Mission (NHM)** encompasses its two Sub-Missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM). The main programmatic components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs.

You can read in detail about National Rural Health Mission, 2005 - https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=969&lid=49

You can read in detail about National Urban Health Mission, 2013 – https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=970&lid=137

National Health Mission, 2013 – https://nhm.gov.in/index4.php?lang=1&level=0&linkid=445&lid=38

D. **Ayushman Bharat** or "Healthy India" is a national initiative launched by Prime Minister as the part of National Health Policy 2017, in order to achieve the vision of Universal Health Coverage (UHC). This initiative has been designed on the lines as to meet Sustainable Development Goals (SDG).

The National Health Policy, 2017 recommended strengthening the delivery of Primary Health Care, through establishment of "Health and Wellness Centres" as the platform to deliver Comprehensive Primary Health Care and called for a commitment of two thirds of the health budget to primary health care. In February 2018, the Government of India announced that 1,50,000 Health & Wellness Centres (HWCs) would be created by transforming existing Sub Health Centres and Primary Health Centres to deliver Comprehensive Primary Health Care and declared this as one of the two components of Ayushman Bharat. This was the first step in the conversion of policy articulations to a budgetary commitment. At present Health and Wellness Centres are known as Ayushman Arogya Mandir.

Ayushman Bharat is an attempt to move from sectoral and segmented approach of health service delivery to a comprehensive need-based health care service i.e. prevention, promotion and ambulatory care, at primary, secondary and tertiary level.

Ayushman Bharat document also highlighted that to ensure delivery of Comprehensive Primary Health Care (CPHC), existing Sub Health Centres (SHCs) will cover a population of 3,000 - 5,000 and will be converted into Health and Wellness Centres (AB-HWCs). Primary Health Centres (PHCs) in rural and urban areas are also being converted into AB-HWCs. CPHC will also cover outreach services which will include mobile medical units and home and community-based care, to provide continuum of care that ensures the principles of equity, universality and removing any financial hardship.

Ayushman Bharat adopts a continuum of care approach, comprising of two inter-related components, which are:

1. **Establishment of Health and Wellness Centres –** Creation of 1,50,000 Health and Wellness Centres which will bring health care closer to the homes of the people. These centers are providing Comprehensive Primary Health Care (CPHC), covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services. Existing Sub-Centres (SCs) covering 3000-5000 population, Primary Health Centres (PHCs) and Urban PHCs to be converted into Health and Wellness Centres (HWCs). Outreach services are provided through Mobile Medical vans, health camps, home visits and interaction with the community at their setting. The principle of continuum of care is kept in mind for equity, quality, universality and no financial hardship. Health and Wellness centres renamed as Ayushman Arogya Mandir with tagline Arogyam Parmam Dhanam.

The HWC will have following trained staff:

- Mid-Level Health Provider (MLHP)
- Multi-Purpose Workers (male and female)
- ASHAs

Mid Level Health Provider (MLHP) (Community Health Officer) - B.Sc. Nurse or GNM Nurse or AYUSH doctor trained and certified to work as a MLHP and provide CPHC services. Posting of MLHP will help to provide range of services at HWC, continuity of care, prevention and control of diseases, early treatment, diagnosis and referral, it help in utilisation of services at HWCs and will help to reduce Out of Pocket Expenses (OOPE).

Responsibilities of MLHP:

1. Ensure all the families are empanelled with HWC and digital data of families is maintained
2. Provide OPD and first aid treatment as per Standard Treatment Protocols (SOPs)
3. Screening of patients with chronic diseases and referral of patients to the specialist and provide tele-health services
4. Ensure patients adhere to the treatment prescribed by the MO or Specialist
5. Participate as team member during disasters, epidemics, pandemics for various activities

6. Provide support, training, supervision and monitoring the work of MPHWs and ASHAs
7. Review and analyse the reports and interpret for future planning
8. Coordinate with Village Health Sanitation and Nutrition Committee, PRIs, local NGOs and other community groups
9. Plan and organise Behaviour Change and Communication (BCC) activities
10. Relate to local social, environmental determinants of health and work with local organizations

Expanded range of services provided by HWC:

1. Care of pregnant women and after delivery
2. Care to neonate and infant
3. Care of children and adolescents
4. Reproductive/Sexual health and family planning services
5. Out-Patient services handling minor disorders, acute emergency services
6. Services under communicable diseases control national health programmes
7. Screening, prevention and control of non-communicable diseases
8. Care of patients with Eye and ENT problems
9. Providing oral health care
10. Care of elderly and palliative care
11. Providing emergency medical services
12. Screening and management of mental health disorders
13. Distribution of medicines and lab. facilities
14. Referral, follow up
15. Tele-Consultation services with specialist
16. Maintain records
17. Health education and awareness activities

Primary Health Centre

Primary Health Centre (PHC) will have trained staff as per Indian Public Health Standards (IPHS - PHC) and it is linked to a cluster of HWCs would serve as the first point of referral. It will be well equipped with all the equipments and supplies and IT infrastructure. The Medical Officer (MO) at PHC is responsible for providing CPHC services at HWCs. Block PHC and CHC will function as a referral unit, provide specialist and emergency obstetrics care to the patients referred from the HWCs. High risk obstetric cases, sick newborns and other serious patients to be referred directly to District hospital from HWCs

Urban Primary Health Centres (UPHC) or Urban Health Posts in urban areas covering 50,000 population will provide comprehensive healthcare services at the centre and outreach services. 1 MPHW (Female) / 10,000 population with 4 ASHAs will be trained and posted in UPHC.

ASHA is the key contact person with the families, visit them and provide health education, motivate them to take treatment, follow up families for referral etc.

Health and Wellness Centres (HWCs) and Referral Mechanism

First to review services provided by the HWCs

Preventive, promotive, curative, rehabilitative health care at three the level of:

- Family/Household and community levels through outreach OPDs, Health Mela, Village Panchayat, Village and Home Visits, School and Anganwadi visits
- AB-HWCs
- Referral Facilities/Sites: Delivery of services closer to the community for monitoring.

Let us understand the referral mechanism for AB-HWCs.

Patients who need consultation by specialist or need advanced diagnosis will be referred to Primary Health Centre (PHC) or First Referral Unit (FRU), AYUSH dispensaries at Community Health Centres (CHC) / District Hospital (DH) / AYUSH integrated hospitals, teaching hospitals, national level institutions, etc. A two-way referral would be ensured between different level of health care facilities. For chronic disease conditions which require periodic specialist referral, tele-consultation platform would be utilized to facilitate the process.

Patients requiring advanced care are referred to Allopathic centres and vice versa depending upon the decision of Community Health Officer in consultation with the Medical Officer of PHC. The continuum of care is ensured through referral to higher centres and reverse referral to AB-HWCs. Whenever patients come home after getting treatment from higher health care facilities, ensuring their day-to-day management including compliance to advice and follow-ups is the responsibility of HWC team.

2. **Pradhan Mantri Jan Arogya Yojana (PM-JAY) –** PM-JAY is one of the important steps towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3). It aims to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health incidences.

A catastrophic illness is a major health event that takes place during a particular period, such as a heart attack, stroke, or cancer.

Out-of-pocket for healthcare is termed as catastrophic when the total health expenditure equals or exceeds 40% of the total household's capacity to pay.

71st Round of National Sample Survey Organization (NSSO) has found 85.9% of rural households and 82% of urban households have no access to healthcare insurance/assurance. More than 17% of Indian population spends at least 10% of household budgets for health services. Catastrophic healthcare related expenditure pushes families into debt, with more than 24% households in rural India and 18% population in urban area have met their healthcare expenses through some sort of borrowings. PMJAY primarily targets the poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data for both rural and urban areas as well as the active families under the Rashtriya Swasthya Bima Yojana (RSBY).

Pradhan Mantri Jan Arogya Yojana (PM-JAY) provide financial protection (Swasthya Suraksha) to 10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries) and added all elderly above 70 years. It provides cover of Rs. 500,000 per family per year (on a family floater basis). PM-JAY cover medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures. PM-JAY has defined 1,350 medical packages covering surgery, medical and day care treatments including medicines, diagnostics and transport.

Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) is a national health protection scheme (NHPS).

To ensure that nobody is left out (especially girl child, women, children and elderly), there is no cap on family size and age. The scheme is cashless and paperless at public hospitals and empaneled private hospitals. The beneficiaries is not required to pay any charges for the hospitalization expenses. The benefit also includes pre- and post-hospitalization expenses. The scheme is an entitlement based; the beneficiary is decided on the basis of family being figured in SECC database.

It is the "world's largest government funded healthcare program" targeting more than 50 crore beneficiaries. Ayushman Bharat – Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) is a paradigm shift from sectorial, segmented and fragmented approach of service delivery through various national and State schemes to a more comprehensive and better converged and need based service delivery of secondary and tertiary care.

Salient Features of PMJAY are following:

1. PMJAY is centrally sponsored scheme. It is entirely funded by Government and the funding is shared between Centre and State governments as per prevailing guidelines of Ministry of Finance.
2. PMJAY provides health coverage up to Rs. 5 lakh per family per year for secondary and tertiary hospitalization to around 10.74 crore entitled families (approx. 50 crore beneficiaries) and all elderly above 70 years.

3. PMJAY is an entitlement-based scheme. This scheme covers poor and vulnerable families based on deprivation and occupational criteria as per SECC data and all elderly above 70 years.

4. PMJAY provides cashless and paperless access to services for the beneficiary at the point of service in any (both public and private) empanelled hospitals across India. Beneficiary from one State can avail benefits from an empanelled Hospital anywhere in the Country.

5. Under PMJAY, the States are free to choose the modalities for implementation. They can implement the scheme through insurance company or directly through the Trust/ Society or mixed model. There is no restriction on family size, ensuring all members of designated families specifically girl child and senior citizens get coverage.

6. At National level, National Health Authority (NHA) has been set up to implement the scheme.

7. MoU has been signed between National Health Agency (now National Health Authority) and States/UTs to implement PMJAY.
   - Nearly 1350 treatment packages are available for the beneficiaries under PMJAY. Services include approximately 1,929 procedures covering all the costs related to treatment, including but not limited to drugs, supplies, diagnostic services, physician's fees, room charges, surgeon charges, OT and ICU charges etc.

8. The benefits can be availed through a network of over 30,072 hospitals, including 13,352 private hospitals.

The objectives of the Yojana is to reduce out of pocket hospitalisation expenses, and improve access of identified families to quality inpatient care and day care surgeries.

3. National Digital Health Mission (NDHM)

Ministry of Health and Family Welfare constituted a committee headed by Shri J. Satyanarayana to develop an implementation framework for the National Health Stack. This committee produced the National Digital Health Blueprint (NDHB), and an action plan to implement digital health.

What is National Health Stack (NHS) is conceived as a set of building blocks essential to implement the digital health infrastructure and avoid duplication of efforts to successfully achieve convergence. NHS is the foundation on which the National Health Digital Mission (NHDM) will function.

Vision of National Digital Health Mission (NDHM)

To create a national digital health system that supports universal health coverage in an efficient, accessible, inclusive, affordable, timely and safe manner, that provides a data, information and infrastructure services and ensures the security, confidentiality and privacy of health-related personal information.

Objectives of National Digital Health Mission (NDHM)

To strengthen the accessibility and equity of health services, including continuum of care where citizen will be the owner of data, in a holistic way using information technology (IT) and other associated technologies to support the existing health systems in a 'citizen-centric' approach.

Objectives of NDHM

1. To establish state-of-the-art digital health systems, to manage the digital health data, and the infrastructure required for its functioning;
2. To establish registries to create single source of clinical establishments, healthcare professionals, health workers, drugs and pharmacies data;
3. To enforce adoption of standards by all national digital health stakeholders;
4. To create a system of personal health records, based on international standards, easily accessible to individuals and healthcare professionals and services providers, based on individual's informed consent;
5. To adopt the best principles of cooperation while working with the States and Union Territories for fulfilling the vision;
6. To ensure that the healthcare institutions and professionals in the private sector participate actively with public health authorities in the building of the NDHM;
7. To ensure national portability in the provision of health services;
8. To promote the use of clinical decision support (CDS) systems by health professionals and practitioners;
9. To promote a better management of the health sector by using health data analytics and medical research;
10. To enhancing efficiency and effectiveness of governance at all levels;
11. To support effective step for ensuring quality of healthcare; and
12. To strengthen existing health information systems, by ensuring their conformity with the defined standards and integration with the proposed NDHM.

Benefits and Impact of NDHM

The implementation of NDHM will improve the efficiency, effectiveness, and transparency of health service delivery. Patients will be able to safely store and access their medical records (such as prescriptions, diagnostic reports and discharge summaries), and share them with health care providers to ensure appropriate treatment and follow-up. They will also have access to more accurate information on health facilities and service providers. Further, they will have the option to access health services remotely through tele-consultation and e-pharmacy. NDHM will empower people to have accurate information to enable informed decision making and increase accountability of healthcare providers.

NDHM will provide choice to the people to access both public and private health services, facilitate laid down guidelines and protocols to be followed by the providers, and ensure transparency in price of services and accountability for the health services provided to them.

Health care professionals from all therapies and disciplines will have better access to patient's medical history (with the necessary informed consent) for prescribing more appropriate and effective health interventions and treatment. This integrated ecosystem will also enable better continuum of care. NDHM will help digitize the claims process and enable faster reimbursement.

Even this will help the policy makers and programme managers to have access to data, enabling more informed decision making by the Government and understand the bottle-necks at field level and solve the issues. It will also help in monitoring and strengthening the implementation of health programmes and policies.

Even the researchers will be benefit from the availability comprehensive, authentic information as they will be able to study and evaluate the effectiveness of various programmes and interventions.

Ayushman Bharat – Health and Wellness Centre https://ab-hwc.nhp.gov.in/download/document/45a4ab64b74ab124cfd853ec9a0127e4.pdf

https://ab-hwc.nhp.gov.in/download/document/45a4ab64b74ab124cfd853ec9a0127e4.pdf

https://www.nhm.gov.in/New_Updates_2018/NHM_Components/Health_System_Stregthening/Comprehensive_primary_health_care/letter/Operational_Guidelines_For_CPHC.pdf

https://www.niti.gov.in/sites/default/files/2021-09/ndhm_strategy_overview.pdf

1.4 HEALTH FINANCING IN INDIA

WHO emphasises that health financing policy focuses on mobilizing and pooling financial resources and allocating them to health care providers in an equitable and efficient way. This will enable provision of essential health services of good quality to all, especially to the poorer communities, and in populations in rural areas. Health financing is a core function of health systems that can enable progress towards universal health coverage by improving effective service coverage and financial protection. Today, millions of people do not access services due to the cost. Many others receive poor quality of services even when they pay out-of-pocket. Carefully designed and implemented health financing policies can help to address these issues. Health financing systems are critical for reaching universal health coverage by increasing budget for health, allocating funds to promote equity and reducing financial barriers by reducing out-of-pocket payments.

WHO definition of health financing: – Health financing is the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system."

The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000).

With reference to the recommendations by the commission on macroeconomics and Health, WHO, India established the National Commission on Macroeconomics and Health (NCMH) in March, 2004. The main objective of the NCMH was to establish the centrality of health to development and make an evidence-based argument to increase investment in health.

The Terms of Reference of the NMCH were mainly cantered on identifying a package of essential health interventions that ought to be made available to all citizens and also list systemic constraints that need to be addressed for ensuring universal access to this package of services. The NCMH was also to indicate the resources required and targets that ought to be achieved by 2015. Principal focus was on critically evaluating the current status of the health system - its organizational structure, financing mechanisms, regulatory frameworks etc. The three key drivers of health costs - namely human resources, drugs and technology were specially studied in detail as the main concern for the future. Clearly, a well conceived system of reform emerged to be the priority area for policy attention so as to develop the capacity to absorb the promised funding of 2-3% of GDP in the next five years committed in the Common Minimum Program.

As we know health is financed by public and private funds. To make progress toward universal health coverage (UHC), a reliance on public funds is necessary. Therefore, the way budgets are formed, allocated and used in the health sector is at the core factor to achieve universal health coverage.

Financial Barriers

Countries with high out-of-pocket expenses have inefficient and insufficient pooling of resources

People are inability to access health services; catastrophic expenditure and debt are associated as people pay from out-of-pocket

Direct payment at the point of service is inequitable, restricts access to health care and can lead to economic burden

High out-of-pocket health spending leads to poverty

1.5 NATIONAL HEALTH ACCOUNTS

Let us try to understand the meaning of term Health Accounts.

National Health Accounts (NHA) for India was envisaged in National Health Policy, 2002 and the National Health Accounts Cell (NHA Cell) was established in the Ministry of Health and Family Welfare, Government of India. NHA Cell produced health accounts estimates for FY 2001-02 and FY 2004-05. National Health Systems Resource Centre (NHSRC) was designated the National Health Accounts Technical Secretariat (NHATS) in August 2014 by Ministry of Health and Family Welfare with a mandate to institutionalize Health Accounts in India. As set out in the National Health Policy 2017, NHATS works towards regular reporting of health expenditures in India through systematic and institutionalised health accounts.

SHA 2011 defines health accounts as a systematic description of the financial flows related to consumption of healthcare goods and services and a standard for classifying health expenditures according to the three axes - consumption, provision and financing.

Health Accounts describe health expenditures and flow of funds in country's health system over a period of time - financial year for India. It answers important policy questions such as what are sources of healthcare expenditures, who manages these, who provides health care services and which services are utilised. It is a practice to describe the health expenditure estimates according to a global standard framework: System of Health Accounts 2011 (SHA 2011), to facilitate comparison of estimates across countries.

It is important for you know who all contributes to health expenditure; let us see the following Box.

Contribution of expenditure by:

Union Government

State Government

Local Bodies

Households – Insurance and Out-of-Pocket

Insurance Companies

NGOs

External Donors/Funding

Now let us review the key health financing indicators. (Source: National Health Accounts Estimates for India, NHATS, NHSRC, MOH&FW, GOI, 2017).

1. Total Health Expenditure (THE) as percent of GDP and Per

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Capita: THE constitutes current and capital expenditures incurred by Government and Private Sources including External funds. THE as a percentage of GDP indicates health spending relative to the country's economic development. THE per capita indicates health expenditure per person in the country.

2. **Current Health Expenditures (CHE) as per cent of THE:** CHE constitutes only recurrent expenditures for healthcare purposes net all capital expenditures. CHE as percent of THE indicate the operational expenditures on healthcare that impact the health outcomes of the population in that particular year.

3. **Government Health Expenditure (GHE) per cent of THE:** GHE constitutes spending under all schemes funded and managed by Union, State and local governments including quasi-governmental organizations and donors in case funds are channelled through government organizations. It has an important bearing on the health system as low government health expenditures may mean high dependence on household out of pocket expenditures.

4. **Out of Pocket Expenditures (OOPE) as per cent of THE:** Out of Pocket Expenditures are expenditures directly made by households at the point of receiving health care. This indicates extent of financial protection available for households towards healthcare payments.

5. **Social Security Expenditure on health as per cent of THE:** Social Security Expenditures include finances allocated by the government towards payment of premiums for union and state Government financed health insurance schemes (RSBY and other state specific health insurance schemes), employee benefit schemes or any reimbursements made to government employees for healthcare purposes and Social Health Insurance scheme expenditures. This indicates extent of pooled funds available for specific categories of population.

6. **Private Health Insurance Expenditures as per cent of THE:** Private health insurance expenditures constitute spending through health insurance companies where in households or employers pay premium to be covered under a specific health plan. This indicates the extent to which there are voluntary prepayments plans to provide financial protection.

7. **External/Donor Funding for health as per cent of THE:** This constitutes all funding available to the country by assistance from donors.

8. **GHE as % of General Government Expenditure (GGE):** This is a proportion of share of government expenditures towards healthcare in the general government expenditures and indicates Government's priority towards healthcare.

9. **Household Health Expenditure as % of THE:** Household health expenditures constitute both direct expenditures (OOPE) and indirect expenditures (prepayments as health insurance contributions or premiums). This indicates the dependence of households on their own income/savings to meet healthcare expenditures.

10. **Union and State Government Health Expenditure as % of GHE:** The Union Government Health Expenditures includes the funds allocated by different Ministries and Departments of Union Government towards healthcare of general population and its employees (including funds allocated to local bodies). Similarly the State Government Health Expenditure includes the funds allocated by different Departments under all the State Governments towards healthcare of general population and its employees (including funds allocated to Local bodies and also the funds allocated for health by Local Bodies from their own resources). This indicates the share of the Union Government and State governments in the government health expenditure which is an important indicator in a federal structure in India.

11. **AYUSH as % of THE:** AYUSH stands for Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy. It includes all the expenditure on non-allopathic care that comprises a range of long-standing and still-evolving practices based on diverse beliefs and theories. This indicates the share of expenditures under AYUSH system of medicines in the total health expenditure.

12. **Pharmaceutical Expenditures as % of CHE:** This includes spending on prescription medicines during a health system contact and self-medication (often referred to as over-the-counter products) and the expenditure on pharmaceuticals as part of inpatient and outpatient care from prescribing physicians. This indicates the share of pharmaceuticals expenditures in the current health expenditure.

Health Expenditure

Health expenditure includes expenditures incurred for consumption of health care goods and services during a given fiscal year. Health expenditures on following activities are include expenditures for:

- Health promotion and prevention
- Diagnosis, treatment, cure and rehabilitation of illness
- Care for persons affected by chronic illness
- Care for persons with health-related impairment and disability
- Palliative care
- Provision of community health programmes
- Governance and administration of the health system
- Medicines/Ancillary services that are purchased/availed independently without prescription from health professional like self-prescriptions/self-diagnosis which involves over the counter medicines are also included as health expenditures

National Health Accounts does not include the following:

- Compensation/benefits for wage loss, for failure of sterilization, maternity benefits (salaries of staff on maternity leave), loss of household income

due to sickness, disablement and death due to employment injury to workers and dependents.

- Expenditures related to purification, testing and supply of potable water, sanitation services, cremation and animal care, disposal of wastes, nutrition programs like mid-day meal, any other programs that compliment but directly do not impact health.
- Other miscellaneous expenditures incurred by the relatives or friends who accompany the patient like transport cost, food expenditures, lodging charges and loss of wage/labour.
- Interest paid on revenues, dividends, reserves of the insurer (after claims are paid including administrative overheads) are not accounted.

https://oxfamilibrary.openrepository.com/bitstream/handle/10546/556476/wp-financing-healthcare-for-all-india-290515-en.pdf?sequence=1

https://www.cehat.org/cehat/uploads/files/A%20246%20Financing%20healthcare.pdf

http://www.uhc-india.org/reports/hleg_report_chapter_2.pdf

https://nhsrcindia.org/national-health-accounts-records

https://mohfw.gov.in/sites/default/files/National%20Health%20Accounts%20Estimates%20Report%202014-15.pdf

Check Your Progress 3

1. Explain 2 components of Ayushman Bharat

2. Briefly explain health financing in India.

1.6 LET US SUM UP

In this unit you have learnt about health planning in India, its meaning and meaning of related terms, steps of planning and steps of planning cycle; various health committees including most important committee Bhore Committee and recommendations of these committees. Five years plans by Planning Commission and now role and objectives of NITI Ayog in planning. This unit also included National health Policy 2017, objectives, priority areas, major features and targets of policy, Sustainable Development Goals and SDG3 related to health; it also emphasised on Universal health Coverage, UHC meaning and principles. Political economy of health emphasised on changing role of State and concept of privatization, New Public Health Management and role of public and private sector in health. Further Unit explains about National Health Mission including NRHM and NUHM; Ayushman Bharat and 2 important components of it i.e. Health and Wellness Centres and services provided at HWCs and role of MLHP and Pradan Mantri Jan Arogya Yojana. Health financing in India meaning, definition, financial resources and barriers and national health accounts meaning, definition, contribution and health expenditure by various agencies.

1.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. Steps of planning cycle are:

   1. **Analysis of the health situation** – Collect data, information, analyse and interpret it. This will help to identify needs and demands and to set priorities.

   2. **Establishment of objectives and goals** – Set goals and objectives. Specify measureable, realist objectives. Long term and short term objectives needs to be specified.

   3. **Assessment of resources** – Resources means manpower, money, material 9equipment, supplies, machines etc), knowledge and skills.

   4. **Fixing priorities** – Set priorities as per magnitude of the problem, political will and community needs and demands.

   5. **Plan formulation** – The plan should be realistic, feasible to implement. All the programmes/institutions should specify targets, resources, budget and timeline to implement the activities and in-build system of monitoring. Approving authority can modify or reject plan activities. Before implementing plan it should be approved by the competent authority.

   6. **Plan implementation** – Effective organization structure is required to implement the plan keeping in mind the principles and elements of management. Human resource or manpower planning is very crucial, selection, recruitment, placement, training, their roles and responsibilities, communication, motivation, supervision are crucial elements.

   7. **Monitoring** – Day to day follow-up during implementation of plan. Managers observe record and report; find deviations and take corrective actions if required.

   8. **Plan evaluation** –Assess the achievements and objective achievement; cost effectiveness, reallocation of resources and priorities are again set as per changing needs and demands.

2. **Health Survey and Development Committee also known as Bhore Committee** - Committee recommended that preventive and curative medical care services should be integrated at all levels; changes in medical education i.e. 3 months training in preventive and social medicine; and establishment of Primary Health Centres (PHC) in 2 stages:

   a. **Short Term** - 1 PHC for 40,000 population with 2 doctor, 1 nurse, 4 public health nurses, 4 midwives, 4 trained dias, 2 sanitary inspectors, 2 health assistants, 1 pharmacist and 15 other class IV employees. Secondary health care delivery institution to provide support and carry out supervision and monitoring.

   b. **Long Term** - Setting up PHC with 75 bedded hospital for 10,000-20,000 population. Secondary level health care unit to have 650

bedded hospital and setting up district hospital with 2500 beds in the region.

3. Objectives of NITI Aayog are to:

1. evolve a shared vision of national development priorities, sectors and strategies.
2. foster cooperative federalism through structured support initiatives and mechanisms.
3. develop mechanisms to formulate credible plans at the village level and at higher levels.
4. ensure, on areas that are specifically, that the interests of national security.
5. pay special attention to the sections of our society that may be at risk of not benefiting from economic progress.
6. design strategic and long-term policy and programme frameworks and initiatives, and monitor their progress and their efficacy and take corrective measures
7. provide advice and encourage partnerships between key stakeholders, national and international, educational and policy research institutions.
8. create a knowledge, innovation and entrepreneurial support system through a collaboration.
9. offer a platform for the resolution of inter-sectoral and inter departmental issues.
10. maintain a state-of-the-art resource centre, be a repository of research on good governance and best practices.
11. actively monitor and evaluate the implementation of programmes and initiatives.
12. focus on technology upgradation and capacity building for implementation of programmes and initiatives.
13. undertake other activities as may be necessary for national development

Check Your Progress 2

1. Principles of UHC

- Universalityà caring all for all health problems
- Equityà Equitable consideration for all
- Non-Exclusion and Non-Discriminationà No one is spared irrespective of social or economic status
- Comprehensive Care of good qualityà A care that is care in totality and good in quality
- Financial protectionà at a low cost
- Protection of Patients Rightsà Survival of the patient is main motto and he gets all cares as a right to health

- Strengthening Public Health provisioningà Making all the public health faculties functional with resources.
- Accountability and Transparencyà Putting everything in clarity
- Community Participationà Taking everybody (community) along with the system
- Putting health in people's handà Making health care availability and utilization as a movement of the people not only the government.

2. It will be interesting to learn about political economy of health. As the word implies political and economy, these are derived from two subjects that is politics i.e. power, governance, authority to make decisions, the state and economy i.e. provision of material, contracts, market economy, , resource generation and distribution, benefit distribution, role of government to improve services etc. As per Todaro, political economy goes beyond simple economics to include social and institutional processes through which economic and political elites choose to allocate resources for their own benefit and then to the wider population. It deals with ways in which politics determines or influences economic activities.

   Political Economy doctrine from 1980 onwards is based on pro-market model. It is concerned with: - Market efficiency and maximization of economic welfare. - Market liberalization (right prices) - Trade liberalization (export oriented) - Privatisation (reduce state expenditure and control) - Private sector as a force for development - Free trade

Check Your Progress 3

1. **Establishment of Health and Wellness Centres –** Creation of 1,50,000 Health and Wellness Centres which will bring health care closer to the homes of the people. These centres will provide Comprehensive Primary Health Care (CPHC), covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services. Existing Sub-Centres (SCs) covering 3000-5000 population, Primary Health Centres (PHCs) and Urban PHC s to be converted into Health and Wellness Centres (HWCs). Outreach services will be provided through Mobile Medical vans, health camps, home visits and interaction with the community at their setting. The principle of continuum of care to be kept in mind for equity, quality, universality and no financial hardship.

   Pradhan Mantri Jan Arogya Yojana (PM-JAY) – PM-JAY is one significant step towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3) .It aims to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health episodes. Pradhan Mantri Jan Arogya Yojana (PM-JAY) will provide financial protection (Swasthya Suraksha) to 10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries). It will provide cover of Rs. 500,000 per family per year (on a family

floater basis). PM-JAY will cover medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures. PM-JAY has defined 1,350 medical packages covering surgery, medical and day care treatments including medicines, diagnostics and transport.

2. WHO definition of health financing: – Health financing is the "function of a health system concerned with the mobilization, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system." The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care" (WHO 2000). As we know health is financed by public and private funds. To make progress toward universal health coverage (UHC), a reliance on public funds is necessary. Therefore, the way budgets are formed, allocated and used in the health sector is at the core factor to achieve universal health coverage.

UNIT 2 HEALTH CARE DELIVERY SYSTEM IN INDIA

Structure

2.0 Introduction

2.1 Objectives

2.2 Health System in India

   2.2.1 At Centre Level

   2.2.2 At State Level

2.3 Health Care Delivery

2.4 Health Care Services

2.5 Let us Sum up

2.6 Answers to Check Your Progress

2.0 INTRODUCTION

Hope all of you have studied about the constitution of India in your school. In our constitution it is mentioned that Health is a responsibility of State. Every State has its own health care delivery system. You must be aware that every Government all over the world is responsible for providing health care services to the citizen of their country. Same stands true for India also. Government tries to provide quality, accessible, affordable health services to all people. Therefore, it is important for you to learn about health care delivery system in India. Thus, in this unit you will learn about health system in India at centre and state level; levels of health care and health care services in India. Let us first go through the objectives of the unit.

2.1 OBJECTIVES

After completion of this unit you will be able to:

1. describe the health system at centre and state level in India;
2. review health care delivery system in India
3. plan to participate in providing health care services; and
4. describe the concept of community participation.

2.2 HEALTH SYSTEM IN INDIA

The Centre plays the role in policy making, planning, coordinating, assisting, monitoring and evaluation. State play's role in delivery of health care and implementation of national health programmes and schemes. Let us now see the health system in India at Centre, State and District levels.

2.2.1 At Centre Level

Let us review health system at Centre level.

At the Centre there are:

A. The Ministry of Health and Family Welfare (MOH&FW)

B. The Directorate General of Health Services (DGHS) and

C. The Central Council of Health and Family Welfare

Let us view the structure of the Ministry of Health and Family Welfare

A. **Ministry of Health and Family Welfare (MOHFW)** is headed by a political head i.e. the Union Minister of Health and Family Welfare; assisted by 2 state level ministers.

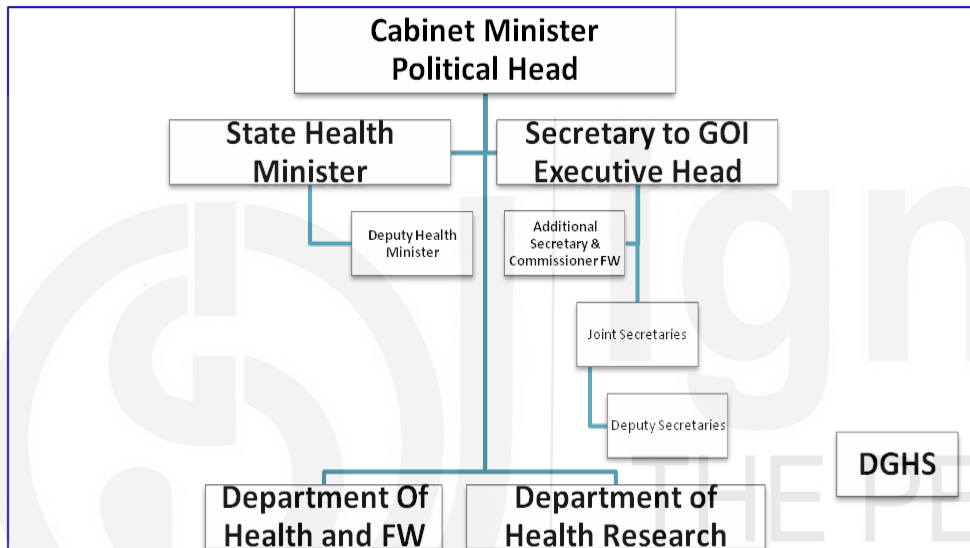

Figure 1.1: Ministry of Health and Family Welfare structure

Ministry of Health and Family Welfare (MOHFW) has 2 departments:

i. **Department of Health and Family Welfare,** headed by the Secretary to GOI, Secretary is executive head and is assisted by the joint and deputy secretaries and administrative staff. It has various departments under it like Central Health Services, Mental Health Division, Medical Education, National Health Programmes, National Health Mission, Training Division, Nursing, Allied Health Services, Drug Food Quality Control etc.

   As per seventh schedule of Article 246 of the Constitution of India there are two list:

   a. Union List

   b. Concurrent List

Few important functions under Union list are:

- International health relations and administration of port quarantine
- Administration of central institutes
- Promotion of research

- Regulation of medical, nursing professions
- Establishment and maintenance of drug standards
- Census and collection and publication of other statistical data

Few important functions under concurrent list are:

- Prevention of communicable diseases
- Prevention of adulteration of food stuffs
- Control of drugs and poisons
- Vital Statistics
- Labour Welfare
- Ports other than major
- Economic and social planning
- Population control and Family Planning

ii. **Department of Research,** the President notified the creation of the Department of Health Research under the Ministry of Health & Family Welfare through an amendment to the Government of India (Allocation of Business) Rules, 1961 on the 17th September 2007.

The Department of Health Research was formally launched on 5th October 2007 by the Minister for Science & Technology and Earth Sciences in a function presided over by the Minister for Health & Family Welfare, in the presence, inter-alia, of the Minister of State for Health & Family Welfare. Department of Health Research (DHR) was created as a separate Department within the Ministry of Health & Family Welfare by an amendment to the Government of India (Allocation of Business) Rules, 1961 on 17th Sept, 2007. The Department became functional from November 2008 with the appointment of first Secretary of the Department.

The aim of the DHR is to bring modern health technologies to the people through research and innovations related to diagnosis, treatment methods and vaccines for prevention; to translate them into products and processes and, in synergy with concerned organizations, introduce these innovations into public health system.

The following 10 functions (nine new functions, plus the function of administering the ICMR) have been allocated to the Department of Health Research:

1. Promotion and co-ordination of basic, applied and clinical research including clinical trials and operational research in areas related to medical, health, biomedical and medical profession and education through development of infrastructure, manpower and skills in cutting edge areas and management of related information thereto.
2. Promote and provide guidance on research governance issues, including ethical issues in medical and health research.
3. Inter-sectoral coordination and promotion of public- private – partnership in medical, biomedical and health research related areas.

4. Advanced training in research areas concerning medicine and health, including grant of fellowships for such training in India and abroad.
5. International co-operation in medical and health research, including work related to international conference in related areas in India and abroad.
6. Technical support for dealing with epidemics and natural calamities.
7. Investigation of outbreaks due to new and exotic agents and development of tools for prevention.
8. Matters relating to scientific societies and associations, charitable and religious endowments in medicine and health research areas.
9. Coordination between organization and institutes under the Central and State Governments in areas related to the subjects entrusted to the Department and for the promotion of special studies in medicine and health.
10. Administering and monitoring of Indian Council of Medical Research (ICMR).

B. The Directorate General of Health Services (DGHS)

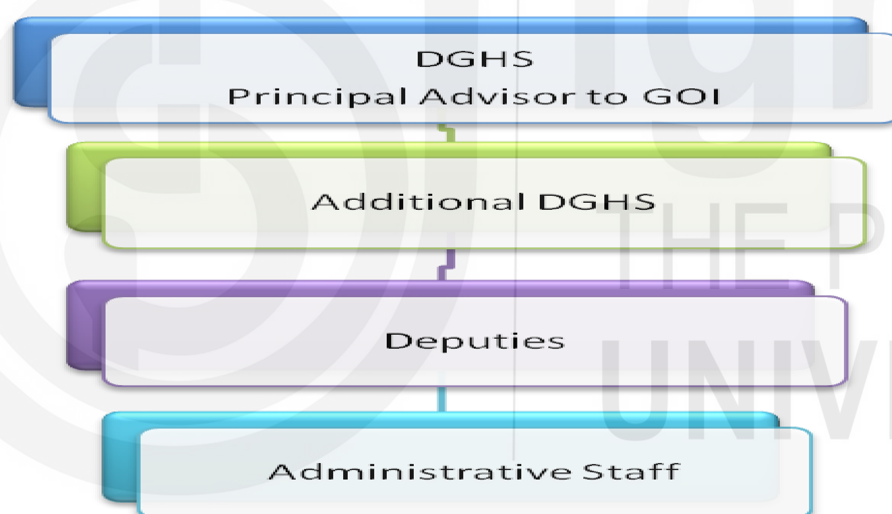

Figure 1.2: DGHS structure

The Directorate General of Health Services (Dte.GHS) is a repository of technical knowledge concerning Public Health, Medical Education and Health Care. It is an attached organisation of the Ministry of Health & Family Welfare. The Directorate GHS is headed by Director General of Health Services (DGHS), an officer of Central Health Services, who provides technical advice on all medical and public health matters to Ministry of Health and Family Welfare.

The Directorate co-ordinates with the Health Directorates of all States/ UTs for implementation of various National Health Programmes through its Regional Offices of Health and Family Welfare. The Dte.GHS oversees the functioning of Central Government Hospitals and their management. It also addresses health concerns of the people through its Subordinate Offices/ Institutes spread all over the country.

Subordinate offices generally function as field establishments or as agencies responsible for the detailed execution of the policies of government. They function under the direction of an attached office, or where the volume of executive direction involved is not considerable, directly under a department. They assist the departments concerned in handling technical matters in their respective fields of specialisation. Following is list of subordinate offices:

1. Regional Co-ordinating Organizations (RCOs) were established in some states in 1958 to co-ordinate between the Centre and the States for National Malaria Eradication Programme (NMEP) activities. Another office, named Regional Health Office (RHO) came into being in 1963 to co-ordinate and supervise the Family Welfare activities. Later on in 1978, when the need for an office of the Government of India in the States to supervise, monitor and co-ordinate the matters of all centrally sponsored Health and Family Welfare programmes was felt, the RCOs and RHOs were merged to form the Regional Office for Health and Family Welfare (ROH&FW). To supplement the activities of CBHI four Health Information Field Units (HIFUs) were established in 1981 and two more in 1986. As of now, there are 19 Regional Offices of Health & Family Welfare functioning under the Directorate General of Health Services (Dte. GHS) located in the various State Capitals.

2. The Central Drugs Laboratory, Kolkata is the nation statutory laboratory of the Government of India for Quality control of Drugs and Cosmetics and is established under the Indian Drugs & Cosmetic Act, 1940. It is the oldest quality control laboratory of the Drugs Controls Authorities in India. It functions under the administrative control of the Director General of Health Services in the Ministry of the Health and Family Welfare.

3. There are seven Central Drug Testing Laboratories under CDSCO. These are at Kolkata, Mumbai, Chennai, Guwahati, Chandigarh, Kasauli and Hyderabad. The Central Drug Laboratory, Kolkata is the appellate laboratory for testing of drugs and is NABL accredited for Chemical and Biological Testing. The Central Drug Testing Laboratory, Mumbai is a statutory Laboratory involved in testing of samples of Drugs from the ports, new drugs and oral contraceptive pills. It is an appellate laboratory for copper T-intrauterine contraceptive device and tubal rings. The Central Drugs Testing Laboratory, Chennai is an appellate Laboratory for condoms and is NABL accredited for both chemical and mechanical sections. The Regional Drugs Testing Laboratory, Guwahati tests the samples of drugs received especially from States in the East Zone and is NABL accredited for both chemical Zone and biological testing. The Regional Drug Testing Laboratory, Chandigarh is NABL Accredited Laboratory as per ISO/IEC 17025:2005 having Chemical, Instrumentation and Microbiological testing. Laboratory is involved in the analysis of Drugs & Cosmetic samples received from the Drugs Inspectors of CDSCO and O/o. Asstt. Drugs Controller (India), IGI Airport, Delhi.

4. The Medical Store Depots were originally established indifferent parts of the country under the Medical Stores Organization primarily to meet the needs of army units in respect of medicines, surgical equipments and other medical supplies. Subsequently, the services of the depots were made available to civilian situations also.

   In1942, the army established its own separate depots and the parent Medical Stores Organisation was transferred to the control of the then Department of Education, Health and Lands (now the Ministry of Health and Family Welfare). Since then, the Medical Stores Organisation has been functioning as a subordinate office of the Ministry of Health & Family Welfare and is being administered through the Directorate General of Health Services.

   At present the Medical Stores Organisation consist of 7 Government Medical Store Depots, located at Mumbai, Kolkata, Chennai, Hyderabad, Guwahati, Karnal and New Delhi. The depots at Mumbai, Kolkata, and Chennai have Chemical Testing Laboratories attached to them to ensure quality of drugs purchased from the firms. Each Government Medical Store Depot is headed by a Deputy Assistant Director General (DADG) (Stores). He is the Principal Executive Officer of the Depot and is responsible to the Directorate General of Health Services, New Delhi through MSO (HQ) at New Delhi for efficient administration of the Depot as a whole. GMSDs consist of three key divisions which are the Office Division, Stores Division and Accounts Division.

5. The National Centre for Disease Control (NCDC), formerly National Institute of Communicable Diseases (NICD) had its origin as Central Malaria Bureau, established at Kasauli (Himachal Pradesh) in 1909 and following expansion was renamed in 1927 as the Malaria Survey of India. The organization was shifted to Delhi in 1938 and called as the Malaria Institute of India (MII). In view of the drastic reduction achieved in the incidence of malaria under National Malaria Eradication Programme (NMEP), Government of India decided to reorganize and expand the activities of the institute to cover other communicable diseases. Thus in 1963 the erstwhile MII was renamed as National Institute of Communicable Diseases (NICD). In year 2009, NICD transforms into National Centre for Disease Control (NCDC) with a larger mandate of controlling emerging and re-emerging diseases. The Institute under administrative control of the Director General of Health Services, Ministry of Health and Family Welfare, Govt. of India. The Director, an officer of the Public Health sub-cadre of Central Health Service, is the administrative and technical head of the Institute.

6. In consonance with the recommendations of the Bhore Committee and the Planning Commission, the Central Health Education Bureau (C.H.E.B.) was created in the year 1956. The publicity Unit of the Directorate General of Health Services. The Bureau which started with one unit and few staff members in 1956 grew in size and activities gradually and had seven Divisions with trained technical personnel and one administrative division.

The goals and objectives of the division include educating the people about health plans and programmes, training health professionals, developing and supplying health education/IEC materials, conducting health behavioural research activities, providing technical assistance to government and non-government agencies in the field of health education, developing health education syllabi for different target groups and collaborating with international agencies in promoting health education. CHEB also works with SHEB, WHO, State health directorate, Depts. of education, NCERT, Board of Secondary Education and other national and international agencies in imparting health education

7. **The Directorate of National Vector Borne Diseases Control Programme (NVBDCP)** is the national level Technical Nodal office equipped with Technical Experts in the field of Public Health, Entomology, Toxicology and parasitology aspects of malaria. The Directorate is responsible for framing technical guidelines and policies as to guide the states for implementation of programme strategies. It is also responsible for budgeting and planning the logistics. Monitoring of implementation through regular reports and returns of MIS is done. The Directorate carries out evaluation of Programme implementation from time to time. The resource gap is also assessed as to provide an equitable support based on the magnitude of the problem.

   Under the Union Ministry of Health and Family Welfare, Government of India, 17 Regional Offices for Health and Family Welfare (ROH & FW) are functioning. These offices are located at different state headquarters. The offices are manned by technical people to coordinate and monitor all national health and family welfare programmes in the concerned states through close liaison and field visits. They are also capable for providing technical advice as well as assistance to the state. Under National Vector Borne Disease Control Programme these offices are entrusted with the responsibility of conducting the entomological studies in collaboration with zonal entomological setup of the state, drug resistance studies, cross checking of blood slides for quality control, capacity building of the states, etc.

   Health being a state matter, the responsibility of implementation of programme strategies and monitoring in accordance to programme guidelines lies with them and the development of infrastructure has to be done by the state. Every state has state vector borne diseases control component under the Directorate of Health Services with stipulated technical components. There is a system of coordination between the state and centre for effective implementation and monitoring of Programme.

8. Rural Health Training Centre, Najafgarh, New Delhi was set up as a health unit in 1937 and evolved for the next 50 years to become a national Scientific institute. The Major Activities of RHTC Najafgarh are as follows:

   There are a number of training activities going on RHTC, Najafgarh i.e. Training to Medical Interns under ROME Scheme. Medical Interns undergone rural posting from this Centre. Training to ANM 10+2 (Voc.)

Students is with intake capacity of 40 students per academic session. Community Health Nursing Training to BSc/MSc/GNM students of various Nursing Institutions like College of Nursing, Safdarjung Hospital, RML Hospital, Lady Hardinge Medical College, Holy Family Hospital, Batra Hospital, Apollo Hospital and various other Govt./State Govt./Pvt. Institutions. Trainees were trained and promotional training for Nursing Personnel, Health Education to the PGDHE Students and One Day Observation Visit. RHTC Najafgarh has been providing Health Services to people of 64 villages and 9 town of Najafgarh through it's three Primary Health Centre and 16 Sub-Centre including 24x7 Emergency Services in PHC Najafgarh.

It conducts field studies, provides RCH, Nutrition, Health Education and Communicable Diseases services and also provides field services for research work to the various health institutions, i.e. NIHAI, AIIMS in public health.

There are a number of additional programme under NRHM implemented by RHTC, Najafgarh. RHTC Najafgarh has implemented the NHM in its three PHCs and 16 sub-centres in collaboration with CDMO (South-West), Govt. of NCT Delhi.

International Health - The Point of Entries (POEs) means the area where any international passenger may enter legally from one country into another country. Health units responsible for undertaking measures for surveillance and response health activities at airports/seaports/Land Border in India are known as APHOs (Airport Health Organizations) / PHOs (Port Health Organizations) and LHUs (Land Health Units). Airport/Port Health Organizations primarily undertake public health activities at international ports/airports. Primary objective of these organizations is preventing entry and transmission of infectious diseases/ PHEIC across international borders along with ensuring a safe environment for travellers at Point of Entries. Health measures at these entry points are undertaken as per International Health Regulations (WHO- IHR 2005) and in accordance with Indian Aircraft (Public Health) Rules and Indian Port Health Rules.

The broad objectives of Directorate General of Health Services would be:

1. To formulate evidence-based policies and strategies and to plan and implement programmes based on transparent, innovative, inclusive policies.
2. To address social and cultural determinants to ensure every citizen has the right to health and well-being.
3. Guarantee food security to provide essential nutrition, especially for mother and child.
4. Ensure potable water, sanitation facilities and proper housing
5. To provide technical support to the Department of Health and Family Welfare in developing the strategies for free universal health care including free essential drugs, accessible to all citizens. Prioritize

special groups that need attention; mother, child, destitute and geriatric population.

6. To take effective measures to prevent, mitigate and eliminate/ eradicate communicable diseases of public health importance and to prevent, mitigate and or contain public health emergencies due to biological including zoonotic, chemical and radiological hazards.

7. To promote health through behavioural change with involvement of community, civil society, community-based organisations, media etc to address issues related to non- communicable diseases such as cancer, cardio vascular disease, stroke, mental illnesses, alcoholism and other substance abuse.

8. To ensure Emergency Medical Services coverage for all that would include medical, surgical (including trauma), paediatric and obstetric emergencies;

9. Address climate change issues impacting health.

10. Lay down specific standards and norms for safety and quality assurance of all aspects of health care

11. To develop and ensure availability of human resources in health sector appropriate to the level of care.

12. To manage information related to health status, health infrastructure and health Services.

13. To monitor progress and evaluate health outcome/ impact through pre-determined health indicators, norms and benchmarks.

14. To provide technical guidance and advice to the state health departments in responding to the challenges in meeting any of the objectives stated above.

C. The Central Council for Health

There is a Central Council of Health & Family Welfare under the chairmanship of the Minister for Health & FW comprising the Health Ministers of State Governments/UTs, MPs, non-officials representing health organizations and public bodies and certain eminent individuals. It is the apex policy formulating body in the field of health and family welfare for recommending broad lines of policy to the Centre and the States.

D. Nursing Directorate at Centre

Various committee have recommended nursing structure at Centre as given below in Figure. Nursing Advisor with 2-3 ADG Nursing are posted on deputation.

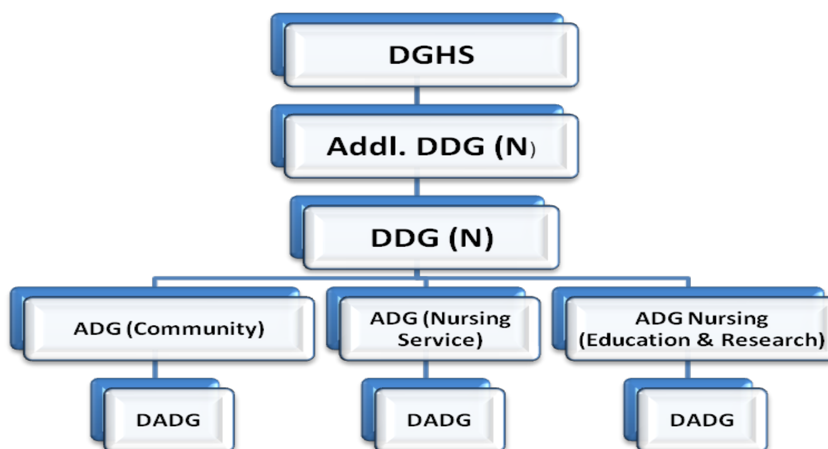

Figure 1.3: Recommended Nursing Directorate structure at Centre

Various committees over time including High Power Committee on Nursing and in 2005 National Rural Health Mission have recommended to strengthen the nursing structure at Centre and to create nursing cell or directorate at State level too. Study by Bagga R. et al have also recommended to strengthen the nursing leadership capacity at Centre and State There is a need to strengthen the structure at Centre so that nurses are involved in policy making with more autonomy and power to nurse administrators.

https://main.mohfw.gov.in/

https://main.mohfw.gov.in/about-us/about-the-ministry

https://main.mohfw.gov.in/organisation/Departments-of-Health-and-Family-Welfare

https://dhr.gov.in/

https://main.mohfw.gov.in/sites/default/files/Organization-Chart_1.pdf

https://main.mohfw.gov.in/about-us/constitutional-provisions

https://dghs.gov.in/

https://main.mohfw.gov.in/Organisation/Departments%20of%20Health%20and%20Family%20Welfare/nursing

Now let us learn about the health structure ay the State level.

2.2.2 At State Level

At the State Level

The State is responsible for all the health matters in the State as per constitution of India. Every State has its own organizational structure. But mainly consists of the following:

A. The State Ministry of Health

B. The State Health Directorate

A. The State Ministry of Health

The State Ministry of Health and Family Welfare is headed a political head i.e. by the Minster of Health and Family Welfare; and in some States there is provision for Deputy Minister of Health and Family Welfare; and Minister of H&FW are also responsible for other departments.

The Health Secretariate is headed by Principal Secretary or Secretary Health and Family Welfare as an executive head; assisted by Additional / Joint / Deputy Secretaries and administrative staff. Health Secretariate is responsible for policy issues, planning, evaluation of health services in the State.

B. The State Health Directorate

The Director, Health Services (DHS) also known as Director, Health and Family Welfare is a technical adviser to the State Health Ministry on matters related to medical and public health; the designation of Director, Health Services varies in many States; in few States there are more than one directorate i.e. Directorate of Health, Directorate of Family Welfare, Director Medical Education or Directorate of Medical and Health Services. DHS is assisted by Additional or Deputy or Assistant Director, Health Services. DHS is responsible for implementation of all the policies and programmes, day to day supervision, monitoring of services.

Under National Health Mission there is a State Health Mission.

- State Health Mission
- Integrated State Health Society

C. Nursing Structure at State Level

Various committee have recommended nursing structure at State level as given below in Figure. But only one State i.e. Orissa have Directorate of Nursing, West Bengal have Department of Nursing with nearly 14-16 nursing officers at State Nursing department. Other States like Kerala, Gujrat, Tamil Nadu, Andhra Pradesh etc. have 1 to 3 posts filled. Most of the States do not have separate nursing directorate.

Figure 1.4: Recommended Nursing Directorate structure at State Level

At the State level there is no uniformity in the structure of Directorate of Nursing and in number of nurse administrators posted in Directorate of Health Services to look after the various nurses' issues and make policy. West Bengal have created Department of Nursing with nearly 17 nursing officers who look after the work of nursing cadre recruitment, selection, administrative work, policy issues, education and services etc. Other States like Gujrat, Tamil Nadu, Assam, Manipur, Uttar Pradesh have created post of Deputy Director / Joint Director Nursing. But in most of the places' nursing cadre is under Director Health Services or under Deputy Secretary and in Orissa first Directorate of Nursing was created but Director Nursing was a medical professional. Although these posts were created but still nurse administrators have less authority to take decisions and many a times not involved in policy making. As there is no State Health Directorate in States all the decisions related to nursing are taken by Senior health administrators and Director, health Services.

> You can go through the link and learn about state health directorate of various states in India.https://mohfw.gov.in/Organisation/state-health-departments-0
>
> You can go through the link and learn about state health societies of various states in India https://mohfw.gov.in/Organisation/state-health-societies

C. District Health System

District is an administrative unit headed by a District Collector. Administrative areas under district are in rural area: sub-districts, tehsils, community development blocks; villages and panchayats; in urban area are: town area committees, municipal boards, corporations. At district level health sector is headed by the Chief Medical Officer with 2 or 3 Deputy Chief Medical Officers. District Health Mission – Integrated District Health Society.

Health Infrastructure at District level which implement all the national health programmes and provide primary health care to people:

1 District hospital
2. Sub-District hospital
3. Community Health Centre
4. Primary Health Centre
5. Health Wellness Centre / Sub-Centre

Nursing Structure at District Level

Various committee have recommended nursing structure at District level as given below in Figure. Hardly any district has nursing directorate as recommended. Few districts have created post of District PHNs and Public Health Nurses only.

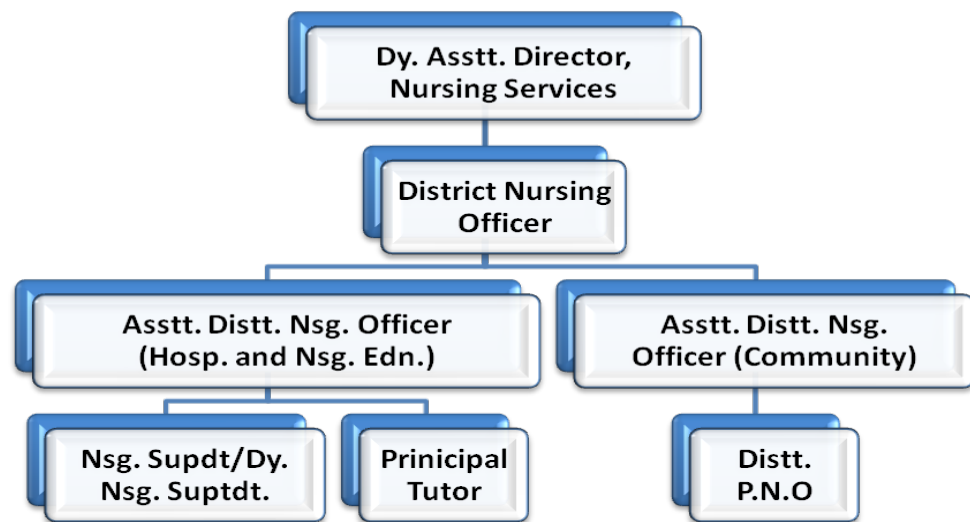

Figure 1.5: Recommended Nursing Directorate structure at District Level

Nursing structure in all the States at district level is very weak. As we know in Indian public health system District Public Health Nurses (DPHN) or District Nursing Officer can play a crucial role in supervision and monitoring the work of Public Health Nurses, ANMs, LHVs etc. The post of the DPHN was created in 1962 to supervise and monitor the performance of public health nursing personnel in the district (Mudaliar committee 1959). Except in States like West Bengal, Tamil Nadu, Gujarat etc very few States have created and filled post of District Public Health Nurse and involved in supervision and monitoring the work of nurses and ANMs at field level. Even under NRHM, MOHFW, GOI have emphasised on strengthening of Public Health Nursing cadre but the situation still remains the same.

2.3 HEALTH CARE DELIVERY

In India health is a State matter and every State have their own system of health care system but basic model for health care delivery remains same.

A. Health status and health problems and resources - Input (Health planning) (Health needs and demands)(Man, money, material)

B. Curative, preventive, promotive, rehabilitative services - Process {Health care services (Allopathic, AYUSH) (UHC -affordable, accessibility to all), Public, private, autonomous, voluntary/NGOs}

C. Changes in health status of people - Output (Health condition, satisfaction)

A. Health status and health problems and resources - Input (Health planning) (Health needs and demands)(Man, money, material)

You will read in detail about health problems and national health programmes in India in Unit 3 of this module.

Health Status and Health Problems

Health status and health problems data are an essential component to planning health care services. Let us think what type of data needs to be collected? So let us learn type of data any health administrator needs. Sources of data

are census reports, survey reports, vital statistics, health profile of country, annual reports of states, health utilization data etc.

To analyze the health situation and defining health problems following data are required:

1. Morbidity and Mortality data

   Morbidity means illness; person can also have co-morbidities i.e. morbidity may lead to morbidity. For example, a person having Diabetes might have kidney damage because of diabetes, the kidney disease is then known as co-morbidity. Prevalence is used to measure the morbidity.

   Now you would like to know what is prevalence? **Prevalence** is total number of cases of a particular disease at a given period of time in a population divided by total population at that time. It is generally expressed in percentage.

   Another term is **Incidence** which means number of only new cases of a disease in a population divided by the number of persons at the risk for the disease during given period of time. It is also expressed in percentage.

   Mortality means death. It is number of deaths due to disease divided by total population.

2. Demographic Data

   Demographic data includes socio-economic like age, sex, education, income, occupation, marital status, religion, size of family etc.

3. Environmental conditions which have impact on health

4. Socio-Economic factors like family income, per capita income and economic assets etc.

5. Cultural factors, attitudes, beliefs, practices etc.

6. Health services and other related services available

7. Other services available which have impact of health

   If the data is analyzed from all the above sources, it will give an idea about health situation of a state or district and health problems prevalent in the area. Then health administrators can assess the health needs of the community and prioritize the health problems, allocate the resources and plan action to implement modified health care action.

   In India major problem is the population; high fertility and high birth rate; low death rate, more young population and increasing elderly population. Every year Indian population increases to a total additional population as large as Australia. Overtime health status of people has improved and death rate is declining and while life expectancy has increased. However as compared to developed nations standard of health status is low in India. Still our maternal and newborn deaths are high as compared to developed nations.

Health Problems

Health problems in India can be grouped as given below:

1. Non-Communicable Diseases in India are increasing and deaths are also increasing due to diabetes, cancer, cardio-vascular, stroke, blindness, mental health and, injuries etc.
2. Communicable Diseases are still public health problems like malaria, filaria, kala azar, diarrhoeal diseases, tuberculosis, leprosy, acute respiratory infections and, HIV/AIDS etc.
3. Nutritional Problems, under nutrition, stunting, anaemia, low birth weight and deficiency disorders etc. are in rise.
4. Increase in Environmental health problems due to air, water, soil pollution, environmental sanitation and climate changes.
5. Population increase leads to problems like unemployment, high density of population in urban areas and slums, rising cost, inadequate infrastructure, low income etc.
6. Medical Care problems are issues related to housing, availability of doctors, nurses, living conditions etc.

A. Curative, preventive, promotive, rehabilitative services, (Allopathic, AYUSH) (UHC -affordable, accessibility to all), Public, private, autonomous, voluntary/NGOs provide health care services. Infrastructure, health manpower and resources are provided by respective under which they are functioning. Some of the national health programmes activities are implemented by all the agencies in collaboration with the State Health and District Health Mission.

B. Changes in health status of people like recovery from illness (fully or partially), any complications or disability; satisfaction of the people and utilisation of services etc.

https://main.mohfw.gov.in/Organisation https://main.mohfw.gov.in/Organisation/state-health-societies/state-health-departments-0 https://hmis.nhp.gov.in/downloadfile?filepath=publications/Rural-Health-Statistics/RHS%202020-21.pdf

Check Your Progress 1

1. Describe the State organisation structure of your State.

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2. Describe the district health system.

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2.4 HEALTH CARE SERVICES

Let us first understand the levels of health care.

A. Levels of Health Care

Health care is provided at 3 levels; type of care and institutions varies at each level. Indian Public Health Standards (IPHS) are followed for infrastructure, human resource, equipment, supplies and services provided at each level by various institutions.

i. Primary Level Care

It is a first level of contact between people or community with health care system; it provides basic need-based health care pr essential health care to people. Primary health care is provided by Health and Wellness Centres (HWCs) / Sub-Centres (SCs) and Primary Health Centres (PHCs) through ASHS, Multipurpose Health Workers Female and Male (also known as ANMs at some places or different States designate then by different names); Anganwadi Workers; local healers or traditional health care workers; RMPs and many other voluntary organizations or Non-Government Organizations (NGOs).

ii. Secondary Level Care

It is a first referral unit where PHC refer the patients for further treatment. Community Health Centres (CHC) and District hospitals provide care to people.

iii. Tertiary Level Care

It is a specialized referral units where care is provided by the specialist through regional institutions, national institutions and tertiary hospitals with or without attached medical colleges.

B. Health Care System in India

Let us now proceed to learn about health care system under public or government sector, private sector, indigenous system and voluntary

sector which provide health care services at all level. Allopathic and AYUSH System (Ayurveda, Yoga and Naturopathy, Unani Siddha and Homeopathy) health care services are provided to people.

i. Public or Government Sector

- Primary Level: Sub-Centres and Primary Health Centres
- Secondary Level: Community Health Centres, Block hospital and District hospital
- Tertiary Level: Secondary 200 bedded hospitals, specialized hospitals, teaching hospitals
- Health Insurance Schemes: Central Government Health Scheme (CGHS), Employees State Insurance (ESI), Railway and Defense institutions provide services to their employees and their families

ii. Private Sector

Private large and small hospitals, nursing homes, polyclinics, dispensaries, private practitioners' clinics

iii. Voluntary Organizations and Non-Government Organizations (NGOs)

Various voluntary health agencies and NGOs provide health care services.

iv. Others

Local healers, untrained practitioners, Registered Medical Practitioners (RMPs) too provide health care services to local people.

In brief we have learnt about health care agencies which provide services to people. As we know that community participation is very important for planning, implementing and monitoring health care services at community level. We will now learn about concept of community participation.

C. Community Participation

Community participation is important for planning, implementation and monitoring of health care services and it is the responsibility of the community in order to take care of the health of the community itself. It is believed by the health administrators must aim at the involvement of community is essential to provide primary health care services and to achieve universal health access. It is important to utilize local resources such human resource, material and money. Since beginning health guides, trained dais, local health workers, multipurpose health workers/ANM, Anganwadi workers and ASHS are involved in providing health care services to people from the community.

Even under National Health Mission is it envisaged that active participation of community is very important and examples are involvement of ASHA, formation of Village Health and Nutrition Committee (VHSNC), involvement of NGOs and public participation in facility-based committees.

Participation does not end in utilizing the human resources. The community should participate in planning and implementation of health care delivery

also. The administrative leadership capacity is being enhanced by different managerial training programmes of the health sector administrators like CMO, Deputy CMO and Medical officers. The Block extension Educator is also being converted as Community Health Managers.

Effective Community monitoring is critically dependent on active intervention by, and capacity building of all stakeholders outside the health department. Involve wide range of beneficiary representatives, community-based organizations, people's movements, voluntary organizations and panchayat representatives, who will form over two-thirds of the membership of all monitoring committees, and involved in monitoring process. Hence it would be desirable to involve networks, organizations and individuals with experience of community mobilization and community-based monitoring.

Monitoring need joint facilitation where the health department officials would play an important role, however agencies with experience of working with civil society groups and panchayats would also need to play a facilitating role. Such joint facilitation could ensure broad representative, balanced and reasonably independent monitoring system, which can give inputs from various sections of the community, not just a formal set of bodies appointed by the health department.

The skills involved in developing participatory monitoring are different from usual programme related skills. The NHM Framework for implementation document outlines the composition and broad roles of monitoring and planning committees at various levels. However, it does not lay out how this entire process should be developed. This will require additional detailing and development at both national and state levels. The kind of capacity required to develop a participatory community monitoring system is quite different from programme implementation and training usually conducted by the health department; hence involving agencies with some experience of accountability building and health rights work would be desirable to help facilitate this process.

Community Action for Health (CAH)

The Community Action for Health (CAH), earlier known as Community Based Monitoring and Planning (CBMP), is a key strategy of the National Health Mission (NHM), which places people at the centre of the process of ensuring that the health needs and rights of the community are being taken care off. It allows them to monitor the progress of the NHM interventions in their areas resulting in the community's participation and contribution towards strengthening the health services. Thereby, Bringing Public into Public Health.

The process involves the following steps:

1. Strengthening of Village Health, Sanitation and Nutrition Committees (VHSNCs), Rogi Kalyan Samities (RKSs), and Planning and Monitoring Committees (PMCs) at the PHC, block, district and state levels;

2. Creating community awareness on NHM entitlements, roles and responsibilities of service providers;

3. Training of VHSNC, RKS and PMC members;
4. Undertaking community level enquiry to assess the availability, range and quality of health services;
5. Developing village and facility level reports to reflect the status of health services;
6. Organising Jan Samwad (public dialogue) for advocacy with health providers and managers to highlight gaps and find solutions; and
7. Corrective action and planning to address the emerging issues and gaps.

The Ministry of Health and Family Welfare (MoHFW) constituted the Advisory Group on Community Action (AGCA) in 2005 to provide guidance on community action initiatives under the National Rural Health Mission (NRHM) at the national level. The AGCA comprises eminent public health professionals associated with major NGOs. The Population Foundation of India (PFI) hosts the Secretariat for the AGCA.

Village Health, Sanitation and Nutrition Committee (VHSNC)

One of the key elements of the National Rural Health Mission is the Village Health, Sanitation and Nutrition Committee (VHSNC). The committee has been formed to take collective actions on issues related to health and its social determinants at the village level. The committee take leadership role in providing a platform for improving health awareness and access of community for health services, address specific local needs and serve as a mechanism for community-based planning and monitoring. The committee is formed at the revenue village level and it act as a sub-committee of the Gram Panchayat. It has a minimum of 15 members which comprise of elected member of the Panchayat who led the committee, all those working for health and health related services, community members / beneficiaries and representation from all community especially the vulnerable sections participate in the committee activities and ASHA is a member secretary and convener of the committee.

Roles and Responsibilities:

- Create awareness about nutritional issues and emphasise on nutrition as an important determinant of health.
- Conduct survey on nutritional status and nutritional deficiencies in the village especially among women and children. Find out causes of malnutrition
- Identify locally available food stuffs of high nutrient value and promote best practices based on with local culture.
- Inclusion of nutritional needs in the Village Health Plan.
- Monitoring and Supervision of Village Health and Nutrition Day to ensure that it is organized every month in the village with the active participation of all the people of the village.
- Facilitate early detection of malnourished children; strengthen referral with Nutritional Rehabilitation Centre (NRC) and follow up the cases.

- Supervise the functioning of Anganwadi Centre (AWC) and facilitate in improving nutritional status of women and children.
- Act as a grievance's redressal forum on health and nutrition issues.

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=148&lid=224

https://nhsrcindia.org/practice-areas/cpc-phc/community-processes-community-platforms

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=149&lid=225

Check Your Progress 2

1. Describe levels of health care in India.

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2. Explain concept of community participation.

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2.5 LET US SUM UP

In this unit you have learnt about health care delivery system in India at Centre, State and District level and their functions. Nursing structure at Centre, State and District level at its need. Health problems and issues in India. Level of health care in India and services providers i.e. public, private, autonomous and voluntary sector, Community participation and need and role of village health and sanitation committee.

2.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. The State is responsible for all the health matters in the State as per constitution of India. Every State has its own organizational structure. But mainly consists of the following:

D. The State Ministry of Health

E. The State Health Directorate

A. The State Ministry of Health

The State Ministry of Health and Family Welfare is headed a political head i.e. by the Minster of Health and Family Welfare; and in some States there is provision for Deputy Minister of Health and Family Welfare; and Minister of H&FW are also responsible for other departments.

The Health Secretariate is headed by Principal Secretary or Secretary Health and Family Welfare as an executive head; assisted by Additional / Joint / Deputy Secretaries and administrative staff. Health Secretariate is responsible for policy issues, planning, evaluation of health services in the State.

B. The State Health Directorate

The Director, Health Services (DHS) also known as Director, Health and Family Welfare is a technical adviser to the State Health Ministry on matters related to medical and public health; the designation of Director, Health Services varies in many States; in few States there are more than one directorate i.e. Directorate of Health, Directorate of Family Welfare, Director Medical Education or Directorate of Medical and Health Services. DHS is assisted by Additional or Deputy or Assistant Director, Health Services. DHS is responsible for implementation of all the policies and programmes, day to day supervision, monitoring of services.

Under National Health Mission there is a State Health Mission.

- State Health Mission
- Integrated State Health Society

C. Nursing Structure at State Level

Various committee have recommended nursing structure at State level as given below in Figure. But only one State i.e. Orissa have Directorate of Nursing, West Bengal have Department of Nursing with various nursing officers at State Nursing department. Other States like Kerala, Gujrat, Tamil Nadu, Andhra Pradesh etc. have 1 to 3 post filled. Most of the States do not have separate nursing directorate.

2. District is an administrative unit headed by a District Collector. Administrative areas under district are in rural area: sub-districts, tehsils, community development blocks; villages and panchayats; in urban area

are: town area committees, municipal boards, corporations. At district level health sector is headed by the Chief Medical Officer with 2 or 3 Deputy Chief Medical Officers. District Health Mission – Integrated District Health Society.

Health Infrastructure at District level which implement all the national health programmes and provide primary health care to people:

1. District hospital
2. Sub-District hospital
3. Community Health Centre
4. Primary Health Centre
5. Health Wellness Centre / Sub-Centre

Nursing Structure at District Level

Various committee have recommended nursing structure at District level as given below in Figure. Hardly any district have nursing directorate as recommended. Few districts have created post of District PHNs and Public Health Nurses only.

Check Your Progress 2

1. Levels of Health Care

Health care is provided at 3 levels; type of care and institutions varies at each level. Indian Public Health Standards (IPHS) are followed for infrastructure, human resource, equipment, supplies and services provided at each level by various institutions.

ii. Primary Level Care

It is a first level of contact between people or community with health care system; it provides basic need based health care pr essential health care to people. Primary health care is provided by Health and Wellness Centres (HWCs) / Sub-Centres (SCs) and Primary Health Centres (PHCs) through ASHS, Multipurpose Health Workers Female and Male (also known as ANMs at some places or different States designate then by different names); Anganwadi Workers; local healers or traditional health care workers; RMPs and many other voluntary organizations or Non-Government Organizations (NGOs).

ii. Secondary Level Care

It is a first referral unit where PHC refer the patients for further treatment. Community Health Centres (CHC) and District hospitals provide care to people.

iii. Tertiary Level Care

It is a specialized referral units where care is provided by the specialist through regional institutions, national institutions and tertiary hospitals with or without attached medical colleges.

2. Community participation is important for planning, implementation and monitoring of health care services and it is the responsibility of the community in order to take care of the health of the community itself. It is believed by the health administrators must aim at the involvement of community is essential to provide primary health care services and to achieve universal health access. It is important to utilize local resources such human resource, material and money. Since beginning health guides, trained dais, local health workers, multipurpose health workers/ ANM, Anganwadi workers and ASHS are involved in providing health care services to people from the community.

   Even under National Health Mission is it envisaged that active participation of community is very important and examples are involvement of ASHA, formation of Village Health and Nutrition Committee (VHSNC), involvement of NGOs and public participation in facility based committees.

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UNIT 3 HEALTH SCENARIO OF INDIA AND NATIONAL HEALTH PROGRAMMES

Structure

3.0 Introduction

3.1 Objectives

3.2 Health Status and Health Problems in India

3.3 National Health Programmes

3.3.1 Reproductive Maternal Neonatal Child Health and Adolescent Programme

3.3.2 Programmes for Communicable Diseases

3.3.3 Programmes for Non-Communicable Diseases

3.3.4 National Nutrition Programmes

3.4 Programmes for Health Systems Strengthening and Quality

3.5 Let us Sum up

3.6 Answers to Check Your Progress

3.7 Key Words

3.8 Practical Activity and Guidelines

3.0 INTRODUCTION

In unit 1 of this module you have learnt about national health planning and health financing in India and in unit 2 you learnt about health care delivery system in India at Centre, State and District level, national health mission and national health policy. It is known to you that a healthy nation can contribute to economic growth and development of a country. Governments are largely responsible to provide healthcare at the door step through various health programs. Similarly, Government of India tries to provide healthcare at doorstep through health programs by health workforce. Therefore, it is important for you to learn about types, categories and services under each health program in India. Thus, in this unit you will learn about health Scenario and programs in India. You will be able to describe the health problems in country and various national health programmes. Let us first go through the objectives of the unit.

3.1 OBJECTIVES

After completion of this unit you will be able to:

1. critically analyse the health status and health problems of people in India;
2. enlist the national health programmes;

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3. plan to participate in implementing activities under various national health programmes; and
4. describe the programmes for health systems strengthening.

3.2 HEALTH STSTUS AND HEALTH PROBLEMS IN INDIA

Let us briefly review the indicators highlighted in world health statistics report 2019; it stated that recent years have seen improvements in 24 (56%) of the 43 health-related SDG indicators. But, at a global level, five of the 43 indicators: i.e. road traffic mortality, children overweight, malaria incidence, alcohol consumption, water sector are still concern areas. It is estimated that on current trends 51 countries will miss the target for under-5 mortality, and more than 60 countries will miss the target for neonatal mortality in 2030.

Populations in low-income countries have less access to essential health services and these countries experience shortages of health care professionals and government health expenditure is less for health sector. The proportion of the population that suffer catastrophic health expenditures (>10% or >25% of total household expenditures or income) is higher in middle-income countries even in high-income countries out-of-pocket health spending is due to medicines.

Catastrophic health expenditure – WHO

When people have to pay fees or co-payments for health care, the amount can be so high in relation to income that it results in "financial catastrophe" for the individual or the household. Such high expenditure can mean that people have to cut down on necessities such as food and clothing, or are unable to pay for their children's education.

World over 44 million house hold face catastrophic expenditure

World over 25 million house holds are pushed into poverty

Many people decide not to use health care services due to direct or indirect cost

As per SDG India Index-Dashboard 2019, document, there is remarkable change and improvement in India's healthcare system; there have been significant shifts in health strategies adopted to achieve the SDG Goals. The emphasis on water and sanitation, through the Swachh Bharat Mission, has

had a considerable impact on the spread of communicable diseases. The malnutrition among adolescents and women has been taken care off through increasing the entitlement to food under the National Food Security Act and National Nutrition Mission and Poshan Abhiyaan. Health management system is improved through – eVIN (electronic vaccine intelligence network) to track and improve immunisation coverage, ANMOL (ANM online) to extend better maternal and newborn care services, and use of Artificial Intelligence to improve diagnostics and treatment. There are significant efforts and initiatives to improve government accountability on health i.e. government has committed to enhancing public health expenditure to 2.5 per cent of GDP by 2025; the National Health Policy, 2017 recommends State governments' health budget to be more than 8 per cent of their total budget by 2020. The government is committed to establishing 1.5 lakh health and wellness centres by 2022 to ensure access to health services.

As per NITI Aayog, Health Systems for New India Building Blocks 2019, document, India have eliminated polio, guinea worm disease, yaws and maternal and neonatal tetanus. Total Fertility 1 2 Rate (TFR) has reduced sharply from 3.4 in 1992-93 to 2.2 in 2015-16; Maternal Mortality Ratio (MMR level of 130 against a target of 139) and almost succeeded in meeting the Under-5 child mortality target (U5 MR level of 43 against a target of 42). There are significant inter-state and intra-state differentials in health outcomes with socio-economically disadvantaged groups being particularly vulnerable to gaps in access as well as quality of healthcare available to them; the double burden of disease i.e. with a rising burden of non-communicable diseases in addition to the persistence of communicable diseases. India's epidemiological profile and burden of disease still shows that India is in the midst of an epidemiological transition. There is a marked burden of communicable diseases as well as Maternal, Newborn and Child Health (MNCH) related morbidity and mortality, particularly among the poor.

A healthy nation may be described where the rural and urban divide is least, access to clean energy and safe water, accessible and affordable health care is available to all, no poverty, illiteracy and crimes against women and children. Therefore, you may understand that the health scenario of a country is based on the various parameters like birth and death rate, availability of safe water and sanitary latrine, population growth rate and economic status of the country. Healthcare system in India made significant progress attributed to the combined efforts of the public and the private sector. India has made considerable progress in many health indicators.

As per National Health Report, 2019, MOH&FW, GOI, non-communicable diseases dominate over communicable in the total disease burden of the country. In a report of India Council of Medical Research (ICMR), titled India: Health of the Nation's States: The India State-Level Disease Burden Initiative (2017), it is observed that the disease burden due to communicable, maternal, neonatal, and nutritional diseases, as measured using Disability-adjusted life years (DALYs), dropped from 61 per cent to 33 per cent between 1990 and 2016. In the same period, disease burden from non-communicable diseases increased from 30 per cent to 55 per cent. The epidemiological

transition, however, varies widely among Indian states: 48% to 75% for non-communicable diseases, 14% to 43% for infectious and associated diseases, and 9% to 14% for injuries.

In recent years India has made ground-breaking progress in reducing the maternal mortality ratio (MMR) by 77% from 556 per 100000 live births in 1990 to 130 per 100000 live births in 2016 and MMR has significantly declined to 97 per 100,000 live births in 2018-20. The Urban-Rural divide traditionally seen in institutional births has been largely closed. Overall, 75% of rural births are now supervised as compared to 89% in urban areas. Significant increase from 78.9% in 2015-16 to 88.6% in 2019-21.

India has attained significant progress in achieving immunization coverage through Universal Immunization Programme (UIP) which provides prevention against six vaccine preventable diseases. In 2013, India along with South East Asia Region, declared commitment towards measles elimination and rubella/ congenital rubella syndrome (CRS) control by 2020. MR vaccine campaign is targeted towards 410 million children across the country. 'Mission Indradhanush' aimed to fully immunize more than 90% of newborns by 2020 through innovative and planned approaches. A total of 528 districts were covered during the various phases of this Mission. India has come a long way in immunisation but has to traverse far before achieving its targets.

Demographic Indicators

Demographic indicators of a country reveal its population size, decadal growth rate of population, territorial distribution, gender composition, changes therein and the components of changes such as nativity, mortality and social morbidity.

Demographic indicators can be divided in two parts

Vital Statistics deals with birth rate, death rate, and natural growth rate, life expectancy at birth, mortality and fertility rates

Population Statistics deals with size and growth of population, sex ratio, density of population etc.

State/UT wise performance of these indicators helps government to identify areas that need policy and programme interventions, setting short- and long-term goals, and decide priorities.

India's population, as per census 2011 is 12108.5 lakhs (6232.7 lakhs males and 5875.8 lakhs females). The population of India in 2021, as per the Census of India, is estimated to be around 1.35 billion people. The sex ratio of India during 1901 was 972 females per 1000 males. Since then, it has continued to decline decade over decade to 926 females against 1000 male in 1991 (except in 1981). The sex ratio has further improved from 1991 it was 933 and 943 female against 1000 female in 2001 and 2011 respectively

in the country. The sex ratio in India, as estimated by the NFHS-5 survey conducted between 2019-2021, is 1020 females per 1000 males The highest sex ratio of 1084 females per 1000 males was reported by State of Kerala followed by Puducherry (1037/1000), Tamil Nadu (996/1000), Andhra Pradesh (993/1000), Chhattisgarh (991/1000) and Meghalaya (989/1000). The lowest sex ratio of 618 females per 1000 males was reported by the UT of Daman & Diu followed by Chandigarh (818/1000), NCT of Delhi (868/1000), Andaman & Nicobar Islands (876/1000), Haryana (879/1000), Jammu & Kashmir (889/1000), Sikkim (890/1000) and Punjab (895/1000).

The highest population density of 11320 populations per square kilometre was reported by NCT of Delhi whereas Arunachal Pradesh has reported the lowest population density of 17. Age group-wise distribution of population of the country projected for 2015 and 2016 i.e. 27% of the total estimated population of 2016 were below the age of 14 years and majority (64.7%) of the population were in the age group of 15-59 years i.e. economically active population and 8.5% population were in the age group of 60 to 85+ years.

There has been consistent decrease in the Birth Rate, Death Rate and Natural Growth Rate in India since 1991 to 2017. As on 2017 India has registered Birth Rate of 20.2 per 1000 populations and Death Rate of 6.3 per 1000 populations while the Natural Growth Rate was 13.9 per 1000 population in India. The Birth Rate in Rural was higher than in the Urban. Similarly, the Death Rate and Natural Growth Rate were also higher in rural as compared to the Urban. In 2021, India's crude birth rate was approximately 17.377 births per 1,000 people, and the crude death rate was around 7.30 deaths per 1,000 people. The sex ratio at birth was 937 female births for every 1,000 male births. Additionally, the total fertility rate (TFR) had decreased to 2, falling below the replacement threshold of 2.1.

The population, however, continues to grow, as the decline in the birth rate is not as rapid as the decline in the death rate. The Life Expectancy of Life at Birth has increased from 49.7 years in 1970-75 to 68.7 years in 2012-16. For the same period, the Life Expectancy for Females is 70.2 years and 67.4 years for Males. Infant Mortality Rate has declined considerably (33 i.e. Per 1000 Live Births in 2016), however differentials of rural (37) & urban (23) are still high. As per the latest data available, Maternal Mortality Ratio is highest in Assam & lowest in Kerala. The Total Fertility Rate (TFR) for the country was 2.3 whereas in rural areas it has been 2.5 and it has been 1.8 in urban areas during 2016.

https://hmis.nhp.gov.in/downloadfile?filepath=publications/Rural-Health-Statistics/RHS%202020-21.pdf

https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1332&lid=713

https://main.mohfw.gov.in/sites/default/files/FinalforNetEnglishMoHFW040222.pdf

Check Your Progress 1

1. Critically analyse health problems in India as per New India Building Block 2019 Niti Ayog document.

2. List the demographic indicators.

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3.3 NATIONAL HEALTH PROGRAMMES

National Health Programmes, launched by the Government of India, have been playing crucial roles in tackling several serious health concerns, communicable and non-communicable diseases, over the last two decades. Health is a state subject and since there is triple burden of disease, that is not limited to geographical boundaries, national health programmes are imperative because they incorporate evidence based strategies for prevention and control. In national programs adequate infrastructure is in place and also resources for programme implementation are available.

As you have learnt in Unit 2 of this module regarding National Health Mission i.e. combine the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) and the main programme components are Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The objective of NHM is to envisage achievement

of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs. Let us now list the national health programmes.

You can read in detail about all national health programmes at the link https://www.nhp.gov.in/healthprogramme/national-health-programmes

3.3.1 Reproductive, Maternal, Neonatal, Child and Adolescent Health Programme

A. **Janani Shishu Suraksha Karyakaram (JSSK) -** Government of India has launched Janani Shishu Suraksha Karyakaram (JSSK) on 1st June, 2011. The scheme is estimated to benefit of pregnant women who access Government health facilities for their delivery.

Following are the Free Entitlements for pregnant women:

- Free and cashless delivery
- Free C-Section
- Free drugs and consumables
- Free diagnostics
- Free diet during stay in the health institutions
- Free provision of blood
- Exemption from user charges
- Free transport from home to health institutions
- Free transport between facilities in case of referral
- Free drop back from Institutions to home after 48hrs stay

Following are the Free Entitlements for Sick newborns till 30 days after birth. This has now been expanded to cover sick infants:

- Free treatment
- Free drugs and consumables
- Free diagnostics
- Free provision of blood
- Exemption from user charges
- Free Transport from Home to Health Institutions
- Free Transport between facilities in case of referral
- Free drop Back from Institutions to home

B. **Rashtriya Bal SwasthyaKaryakram (RBSK) -** Rashtriya Bal Swasthya Karyakram (RBSK), an innovative initiative, which includes Child Health Screening and Early Intervention Services, a systemic approach of early identification of medical conditions and link to care, support and treatment. This programme replaces the existing school health programme.

Objective - Early identification and early intervention for children from birth to 18 years to cover 4 'D's viz. Defects at birth, Diseases in children, Deficiency conditions and Developmental delays including Disabilities.

C. Universal Immunisation Programme

Immunization is the process whereby a person is made immune or resistant to an infectious disease, by the administration of a vaccine. Vaccines are substances that stimulate the body's own immune system to protect the person against subsequent infection or disease.

Immunization Programme in India was introduced in 1978 as 'Expanded Programme of Immunization' (EPI) by the Ministry of Health and Family Welfare, Government of India. In 1985, the programme was modified as 'Universal Immunization Programme' (UIP) implemented in phased manner to cover all districts in the country by 1989-90 with the one of largest health programme in the world. Despite being operational for many years, UIP has been able to fully immunize only 65% children in the first year of their life. Government of India is providing vaccination free of cost against vaccine preventable diseases include diphtheria, pertussis, tetanus, polio, measles, severe form of childhood tuberculosis, hepatitis B, meningitis and pneumonia (Hemophilus influenza type B infections), Japanese encephalitis (JE) in JE endemic districts with introduction of newer vaccines such as rotavirus vaccine, IPV, adult JE vaccine, pneumococcal conjugate vaccine (PCV) and measles-rubella (MR) vaccine.

Mission Indradhanush / Intensified Misson Indradhanush

To strengthen and re-energize the programme and achieve full immunization coverage for all children and pregnant women at a rapid pace, the Government of India launched "**Mission Indradhanush"** in December 2014.

The ultimate goal of Mission Indradhanush is to ensure full immunization with all available vaccines for children up to two years of age and pregnant women. The Government has identified 201 high focus districts across 28 states in the country that have the highest number of partially immunized and unimmunized children.

Intensified Mission Indradhanush (IMI)

To further intensify the immunization programme, Prime Minister launched the **Intensified Mission Indradhanush (IMI)** on October 8, 2017. Through this programme, Government of India aims to reach each and every child up to two years of age and all those pregnant women who have been left uncovered under the routine immunisation programme/UIP.

Intensified Mission Indradhanush has covered low performing areas in the selected districts (high priority districts) and urban areas. Special attention was given to unserved/low coverage pockets in sub-centre and urban slums with migratory population. The focus was also on the urban settlements and cities identified under National Urban Health Mission (NUHM).

Intensified Mission Indradhanush (IMI) 2.0

To boost the routine immunization coverage in the country, Government of India has introduced Intensified Mission Indradhanush 2.0 to ensure reaching the unreached with all available vaccines and accelerate the coverage of children and pregnant women in the identified districts and blocks. The IMI 2.0 aims to achieve targets of full immunization coverage in 272 districts in 27 States and at block level (652 blocks) in Uttar Pradesh and Bihar among hard-to-reach and tribal populations.

Several ministries, including the Ministry of Women and Child Development, Panchayati Raj, Ministry of Urban Development, Ministry of Youth Affairs and others have come together to make the mission a resounding success and support the central government in ensuring the benefits of vaccines.

D. Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana (JSY) is a safe motherhood intervention under the National Rural Health Mission (NRHM) being implemented with the objective of reducing maternal and neo-natal mortality by promoting institutional delivery among the poor pregnant women. The Yojana, launched on 12th April 2005, by the Hon'ble Prime Minister, is being implemented in all states and UTs with special focus on low performing states. JSY is a 100 % centrally sponsored scheme and it integrates cash assistance with delivery and post-delivery care.

ASHA (Accredited Social Health Activist) are effective link between the Government and the pregnant women in l0 low performing states, namely the 8 EAG states and Assam and J&K and the remaining NE States. In other states and UTs, wherever, AWW ((Anganwadi workers) and TBAs or ASHA like activist has been engaged.

E. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)

As India strives towards achieving the Sustainable Development Goals (SDGs) and looks ahead to the post-2015 era, progress in reducing maternal mortality becomes an important goal. In 2007-08, India had 47% institutional deliveries (DLHS 3). However as per latest data of the Rapid Survey on Children (2013- 14), the institutional deliveries in India are 78.7%. In spite of this massive increase in the number of pregnant women coming to institutions for delivery, till date only 61.8% women receive first ANC in first trimester and the coverage of full ANC (provision of 100 IFA tablets, 2 tetanus toxoid injections and minimum 3 ANC visits) is as low as 19.7%. Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) was launched in the year 2016 under National Health Mission. The program aims to provide assured, comprehensive and quality antenatal care, free of cost, universally to all pregnant women on the 9th of every month. A fixed day ANC is given every month across the country. If the 9th day of the month is a Sunday/ a holiday, then the Clinic is to be organized on the next working day. This service is given in addition to the routine ANC at the health facility. This will improve the quality and coverage of Antenatal Care (ANC) including

diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy.

F. Navjaat Shishu Suraksha Karyakram (NSSK)

NSSK is a programme aimed to train health personnel in basic newborn care and resuscitation, has been launched to address care at birth issues i.e. Prevention of Hypothermia, Prevention of Infection, Early initiation of Breast feeding and Basic Newborn Resuscitation. **Objective i**s to have a trained health personal in basic newborn care and resuscitation at every delivery point. The training is for 2 days and is expected to reduce neonatal mortality significantly in the country.

G. National Programme for Family planning

India was the first country in the world to have launched a National Programme for Family Planning in 1952.

Over the decades, the programme has undergone transformation in terms of policy and actual programme implementation and currently aimed to achieve **population stabilization** goal, promote **reproductive health** and reduce **maternal, infant & child mortality and morbidity.** Under the programme public health sector provides various family planning services at various levels of health system.

"**Mission Pariwar Vikas"** - For improved access to contraceptives and family planning services in high fertility districts spreading over seven high focus states, the Ministry of Health and Family Welfare launched "**Mission Pariwar Vikas"** in 2016. Special focus has been given to 146 high fertility Districts of *Bihar, Uttar Pradesh, Assam, Chhattisgarh, Madhya Pradesh, Rajasthan & Jharkhand,* with an aim to ensure availability of contraceptive methods at all the levels of Health Systems.

1.1.2 Programmes for Communicable Diseases

The diseases, which may spread from one person to another through many routes including vectors, contact, air, water and sexually transmitted, are called communicable diseases. The programs for these diseases are launched on the basis of population affected at National level. The microorganisms that cause these are dynamic, resilient, and well adapted to exploit opportunities for change and spread. Their public health significance in terms of human suffering, deaths, and disability is compounded by the considerable toll they take on economic growth and development.

For many important diseases, either control is not possible because of the lack of effective vaccines and therapeutic drugs, or because of existing drugs are becoming ineffective as antimicrobial resistance increasing.

Following programs were launched to control communicable diseases in India:

A. Integrated Disease Surveillance Programme (IDSP)

GOI launched IDSP with World Bank assistance in 2004 to detect and respond to disease outbreaks. It is intended to identify prevalence of "communicable

diseases", detect early warning signals of impending outbreaks, and help initiate an effective response in a timely manner.

IDSP focus on Surveillance of outbreaks and Rapid Response to tackle the problem and action taken on further incidence. Under this surveillance units have been established with Central Surveillance Unit (CSU) at National Centre for Disease Control, Delhi. Surveillance Teams and Rapid Response Teams (RRT) created and trained. Under the project weekly disease surveillance data on epidemic prone disease are being collected from reporting units such as sub centres, PHC/ CHC/DH including government and private sector hospitals and medical colleges. The data are being collected on 'S' syndromic; 'P' probable; and 'L' laboratory formats using standard case definitions.

Media scanning and verification cell was established under IDSP in 2008. It detects and shares media alerts with the concerned states/districts for verification and response. A 24X7-call centre was established in 2008 to receive disease alerts on a Toll-Free telephone number (1075). District laboratories are being strengthened for diagnosis of epidemic prone diseases. Program dealing with surveillance for malaria, acute diarrhoeal diseases, TB, measles, polio, plague, and new emerging diseases like Seasonal Influenza H1N1, Zika Virus, Nipah Virus and Ebola etc.

B. Revised National Tuberculosis Control Programme (RNTCP)

Indian government started RNTCP in 1997 that later covered entire nation by 2006. RNTCP uses the WHO recommended Directly Observed Treatment Short Course (DOTS) strategy and initiated services to address TB/HIV, MDR-TB and to extend RNTCP to the private sector. The Central TB Division developed a case based and web based system called "Nikshay". This helped with the reporting of all TB cases. GOI set up more than 600 CB-NAAT laboratories, and enhanced their capacity with highly sensitive diagnostic services. CB-NAAT is the name given in India to Cartridge Based Nucleic Acid Amplification tests.

GOI introduced National Strategic Plan 2017-2025 to eliminate TB in India. There are four strategic areas of Detect, Treat, Prevent & Build and five-thrust areas as private sector engagement; plugging the "leak" from the TB care cascade, active case finding among key populations; preventing the development of active TB in people with latent TB, and programmatic management of drug-resistant TB (PMDT).

C. National Leprosy Eradication Programme (NLEP)

The National Leprosy Eradication Programme is a centrally sponsored Health Scheme of the Ministry of Health and Family Welfare, Govt. of India. The Programme is headed by the Deputy Director of Health Services (Leprosy) under the administrative control of the Directorate General Health Services Govt. of India. While the NLEP strategies and plans are formulated centrally, the programme is implemented by the States/UTs. The Programmes also supported as Partners by the World Health Organization, The International Federation of Anti-leprosy Associations (ILEP) and few other Non-Govt. Organizations.

D. National Vector Borne Disease Control Programme

Launched in year 2003-04, major vector borne diseases covered in this are six diseases viz. malaria, filaria, kala-azar, JE, Dengue and Chikungunya. The activities implemented under this program are integrated vector management, Behaviour change communication, integration with national health mission as the program has captured ASHA and village health sanitation committee. The integrated vector management targeted source reduction of vectors, utilization of gambusia fish for larval control, distribution of insecticide treated bed nets (ITNs) and regular spray with DDT.

E. National AIDS Control Programme (NACP)

The National AIDS Control Programme (NACP), launched in 1992, implemented as a comprehensive programme for prevention and control of HIV/ AIDS in India. Over time, the focus has shifted from raising awareness to behaviour change, from a national response to a more decentralized response and to increasing involvement of NGOs and networks of People living with HIV (PLHIV). The current phase aims to accelerate the process of reversal and further strengthen the epidemic response in India through a cautious and well-defined integration process with the objective of optimal utilization of existing NRHM/RCH resources for strengthening NACP services. The program is a global success which is achieved through prevention services high risk groups and general population; expanding IEC; promoting comprehensive care, support and treatment and strengthening management information system.

F. National Viral Hepatitis Control Programme

The National Viral Hepatitis Control Program has been launched by Ministry of Health and Family Welfare, Government of India on the occasion of the World Hepatitis Day, 28th July 2018. It is an integrated initiative for the prevention and control of viral hepatitis in India to achieve Sustainable Development Goal (SDG) 3.3 which aims to ending viral hepatitis by 2030. This is a comprehensive plan covering the entire gamut from Hepatitis A, B, C, D & E, and the whole range from prevention, detection and treatment to mapping treatment outcomes.

G. National Programme on Containment of Anti-Microbial Resistance (AMR)

Antimicrobial resistance in pathogens causing important communicable diseases has become a matter of great public health concern globally including our country. Resistance has emerged even to newer and more potent antimicrobial agents like Carbapenems. The rapid spread of multi-resistant bacteria and the lack of new antibiotics to treat infections caused by these organisms pose a rapidly increasing threat to public and animal health and needs to be tackled if we are to contain the problem and prevent untreatable illness becoming a reality. Government of India has launched a "National Programme on Containment of Antimicrobial Resistance" under the 12th five-year plan (2012-2017).

1.1.3 Programmes for Non Communicable Diseases

As you know, the diseases, which don't spread from one person to another but arise because of multiple factors because of our life style including tobacco chewing, alcohol consumption, sedentary life style and stressful life, are called as non-communicable diseases.

Following programs were launched to control non communicable diseases in India

A. National Tobacco Control Programme (NTCP)

Tobacco use is one of the main risk factors for a number of chronic diseases, including cancer, lung diseases, and cardiovascular diseases. India is the 2nd largest producer and consumer of tobacco and a variety of forms of tobacco use is unique to India. Apart from the smoked forms that include cigarettes, bidis and cigars, a plethora of smokeless forms of consumption exist in the country.

The Government of India has enacted the national tobacco-control legislation namely, "The Cigarettes and other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003" in May, 2003. India also ratified the WHO-Framework Convention on Tobacco Control (WHO-FCTC) in February 2004. Further, in order to facilitate the effective implementation of the Tobacco Control Law, to bring about awareness about the harmful effects of tobacco as well as to fulfill the obligations under the WHO-FCTC, the Ministry of Health and Family Welfare, Government of India launched the National Tobacco Control Programme (NTCP) in 2007- 08.

B. National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS)

The country is experiencing a rapid health transition with a rising burden of Non-Communicable Diseases (NCDs) which are emerging as the leading cause of death in India with considerable loss in potentially productive years (aged 35-64 years) of life. Major modifiable risk factors are raised blood pressure, tobacco use, unhealthy diet, physical inactivity, alcohol consumption, and obesity.

Government of India initiated an integrated National Programme for Prevention and Control of Cancers, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) under the National Health Mission. The focus of the Programme is on health promotion and prevention, strengthening of infrastructure including human resources, early diagnosis and management and integration with the primary health care system through NCD cells at different levels for optimal operational synergies.

The program focuses on following strategies

- Health promotion and health education advocacy
- Early detection of people with high levels of risk factors through 'opportunistic screening'.

- Capacity building of health systems at all levels to tackle NCDs and improve the quality of care.
- District NCD Programmes will include 'District Health Promotion Centres' and the 'District NCD Cells' for creating awareness on lifestyle related diseases with a focus on the adoption of healthy lifestyles at schools, community, work places etc.

C. National Mental Health Programme

The Government of India has launched the National Mental Health Programme (NMHP) in 1982, to ensure the availability and accessibility of minimum mental healthcare for all, encourage the application of mental health knowledge in general healthcare and in social development; and to promote community participation. It has three components treatment of mentally ill, rehabilitation, prevention and promotion of positive mental health.

District Mental Health Programme has thrust areas including to cover the entire country and be more effective with modernization /streamlining of mental hospitals, upgrading Dept of Psychiatry in Medical Colleges and enhancing the psychiatric content, research and training in the field of community mental health, substance abuse and child adolescent psychiatric clinics. In India, the Mental Health Care Act 2017 was passed on 7 April 2017 and came into force from 7 July 2018.

D. National Programme for Control of Blindness & Visual Impairment (NPCB&VI)

Launched in the year 1976, it was a fully centrally sponsored scheme with the goal of reducing the prevalence of blindness to 0.3% by 2020. The objective of the program is to reduce the avoidable blindness through identification and treatment of curable blindness, develop and strengthen the strategy of NPCB for "Eye Health for All" and prevention of visual impairment, Strengthening and up-gradation of identified eye care institutions, developing additional human resources for providing high quality comprehensive Eye Care in all districts of the country, enhance community awareness on eye care and lay stress on preventive measures and secure participation of Voluntary Organizations/Private Practitioners in delivering eye Care services.

E. Pradhan Mantri National Dialysis Programme

End Stage Renal Disease continues to be a result of existing and emerging burden of non-communicable disease. Providing for renal transplant facilities for End Stage Renal Disease (ESRD) patients depends upon availability of infrastructure and robust organ donation system coupled with adequate availability of trained qualified manpower. Within the limited choices, dialysis practically remains the first and in majority of cases, the only choice for ESRD patients.

Every year about 2.2 Lakh new patients of End Stage Renal Disease (ESRD) get added in India resulting in additional demand for 3.4 Crore dialysis every year. With approximately 4950 dialysis centres, largely in the private sector in India, the demand is less than half met with existing infrastructure. Since every Dialysis has an additional expenditure tag of about Rs.2000, it results

in a monthly expenditure for patients to the tune of Rs.3-4 Lakhs annually. Besides, most families have to undertake frequent trips, and often over long distances to access dialysis services incurring heavy travel costs and loss of wages for the patient and family members accompanying the patient. Keeping this in mind, strengthening of District Hospitals by providing affordable multispecialty care including dialysis services in district hospitals would be an important step in this direction. It has also been proposed that Dialysis program be undertaken in Public Private Partnership.

F. National Programme for the Health Care for the Elderly (NPHCE)

With a comparatively young population, India is still poised to become home to the second largest number of older persons in the world. Projection studies indicate that the number of 60+ in India will increase from 100 million in 2013 and to 198 million by 2030. Non-communicable diseases requiring large quantum of health and social care are extremely common in old age, irrespective of socio-economic status. Disabilities resulting from these non-communicable diseases are very frequent which affect functionality compromising the ability to pursue the activities of daily living. The treatment/ management of these chronic diseases is also costly, especially for services like joint replacements, heart surgery, neurosurgical procedures etc.

To overcome this out of bound expenses for elderly whose income decreases post retirement and dependent elderly women, Ministry of Health and Family Welfare launched The National Programme for Health Care for the Elderly (NPHCE). It is a attempt to provide a comprehensive health care set up completely dedicated and tuned to the needs of the elderly.

G. National Programme for Prevention and Control of Deafness (NPPCD)

Hearing loss is the most common sensory deficit in humans today. As per WHO estimates in India, there are approximately 63 million people, who are suffering from significant auditory impairment; this places the estimated prevalence at 6.3% in Indian population. As per NSSO survey, currently there are 291 persons per one lakh population who are suffering from severe to profound hearing loss (NSSO, 2001). Of these, a large percentage is children between the ages of 0 to 14 years. With such a large number of hearing-impaired young Indians, it amounts to a severe loss of productivity, both physical and economic. An even larger percentage of our population suffers from milder degrees of hearing loss and unilateral (one sided) hearing loss.

Objectives of the programme:

1. To prevent avoidable hearing loss on account of disease or injury.
2. Early identification, diagnosis and treatment of ear problems responsible for hearing loss and deafness.
3. To medically rehabilitate persons of all age groups, suffering with deafness.
4. To strengthen the existing inter-sectoral linkages for continuity of the rehabilitation programme, for persons with deafness.

5. To develop institutional capacity for ear care services by providing support for equipment, material and training personnel.

   Long term objective: To prevent and control major causes of hearing impairment and deafness, so as to reduce the total disease burden by 25% of the existing burden by the end of 12th Five Year Plan.

Components of programme

1) Manpower training and development – For prevention, early identification and management of hearing impaired and deafness cases, training would be provided from medical college level specialists (ENT and Audiology) to grass root level workers.

2) Capacity building – for the district hospital, community health centres and primary health centre in respect of ENT/ Audiology infrastructure.

3) Service provision–Early detection and management of hearing and speech impaired cases and rehabilitation, at different levels of health care delivery system. 4) Awareness generation through IEC/BCC activities – for early identification of hearing impaired, especially children so that timely management of such cases is possible and to remove the stigma attached to deafness.

Strategies of programme

1. To strengthen the service delivery for ear care.
2. To develop human resource for ear care services.
3. To promote public awareness through appropriate and effective IEC strategies with special emphasis on prevention of deafness.
4. To develop institutional capacity of the district hospitals, community health centres and primary health centres selected under the Programme.

H. National programme for Prevention & Management of Trauma & Burn Injuries (NPPMT&BI)

The programme have two components - Trauma Care & Burn Injury management. The programme on Trauma care was initiated on pilot mode during 9th FYP to strengthen the Emergency Facilities on National Highways in Government Hospitals. Thereafter, the programme was implemented at a national level during 11th & 12th FYP period along with other technical components such a - National injury Surveillance Centre, Pre-Hospital Trauma Technician Course, trainings for Nurses and Doctors in BLS & ATLS respectively, IEC activities on first-aid/good Samaritan etc. The programme on Burn Injury Management was initiated on pilot mode during the 11th FYP and was implemented at a national level during 12th FYP. Both these components merged into NPPMT&BI after 12th FYP i.e. 2017 into one under the umbrella scheme - 'Territory Care Programmes' of Ministry of Health & FW.

I. National Programme for Prevention and Control of Fluorosis (NPPCF)

The National Programme for Prevention and Control of Fluorosis (NPPCF) was a new health initiative during 11th Five Year Plan, initiated in 2008-09 and is being expanded in a phased manner. 100 districts of 17 States were covered during 11th Plan, further 11 districts were taken up during 2013-15 (over 19 States) and additional 84 new districts are to be taken up during the remaining period of 12th plan.

Aim of the programme is to prevent and control Fluorosis cases in the country.

Objectives of the programme:

- To collect, assess and use the baseline survey data of fluorosis of Ministry. of Drinking Water and Sanitation for starting the project;
- Comprehensive management of fluorosis in the selected areas;
- Capacity building for prevention, diagnosis and management of fluorosis cases.

Strategies of programme:

- surveillance of fluorosis in the community;
- capacity building (Human Resource) in the form of training and manpower support; · establishment of diagnostic facilities in the medical hospitals;
- management of fluorosis cases including treatment surgery, rehabilitation
- health education for prevention and control of fluorosis cases.

Activities of programme:

- Community Diagnosis of Fluorosis village/block/cluster wise.
- Facility mapping from prevention, health promotion, diagnostic facilities, reconstructive surgery and medical rehabilitation point of view – village/ block/district wise.
- Gap analysis in facilities and organization of physical and financial support for bridging the gaps, as per strategies listed above. (a) Diagnosis of individual cases and providing its management. (b) Public health intervention on the basis of community diagnosis.
- Behaviour changes by IEC.
- Training

J. National oral Health Programme

Government of India has initiated a National Oral Health Programme to provide integrated, comprehensive oral health care in the existing health care facilities with the following objectives.

Objective of programme:

- o To improve the determinants of oral health
- o To reduce morbidity from oral diseases
- o To integrate oral health promotion and preventive services with general health care system
- o To encourage Promotion of Public Private Partnerships (PPP) model for achieving better oral health.

https://notto.gov.in/WriteReadData/Portal/images/THOA-ACT-1994.pdf

https://notto.gov.in/WriteReadData/Portal/images/THO-Rules-1995-(Original-Rules).pdf

https://notto.gov.in/WriteReadData/Portal/images/THOA-amendment-2011.pdf

https://notto.gov.in/WriteReadData/Portal/images/THOA-Rules-2014.pdf

https://notto.mohfw.gov.in/about-us.htm

Government of India has decided to assist the State Governments in initiating provision of dental care along with other ongoing health programmes implemented at various levels of the primary health care system. Funding has been made available through the State PIPs for establishment of a dental unit [at district level or below]. This dental unit equipped with necessary trained manpower, equipments including dental chair and support for consumables would be provided to the states through the NOHP. **K. National Programme for Palliative Care (NPPC)**

Palliative care is also known as supportive care which is required in the terminal cases of Cancer, AIDS etc. Effective palliative care requires a multidisciplinary approach that includes the family and makes use of available community resources. It can be provided in tertiary care facilities, in community health centres and even in patients' homes. It improves the quality of life of patients and families who face life-threatening illness, by providing pain and symptom relief, spiritual and psychosocial support from diagnosis to the end of life and bereavement.

The Ministry of Health & Family Welfare, Government of India constituted an expert group on Palliative care which submitted its report 'Proposal of Strategies for Palliative Care in India' in November, 2012. No separate budget is allocated for the implementation of National Palliative Care Program. However, the Palliative Care is part of the 'Mission Flexipool' under National Health Mission (NHM).

Beneficiaries:

The terminal cases of Cancer, AIDS etc.

Goal: Availability and accessibility of rational, quality pain relief and palliative care to the needy, as an integral part of Health Care at all levels, in alignment with the community requirements.

Objectives of programme:

- Improve the capacity to provide palliative care service delivery within government health programs such as the National Program for Prevention and Control of Cancer, Cardiovascular Disease, Diabetes, and Stroke; National Program for Health Care of the Elderly; the National AIDS Control Program; and the National Rural Health Mission.
- Refine the legal and regulatory systems and support implementation to ensure access and availability of Opioids for medical and scientific use while maintaining measure for preventing diversion and misuse
- Encourage attitudinal shifts amongst healthcare professionals by strengthening and incorporating principles of long-term care and palliative care into the educational curricula (of medical, nursing, pharmacy and social work courses).
- Promote behaviour change in the community through increasing public awareness and improved skills and knowledge regarding pain relief and palliative care leading to community owned initiatives supporting health care system.
- Develop national standards for palliative care services and continuously evolve the design and implementation of the National program to ensure progress towards the vision of the programme.

L. National Iodine Deficiency Disorders Control Programme

Iodine is an essential micro nutrient. It is required at 100-150 micrograms daily for normal human growth and development. The disorders caused due to deficiency of nutritional iodine in the food/diet are called iodine deficiency disorders (IDDs).

Objectives of programme:

- Surveys to assess the magnitude of the Iodine Deficiency Disorders.
- Supply of iodated salt in place of common salt.
- Resurvey after every 5 years to assess the extent of Iodine Deficiency Disorders and the impact of iodised salt.
- Laboratory monitoring of iodated salt and urinary iodine excretion.
- Health education & Publicity.

M. National Organ Tissue and Transplant

The Transplantation of Human Organs Act, 1994 - It provides for the regulation of removal, storage and transplantation of human organs for therapeutic purposes and for the prevention of commercial dealings in human organs and for matters connected therewith or incidental thereto. Amendments were carried out in 2011 and 2014.

National Organ and Tissue Transplant Organization (NOTTO) is a national level organization set up under Directorate General of Health Services, Ministry of Health and Family Welfare, Government of India. It has following two divisions:

- "National Human Organ and Tissue Removal and Storage Network"
- "National Biomaterial Centre"

"National Human Organ and Tissue Removal and Storage Network" The network will be established initially for Delhi and gradually expanded to include other States and Regions of the country. This division of the NOTTO is the nodal networking agency for Delhi and shall network for Procurement Allocation and Distribution of Organs and Tissues in Delhi.

Function/Activities National Network division of NOTTO would function as apex centre for All India activities of coordination and networking for procurement and distribution of Organs and Tissues and registry of Organs and Tissues Donation and Transplantation in the country. Following are the activities at National and Delhi NCR level:

National Level:

- Lay down policy guidelines and protocols for various functions.
- Network with similar regional and state level organizations.
- All registry data from States and Regions would be compiled and published.
- Creating awareness, promotion of organ donation and transplantation activities.
- Co-ordination from procurement of organs and tissues to transplantation when organ is allocated outside the region.
- Dissemination of information to all concerned organizations, hospitals and individuals.
- Monitoring of transplantation activities in the Regions and States and maintaining data-bank in this regard.
- To assist in data management for organ transplant surveillance & organ transplant and Organ Donor registry.
- Consultancy support on the legal and non-legal aspects of donation and transplantation.
- Coordinate and Organize trainings for various cadre of workers.

For Delhi and NCR

- Maintaining the waiting list of terminally ill patients requiring transplants.
- Networking with transplant centres, retrieval centres and tissue banks.
- Co-ordination for all activities required for procurement of organs and tissues including medico legal aspects.
- Matching of recipients with donors.
- Allocation, Transportation, Storage and Distribution of Organs and Tissues within Delhi and National Capital Territory region.
- Post-transplant patients & living donor follow-up for assessment of graft rejection, survival rates etc.

- o Awareness, Advocacy and Training workshops and other activities for promotion of organ donation.

National Biomaterial Centre (National Tissue Bank

The Transplantation of Human Organs (Amendment) Act 2011 has included the component of tissue donation and registration of tissue Banks. It becomes imperative under the changed circumstances to establish National level Tissue Bank to fulfil the demands of tissue transplantation including activities for procurement, storage and fulfil distribution of biomaterials. The main objective is to fill up the gap between 'Demand' and 'Supply' as well as 'Quality Assurance' in the availability of various tissues. Following are the functions of the centre:

- o Bone and bone products e.g. deep frozen bone allograft, freeze dried bone allograft, dowel allograft, AAA Bone, Durometer, facialata, fresh frozen human amniotic membrane, high temperature treated board cadaveric joints like knees, hips and shoulders, cadaveric cranium bone graft, loose bone fragment, different types of bovine allograft, used in orthodontics
- o Skin graft
- o Cornea
- o Heart valves and vessels

Other tissues shall be gradually included.

Activities

- o Coordination for tissue procurement and distribution
- o Donor Tissue Screening
- o Removal of Tissues and Storage
- o Preservations of Tissue
- o Laboratory screening of Tissues
- o Tissue Tracking
- o Sterilization
- o Records maintenance, Data Protection and Confidentiality
- o Quality Management in tissues
- o Patient Information on tissues
- o Development of Guidelines, Protocols and Standard Operating Procedures
- o Trainings
- o Assisting as per requirement in registration of other Tissue Banks

3.3.4 National Nutritional Programs

Malnutrition has been identified as a major problem in India for which GOI has launched many nutritional programs. These were able to reduce the severity of nutritional problems but not able to eradicate the same.

Following are the important national programs launched by the GOI:

A. National Iodine Deficiency Disorders Control Programme

IDD control programme in India is one of the success stories of public health in the country. The current 91 per cent household level coverage of iodized salt in India, of which 71 per cent is adequately iodized salt, is a big achievement. The components of a national IDD program are use of iodized salt in place of common salt, monitoring and surveillance, manpower training and mass communication. Each state has a IDD control cell which is responsible for checking iodine levels which is expected to be 30 ppm at the production level and 15 ppm at the consumer level. The iodisation of salt is now the most widely used prophylactic public health measure against endemic goitre. Iodised salt is most economical, conventional and effective means of mass prophylaxis in endemic areas.

B. MAA (Mothers' Absolute Affection) Programme for Infant and Young Child Feeding

MAA - "Mother's Absolute Affection" is a nationwide programme of the Ministry of Health and Family Welfare in an attempt to bring undiluted focus on promotion of breastfeeding and provision of counselling services for supporting breastfeeding through health systems. The programme has been named 'MAA' to signify the support a lactating mother requires from family members and at health facilities to breastfeed successfully.

The *goal* is to revitalize efforts towards promotion, protection and support of breastfeeding practices through health systems to achieve higher breastfeeding rates.

C. Integrated Child Development Services (ICDS)

Largest nutritional program implemented by Government of India through network of around 2 lac Anganwadi's. Six services as a package with the help of Anganwadi were offered i.e. supplementary nutrition, preschool education, immunization, health checkup, referral services, nutrition, and health education. Supplementary nutrition is provided for 300 days a year. On the spot feeding is done as far as possible at the Anganwadi. All children eligible beneficiaries receive daily ration of 300 calories with 8 to 10 g protein. Severely malnourished children, pregnant and lactating mothers receive daily supplementary nutrition providing 600 calories and 18-20 g protein.

ICDS now consists of six sub-schemes: Anganwadi Services (in place of ICDS), Scheme for Adolescent Girls (earlier known as SABLA), Child Protection Services (earlier known as the Integrated Child Protection Scheme), National Crèche Scheme (earlier called the Rajiv Gandhi National Crèche Scheme), National Nutrition Mission and, Pradhan Mantri Matru Vandana Yojana (PMMVY).

D. Mid-Day Meal Programme

Tamil Nadu was the first to initiate a massive noon meal programme to children. Neither a child that is hungry, nor a child that is ill can be expected to learn.

Realizing this need the Mid-Day Meal (MDM) Scheme was launched in primary schools during 1962-63. Mid-Day Meal improves three areas: 1. School attendance 2. Reduced dropouts 3. A beneficial impact on children's nutrition.

The Central Government supplies the full requirement of food grains for the programme free of cost. For its implementation in rural areas, Panchayats and Nagarpalikas are also involved or setting up of necessary infrastructure for preparing cooked food. For this purpose, NGOs, women's group and parent-teacher councils can be utilized. The total charges for cooking, supervision and kitchen are eligible for assistance under Poverty Alleviation Programme. In several states, supplementary feeding was assisted by food supplies from Cooperation for American Relief Everywhere (CARE) and World Food Programme (WFP). There are problems of administration and quality of food that have affected the programme outcomes.

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=1041&lid=614

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=1056&lid=616

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168

Check Your Progress 2

1. Describe national programme for elderly.

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2. Briefly describe the ICDS and Midday meal programmes.

3.4 PROGRAMMES FOR HEALTH SYSTEMS STRENGTHENING AND QUALITY

Let us learn about programmes which are launched by the government to strengthen the health system to provide universal health coverage to the people of the country. Review the Ayushman Bharat Scheme in Unit 1 of this Block.

A. Ayushman Bharat Yojana

Ayushman Bharat or "Healthy India" is a national initiative launched by Prime Minister as the part of National Health Policy 2017, in order to achieve the vision of Universal Health Coverage (UHC). This initiative has been designed on the lines as to meet SDG and its underlining commitment, which is "leave no one behind".

Ayushman Bharat is an attempt to move from sectoral and segmented approach of health service delivery to a comprehensive need-based health care service. Ayushman Bharat aims to undertake path breaking interventions to holistically address health (covering prevention, promotion and ambulatory care), at primary, secondary and tertiary level.

Ayushman Bharat adopts a continuum of care approach, comprising of two inter-related components, which are:

1. **Establishment of Health and Wellness Centres**–The first component, pertains to creation of 1,50,000 Health and Wellness Centres which will bring health care closer to the homes of the people. These centres will provide Comprehensive Primary Health Care (CPHC), covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

2. **Pradhan Mantri Jan Arogya Yojana (PM-JAY)** –PM-JAY is one significant step towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3).It aims to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health episodes.

Pradhan Mantri Jan Arogya Yojana (PM-JAY) will provide financial protection (Swasthya Suraksha) to 10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries). It will offer a benefit cover of Rs. 500,000 per family per year (on a family floater basis).

PM-JAY will cover medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures. PM-JAY has defined 1,350 medical packages covering surgery, medical and day care treatments including medicines, diagnostics and transport.

To ensure that nobody is left out (especially girl child, women, children and elderly), there will be no cap on family size and age in the Mission. The scheme will be cashless & paperless at public hospitals and empaneled private hospitals. The beneficiaries will not be required to pay any charges for the hospitalization expenses. The benefit also includes pre and post-hospitalization expenses. The scheme is an entitlement based, the beneficiary is decided on the basis of family being figured in SECC database. When fully implemented, the PM-JAY will become the world's largest government funded health protection mission.

Benefits of PM-JAY

Beneficiary Level

- Government provides health insurance cover of up to Rs. 5,00,000 per family per year.
- More than 10.74 crore poor and vulnerable families (approximately 50 crore beneficiaries) covered across the country.
- All families listed in the SECC database as per defined criteria will be covered. No cap on family size and age of members.
- Priority to girl child, women and senior citizens.
- Free treatment available at all public and empaneled private hospitals in times of need.
- Covers secondary and tertiary care hospitalization.
- 1,350 medical packages covering surgery, medical and day care treatments, cost of medicines and diagnostics.
- All pre-existing diseases covered. Hospitals cannot deny treatment.
- Cashless and paperless access to quality health care services.
- Hospitals will not be allowed to charge any additional money from beneficiaries for the treatment.

- Eligible beneficiaries can avail services across India, offering benefit of national portability. Can reach out for information, assistance, complaints and grievances to a 24X7 helpline number - 14555

Health System Level

- Help India progressively achieve Universal Health Coverage (UHC) and Sustainable Development Goals (SDG).
- Ensure improved access and affordability, of quality secondary and tertiary care services through a combination of public hospitals and well measured strategic purchasing of services in health care deficit areas, from private care providers, especially the not-for profit providers.
- Significantly reduce out of pocket expenditure for hospitalization. Mitigate financial risk arising out of catastrophic health episodes and consequent impoverishment for poor and vulnerable families.
- Acting as a steward, align the growth of private sector with public health goals.
- Enhanced used to of evidence-based health care and cost control for improved health outcomes.
- Strengthen public health care systems through infusion of insurance revenues.
- Enable creation of new health infrastructure in rural, remote and under-served areas.
- Increase health expenditure by Government as a percentage of GDP.
- Enhanced patient satisfaction.
- Improved health outcomes.
- Improvement in population-level productivity and efficiency
- Improved quality of life for the population

B. Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) aims at correcting the imbalances in the availability of affordable healthcare facilities in the different parts of the country in general, and augmenting facilities for quality medical education in the under-served States in particular. The scheme was approved in March 2006.

The first phase in the PMSSY has two components - setting up of six institutions in the line of AIIMS; and upgradation of 13 existing Government medical college institutions.

It has been decided to set up 6 AIIMS-like institutions, one each in the States of Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneswar), Rajasthan (Jodhpur) and Uttaranchal (Rishikesh). Each institution will have a 960 bedded hospital (500 beds for the medical college hospital; 300 beds for Speciality/Super Speciality; 100 beds for ICU/Accident trauma; 30 beds for Physical Medicine & Rehabilitation and 30 beds for Ayush) intended to provide healthcare

facilities in 42 Speciality/Super-Speciality disciplines. Medical College will have 100 UG intake besides facilities for imparting PG/doctoral courses in various disciplines, largely based on Medical Council of India (MCI) norms and also nursing college conforming to Nursing Council norms.

In addition to this, 13 existing medical institutions spread over 10 States will also be upgraded. In the second phase of PMSSY, the Government has approved the setting up of two more AIIMS-like institutions, one each in the States of West Bengal and Uttar Pradesh and upgradation of six medical college institutions. In the third phase of PMSSY, it is proposed to upgrade the few other existing medical college institutions.

C. LaQshya' programme (Labour Room Quality Improvement Initiative)

After launch of the National Health Mission (NHM), there has been substantial increase in the number of institutional deliveries. However, this increase in the numbers has not resulted into improvements in the maternal and new-born health indicators. It is estimated that approximately 46% maternal deaths, over 40% stillbirths and 40% newborn deaths take place on the day of the delivery. A transformational change in the processes related to the care during the delivery, which essentially relates to intrapartum and immediate postpartum care, is required to achieve results. Prerequisite of such approach require the health system's preparedness for prompt identification and management of maternal and newborn complications.

'LaQshya' programme of the Ministry of Health and Family Welfare aims at improving quality of care in labour room and maternity Operation Theatre (OT). The goal is to reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.

Strategies:

1. Reorganizing/aligning Labour room & Maternity Operation Theatre layout and workflow as per 'Labour Room Standardization Guidelines' and 'Maternal & Newborn Health Toolkit' issued by the Ministry of Health & Family Welfare, Government of India.

2. Ensuring that at least all government medical college hospitals and high case-load district hospitals have dedicated obstetric HDUs (High Dependency Units) as per GoI MOHFW Guidelines, for managing complicated pregnancies that require life-saving critical care.

3. Ensuring strict adherence to clinical protocols for management and stabilization of the complications before referral to higher centres.

D. National Health Mission

The National Rural Health Mission (NRHM) was launched by the Hon'ble Prime Minister on 12th April 2005, to provide accessible, affordable and quality health care to the rural population, especially the vulnerable groups.

The Union Cabinet vide its decision dated 1st May 2013, has approved the launch of National Urban Health Mission (NUHM) as a Sub-mission of an over-arching National Health Mission (NHM), with National Rural Health Mission (NRHM) being the other Sub-mission of National Health Mission.

The National Urban Health Mission (NUHM) as a sub-mission of National Health Mission (NHM) has been approved by the Cabinet on 1st May 2013. NUHM envisages to meet health care needs of the urban population with the focus on urban poor, by making available to them essential primary health care services and reducing their out-of-pocket expenses for treatment. This will be achieved by strengthening the existing health care service delivery system, targeting the people living in slums and converging with various schemes relating to wider determinants of health like drinking water, sanitation, school education, etc. implemented by the Ministries of Urban Development, Housing & Urban Poverty Alleviation, Human Resource Development and Women & Child Development.

The National Health Mission (NHM) encompasses its two Sub-Missions, **The National Rural Health Mission (NRHM)** and **The National Urban Health Mission (NUHM)**. The main programmatic components include Health System Strengthening, Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable & quality health care services that are accountable and responsive to people's needs. Continuation of the National Health Mission - with effect from 1st April 2017 to 31st March 2020 has been approved by Cabinet in its meeting dated 21.03.2018.

National Health Mission (NHM) was launched by the government of India in 2013 subsuming the National Rural Health Mission and National Urban Health Mission. It was further extended in March 2018, to continue till March 2020.

The main programme components include Health System Strengthening in rural and urban areas for - Reproductive-Maternal- Neonatal-Child and Adolescent Health (RMNCH+A), and Communicable and Non-Communicable Diseases. The NHM envisages achievement of universal access to equitable, affordable and quality health care services that are accountable and responsive to people's needs.

Six financing components:

(i) NRHM-RCH Flexipool,

(ii) NUHM Flexipool,

(iii) Flexible pool for Communicable disease,

(iv) Flexible pool for non-communicable disease including Injury and Trauma,

(v) Infrastructure Maintenance and

(vi) Family Welfare Central Sector component.

Within the broad national parameters and priorities, states have the flexibility to plan and implement state specific action plans. The state PIP spells out the key strategies, activities undertaken, budgetary requirements and key health outputs and outcomes. The State PIPs is a combination of the district/city health action plans, and include activities to be carried out at the state level. The state PIP will also include all the individual district/city plans. This has several advantages: one, it will strengthen local planning at the district/city level, two, it would ensure approval of adequate resources for high priority district action plans, and three, enable communication of approvals to the districts at the same time as to the state. The fund flow from the Central Government to the states/UTs as per the procedure prescribed by the Government of India.

The National Health Mission seeks to ensure the achievement of the following indicators: -

- Reduce MMR to 1/1000 live births
- Reduce IMR to 25/1000 live births
- Reduce TFR to 2.1
- Prevention and reduction of anemia in women aged 15–49 years
- Prevent and reduce mortality & morbidity from communicable, non-communicable; injuries and emerging diseases
- Reduce household out-of-pocket expenditure on total health care expenditure
- Reduce annual incidence and mortality from Tuberculosis by half
- Reduce prevalence of Leprosy to <1/10000 population and incidence to zero in all districts
- Annual Malaria Incidence to be <1/1000
- Less than 1 per cent microfilaria prevalence in all districts
- Kala-azar Elimination by 2015, <1 case per 10000 population in all blocks

Indian Public Health Standards (IPHS)

IPHS are the standards gives guidelines for manpower, services to be provided, equipment and supplies to ensure quality of services to be provided by Sub-Centres/ HWCs, PHC, CHC, District hospital.

Indian Public Health Standards (IPHS) for Sub-centres, Primary Health Centres (PHCs), Community Health Centres (CHCs), Sub-District and District Hospitals were published in January/ February, 2007. These are used as the reference point for public health care infrastructure planning and up-gradation in the States and UTs. IPHS are a set of uniform standards to improve the quality of health care delivery in the country. The IPHS documents have been revised in 2012 keeping in view the changing protocols of the existing programmes and introduction of new programmes especially for Non-Communicable Diseases. Flexibility is allowed to suit the diverse

needs of the States. IPHS guidelines act as the bench mark for assessing the functional status of health facilities.

IPHS guidelines has been further revised in 2022 and released on 16th April 2022 for District/Sub-District Hospital, Community Health Centres, Health and Wellness Centre-Primary Health Centres and Health and Wellness Centre-Sub Health Centres.

https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=971&lid=154#:~:text=IPHS%20are%20a%20set%20of,especially%20for%20Non%2DCommunicable%20Diseases.

Standards for Quality

Guidelines and protocols are given for Reproductive and Child Health Care and various other services and clinical protocols, management processes e.g. few guidelines are given below. You can read all the guidelines at the link given below.

Maternal Health Guidelines:

- Training Manual for Medical Method of Abortion (MMA) in early Gestation
- Scope of Practice of Midwifery Educator and Nurse Practitioner Midwife
- Standard Operating Procedures for HIV and Syphilis Screening of Pregnant Women at VHNSD site
- SUMAN - Surakshit Matritva Asshwasan
- JSSK Dietary Guidelines
- Guidelines for Midwifery Services in India

Child Health Guidelines

- Operational Guidelines for establishing hospital-based birth defect sentinel surveillance system
- Guidelines for home-based care of young children
- National Guidelines on Lactation Management centres in public health facilities
- Operational Guidelines on family participatory care for improving newborn health
- Operational Guidelines on strengthening facility based pediatric care
- India Newborn Action Plan
- Operational Guidelines Kangaroo Mother Care 9KMC) and optimal feeding of Low-Birth-Weight Infants
- Operational Guidelines Child Death Review

https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=839&lid=377

https://nhm.gov.in/index1.php?lang=1&level=3&sublinkid=1182&lid=364

Standard Treatment Protocols and Skill Gaps

Standard treatment and skill protocols and guidelines are provided for RCH services, training etc i.e. Skill Birth Attendance training, Navjat Shishu Suraksha Karyakram (NSSK) and the IMNCI package, the Home-Based Newborn Care (HBNC), and the Emergency Obstetric Care (EmOC) package. These training packages also introduced the standard treatment protocols.

https://nhm.gov.in/index1.php?lang=1&level=1&sublinkid=794&lid=168

https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=822&lid=218

https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=819&lid=219

Rogi Kalyan Samiti (RKS) - (Hospital Management Society)

Rogi Kalyan Samities (RKSs) / Hospital Management Committees were introduced in 2005 under the National Rural Health Mission (NRHM) as a forum to improve the functioning and service provision in public health facilities, increase participation and enhance accountability. The National Health Mission (NHM), recognizing the challenges in making RKS effective, reinforces and stresses on the need to strengthen the RKS to oversee governance and serve as an effective Grievance Redressal mechanism at the facility level, with active engagement of Panchayati Raj Institutions (PRIs)/ Urban Local Bodies (ULBs).

Experiences of RKS functioning across the country were mixed. Some States have experience of effective RKS functioning, overall findings from Common Review Missions, monitoring visits, and evaluations indicate that strengthening of RKS is an important area of focus. The findings also show that changes are needed in the governance structures, mandate, functions, revenue models, and above all a better understanding of members of their roles and responsibilities in enabling improved service quality and public accountability.

Objectives of the RKS:

1. Serve as a consultative body to enable active citizen participation for the improvement of patient care and welfare in health facilities.

2. Ensure that essentially no user fees or charges are levied for treatment related to care in pregnancy, delivery, family planning, postpartum period, newborn and care during infancy, or related to childhood malnutrition, national disease control programmes such as Tuberculosis, Malaria, HIV/AIDS, etc. and other government funded programmes which are provided as assurance or service guarantees to those accessing public sector health facilities.

3. Decide on the user fee structure for outpatient and inpatient treatment, which should be displayed in a public place and be set at rates which are minimal and do not become financial barrier to accessing healthcare.

4. Ensure that those patients who are Below Poverty Line, vulnerable and marginalized groups and other groups as may be decided by the state government, do not incur any financial hardship for their treatment, and create mechanisms to cover part/full costs related to transport, diet, and stay of attendant.

5. Develop mechanisms to guard against denial of care to any patient who does not have the ability to pay, especially for services that are being provided at the government's expense.

6. Ensure provision of all non-clinical services and processes such as provisioning of safe drinking water, diet, litter free premises, clean toilets, clean linen, help desks, support for navigation, comfortable, patient waiting halls, security, clear signage systems, and prominent display of Citizens' Charter.

7. Ensure availability of essential drugs and diagnostics, and use of standard treatment protocols/standard operating procedures, patient safety, effective mechanisms for maintaining patient records, periodic review of medical care/deaths.

8. Enable assured health services to all who seek services in the government health facility will allow the hospital in charge to procure essential drugs/ diagnostics not available in the health facility out of the RKS funds. Such local purchases must be made only as a short-term interim measure. The Executive Committee will review such purchases in each meeting and ensure that the rationale for the purchase is justified and that this is not undertaken repeatedly.

9. Promote a culture of user-friendly behaviour amongst service providers and hospital staff for improved patient welfare, responsiveness and satisfaction through inter-alia organizing training/ orientation/ sensitisation workshops periodically.

10. Operationalize a Grievance Redressal Mechanism including a prominent display of the "Charter of Patient Rights" (Annexure I) in the health facility and address complaints promptly thus building confidence of people in the public health facilities.

11. Create mechanisms for enabling feedback from patients, at least at the time of discharge and take timely and appropriate action on such feedback.

12. Undertake special measures to reach the unreached / disadvantaged groups e.g. Campaigns to increase awareness about services available in the facility.

13. Ensure overall facility maintenance to ensure that the facility conforms/ aspires to conform to the Indian Public Health Standards (IPHS).

14. Supervise, maintain, and enable expansion of hospital building for efficient and rational use and management of hospital land and buildings.

15. Facilitate the operationalization of National and State Health programmes as appropriate for the level of the facility.

16. Proactively seek out participation from charitable and religious institutions, community organisations, corporates for cleanliness and upkeep of the facility.
17. Facilitate participation and contribution from the community in cash/ kind (drugs/ equipment/diet), labour including free professional services.

Composition of Governing Body (GB) of RKS at District Hospital

- Chairperson: In-charge Minister/ local MP/ President Zila Panchayat/ District Magistrate
- Member Secretary: Medical Superintendent/Civil Surgeon/Hospital- in-charge
- Members (Ex-officio)

1. District Magistrate, (if not chairperson)
2. Local MLA, in whose jurisdiction the health facility is located
3. Chairperson-Zilla Panchayat
4. Mayor/Chairperson of the Urban Local Body at the District Hospital headquarters
5. Chief Executive Officer, District Panchayat
6. Commissioner/Chief Municipal Officer, Municipal Corporation/ Council.
7. Chief Medical and Health Officer
8. Medical Superintendent In-charge of DH Member Secretary
9. District AYUSH Officer
10. District Officer of Departments of Women and Child Development, Water and Sanitation, Education, Social Welfare, Public Health Engineering Department, Public Works Department, (including Electrical and Mechanical), Electricity Board
11. Individuals/ institutional donors as associate membership

    Nominated Members (names to be recommended by Member Secretary/ District Magistrate)

    - Three eminent citizens, of whom one must be a female, nominated by the Chairperson from the names recommended by Member Secretary/ District Magistrate
    - Two Civil society representatives
    - One Representative of local medical college, if any. The senior specialists in-charge of different wards and DPHN/Nurse Matron should be invited as permanent special invitees

https://nhm.gov.in/New_Updates_2018/communization/RKS/Guidelines_for_Rogi_Kalyan_Samiti https://nhm.gov.in/index1.php?lang=1&level=2&sublinkid=1078&lid=145#:~:text=2.1%20Rogi%20Kalyan%20Samiti%20(Patient,the%20affairs%20of%20the%20hospital.es_in_Public_Health_Facilities.pdf

Programmes for Quality Improvement

Quality of health care is people's right, though under NHM there has been considerable improvement in an infrastructure, human resource and increased budgetary allocation; quality of services but still there are many issues and challenges.

Quality Assurance (QA) refers to the planned and systematic activities implemented in a quality system, so that quality requirements for facility's service will be fulfilled.

Quality Standard refers to set of requirements, which are essential to ensure that the service delivered, leads to desired outcomes, as well as ensures users' safety, comfort and satisfaction.

The need for improving quality of care in health institutions there is a need to provide support to those concerned with quality assurance in the institutions to ensure efficiency and effectiveness of the services rendered. The improvements in service quality will help in achieving programme objectives, also lead to patient satisfaction and therefore increased utilization of services being offered.

The Quality Improvement and Quality Assurance Cell, the reorganized and modified version of Hospital Development Team was established in 2013 as per the Operational Guidelines for Quality Assurance in Public Health Facilities of Government of India. The primary role of the Quality Improvement and Quality Assurance Cell is to facilitate implementation of Quality Standards at all Public Health Facilities leading to improvement of Quality Health Care with emphasis on RMNCH+A services. NABH and ISO 9001 guidelines and NHM also support quality management system. Details of guidelines and NQAS checklist under National Health Mission can be referred through link provided below.

Ministry of Health & Family Welfare, Government of India in collaboration with state health departments has developed and implementing a comprehensive quality assurance framework for public health facilities and Programs. This Framework comprises of four interrelated approach and activities to achieve patient centric quality system

- Instituting Organizational Framework for Quality
- Defining Standards of Service Delivery and Patient Care
- Continuous Assessment of services against set standards
- Improving Quality through closing gaps and implementing opportunities for Improvement.

The main pillars of Quality Measurement Systems are Quality Standards. These standards have been defined for various level of facilities. The Standards have been grouped within the eight **Areas of Concern** i.e. service provision, patient rights, inputs, support services, clinical services, infection control, quality management and outcomes. Each Standard further has specific **Measurable Elements**. These standards and measurable elements are checked in each department of a health facility through department specific **Checkpoints**. All Checkpoints for a department are collated, and together they form assessment tool called '**Checklist**'. Scored/filled-in Checklists would generate scorecards.

http://www.nrhmorissa.gov.in/frmqaqi.aspx

https://qps.nhsrcindia.org/quality-assurance-framework/operational-guidelines

https://qps.nhsrcindia.org/national-quality-assurance-standards/quality-RNQAS

https://qps.nhsrcindia.org/national-quality-assurance-standards/nqas-Guidelines

https://qps.nhsrcindia.org/national-quality-assurance-standards/nqas-tools

National Digital Health Mission

In a follow-up of the NHP's specific goals for adopting digital technologies, the Ministry of Health and Family Welfare constituted a committee headed by Shri J. Satyanarayana to develop an implementation framework for the National Health Stack. This committee produced the National Digital Health Blueprint (NDHB), laying out the building blocks and an action plan to comprehensively and holistically implement digital health. 1.1.3. Taking forward the NDHB, this document describes the broad context, rationale, scope, and implementation arrangements for a digital ecosystem for healthcare services across the country. Since the implementation is envisioned to be in a mission mode, the initiative is referred to as the National Digital Health Mission (NDHM). 1.2. Vision of National Digital Health Mission 1.2.1. To create a national digital health ecosystem that supports universal health coverage in an efficient, accessible, inclusive, affordable, timely and safe manner, that provides a wide-range of data, information and infrastructure services, duly leveraging open, interoperable, standards based digital systems, and ensures the security, confidentiality and privacy of health-related personal information. 1.3. Objectives of National Digital Health Mission 1.3.1. To strengthen the accessibility and equity of health services, including continuum of care with citizen as the owner of data, in a holistic healthcare programme approach leveraging IT & associated technologies and support the existing health systems in a 'citizen-centric' approach, the NDHM envisages the following specific objectives: 1. To establish state-of-the-art digital health systems, to manage the core digital health data, and the infrastructure required for its seamless exchange; 2. To establish registries at appropriate level to create single source of truth in respect of clinical establishments, healthcare professionals, health workers, drugs and pharmacies; 3. To enforce adoption

of open standards by all national digital health stakeholders; 4. To create a system of personal health records, based on international standards, easily accessible to individuals and healthcare professionals and services providers, based on individual's informed consent; 5. To promote development of enterprise-class health application systems with a special focus on achieving the Sustainable Development Goals for health; 6. To adopt the best principles of cooperative federalism while working with the States and Union Territories for the realization of the vision; 7. To ensure that the healthcare institutions and professionals in the private sector participate actively with public health authorities in the building of the NDHM, through a combination of prescription and promotion; 8. To ensure national portability in the provision of health services; 9. To promote the use of clinical decision support (CDS) systems by health professionals and practitioners; 10. To promote a better management of the health sector leveraging health data analytics and medical research; 11. To provide for enhancing the efficiency and effectiveness of governance at all levels; 12. To support effective steps being taken for ensuring quality of healthcare; and 13. To strengthen existing health information systems, by ensuring their conformity with the defined standards and integration with the proposed NDHM. 1.4. Opportunity for the National Digital Health Mission 1.4.1. The current strong public digital infrastructure—including that related to Aadhaar, Unified Payments Interface and wide reach of the Internet and mobile phones (JAM trinity) —provides a strong platform for establishing the building blocks of NDHM. The existing ability to digitally identify people, doctors, and health facilities, facilitate electronic signatures, ensure non-repudiable contracts, make paperless payments, securely store digital records, and contact people provide opportunities to streamline healthcare information through digital management

https://www.nhp.gov.in/national-digital-health-mission-(ndhm)_pg

Check Your Progress 3

1. Describe AYUSHMAN BHARAT Scheme.

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2. Describe LaQshay programme.

3.5 LET US SUM UP

In this unit you have learnt about health status and health problems in India. Various national health programmes for communicable and non-communicable diseases. National health mission and various guidelines for quality of health care services and National Digital Health Mission.

3.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. As per NITI Aayog, Health Systems for New India Building Blocks 2019, document, India have eliminated polio, guinea worm disease, yaws and maternal and neonatal tetanus. Total Fertility 1 2 Rate (TFR) has reduced sharply from 3.4 in 1992-93 to 2.2 in 2015-16; Maternal Mortality Ratio (MMR level of 130 against a target of 139) and almost succeeded in meeting the Under-5 child mortality target (U5 MR level of 43 against a target of 42). There are significant inter-state and intra-state differentials in health outcomes with socio-economically disadvantaged groups being particularly vulnerable to gaps in access as well as quality of healthcare available to them; the double burden of disease i.e. with a rising burden of non-communicable diseases in addition to the persistence of communicable diseases. India's epidemiological profile and burden of disease still shows that India is in the midst of an epidemiological transition. There is a marked burden of communicable diseases as well as Maternal, Newborn and Child Health (MNCH) related morbidity and mortality, particularly among the poor.

2. Demographic Indicators

Demographic indicators can be divided in two parts

Vital Statistics deals with birth rate, death rate, and natural growth rate, life expectancy at birth, mortality and fertility rates

Population Statistics deals with size and growth of population, sex ratio, density of population etc.

Check Your Progress 2

1. With a comparatively young population, India is still poised to become home to the second largest number of older persons in the world. Projection studies indicate that the number of 60+ in India will increase from 100 million in 2013 and to 198 million by 2030. Non-communicable diseases requiring large quantum of health and social care are extremely common in old age, irrespective of socio-economic status. Disabilities resulting from these non-communicable diseases are very frequent which affect functionality compromising the ability to pursue the activities of daily living. The treatment/management of these chronic diseases is also costly, especially for services like joint replacements, heart surgery, neurosurgical procedures etc.

   To overcome this out of bound expenses for elderly whose income decreases post retirement and dependent elderly women, Ministry of Health and Family Welfare launched The National Programme for Health Care for the Elderly (NPHCE). It is a attempt to provide a comprehensive health care set up completely dedicated and tuned to the needs of the elderly.

2. Tamil Nadu was the first to initiate a massive noon meal programme to children. Neither a child that is hungry, nor a child that is ill can be expected to learn. Realizing this need the Mid-Day Meal (MDM) Scheme was launched in primary schools during 1962-63. Mid-Day Meal improves three areas: 1. School attendance 2. Reduced dropouts 3. A beneficial impact on children's nutrition.

   The Central Government supplies the full requirement of food grains for the programme free of cost. For its implementation in rural areas, Panchayats and Nagarpalikas are also involved or setting up of necessary infrastructure for preparing cooked food. For this purpose NGOs, women's group and parent-teacher councils can be utilized. The total charges for cooking, supervision and kitchen are eligible for assistance under Poverty Alleviation Programme. In several states, supplementary feeding was assisted by food supplies from Cooperation for American Relief Everywhere (CARE) and World Food Programme (WFP). There are problems of administration and quality of food that have affected the programme outcomes.

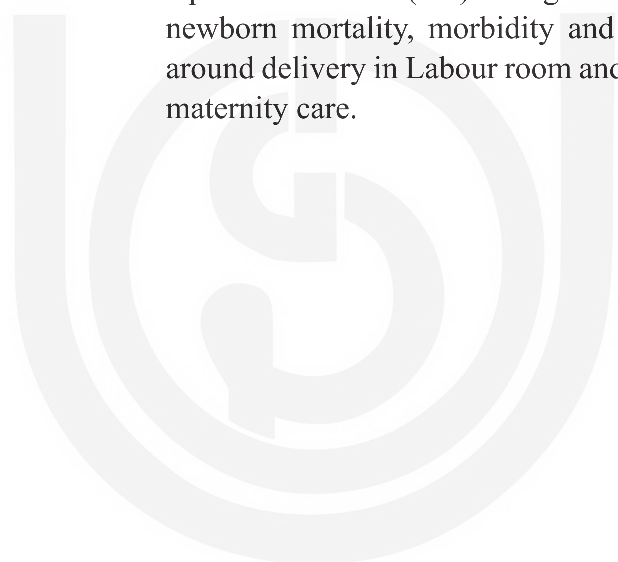
Check Your Progress 3

1. Ayushman Bharat adopts a continuum of care approach, comprising of two inter-related components, which are:

   Establishment of Health and Wellness Centres–The first component, pertains to creation of 1,50,000 Health and Wellness Centres which will bring health care closer to the homes of the people. These centres will provide Comprehensive Primary Health Care (CPHC), covering both maternal and child health services and non-communicable diseases, including free essential drugs and diagnostic services.

   Pradhan Mantri Jan Arogya Yojana (PM-JAY) –PM-JAY is one significant step towards achievement of Universal Health Coverage (UHC) and Sustainable Development Goal - 3 (SDG3).It aims to provide health protection cover to poor and vulnerable families against financial risk arising out of catastrophic health episodes.

2. 'LaQshya' programme of the Ministry of Health and Family Welfare aims at improving quality of care in labour room and maternity Operation Theatre (OT). The goal is to reduce preventable maternal and newborn mortality, morbidity and stillbirths associated with the care around delivery in Labour room and Maternity OT and ensure respectful maternity care.



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UNIT 4 HISTORY AND FUTURE OF NURSING IN INDIA

Structure

4.0 Introduction

4.1 Objectives

4.2 History of nursing in UK, USA and India

4.3 Recommendations of Various Committees

4.4 Nursing Structure

4.4.1 At Centre Level

4.4.2 At State level

4.4.3 At District Level

4.5 Future of Nursing in India

4.6 Issues and challenges related to Nursing in India

4.7 Let us Sum up

4.8 Answers to Check Your Progress

4.0 INTRODUCTION

In the previous units you have leant about health care system in India and nursing is one of the most crucial components of health care delivery system in India. Before one can understand the nature of the nursing profession or define its practice it is imperative to understand the roots and factors that influenced and shaped its growth overtime. It is the outcome of centuries of responsiveness and growth. Its practice was adopted to accommodate the needs of evolving society yet it has maintained its primary goal of care of sick.

For many centuries female family members attended the sick to promote recovery and reduce suffering of family members. The role of mission, religious and charitable group is also significant in the history of nursing. In this unit you will learn about history of nursing in India, recommendations of various committees related to nursing service and nursing education in India. Review the organization structure recommended by committees and compare with the actual nursing structure at the centre, state and district level. Future of nursing in India and challenges related to nursing service and education in India.

4.1 OBJECTIVES

After completion of this unit you will be able to:

1. describe the history of nursing in UK, USA and India;
2. analyse the recommendations of various committee related to nursing in India;

3. draw the organization structure of nursing at centre , state and district level;
4. discuss the strategies to establish nursing directorate at state level ;
5. critically analyse the future of nursing in India; and
6. suggest measure to handle challenges related to nursing in India.

4.2 HISTORY OF NURSING IN UK, USA AND INDIA

You must be wondering why it is important to know the history of nursing? As the history tells you about past events which have led to present and influence of these on the present events. That means trends in nursing service and education have influence nursing today, therefore it is important for you as a manager to review some of the important historical events, recommendations of various committees so that you can understand the past, review the present situation and plan for the future.

The current healthcare system is very different from the past and even health needs, demands and problems are a challenge. New type of diseases are emerging and some old diseases are re-emerging therefore we need well trained health professionals including nurses in India. The complexity of the healthcare influenced by the increasing longevity, shortening of hospital stays, scientific and technological advances, equality, poverty, discrimination, disasters, violence and cultural diversity leads to several challenges that threaten the health and wellbeing of the people.

Let us first review the history of nursing in the UK and USA.

A. Nursing in UK and USA

In olden times if someone was sick in the family, one of the female members of the family or relative used to look after the sick person. As there was no formal education for women to take care of sick in the family or community, women learn taking care of sick through observation, tradition passed from one generation to another or by trial / error.

Florence Nightingale had laid foundation of nursing and brought in changes. In 1854, during Crimean War mortality rate among British troops was very high due to various diseases. Nightingale with few women from upper class families went to Crimea to take care of sick solders. She emphasized on ventilation, cleanliness and fresh air in hospital and wards this helped in reducing number of deaths. She documented the observations and statistically analysed and laid foundation for evidence-based-practice. When she returned to London, Nightingale Trust was established and first School of Nursing was established for formal education of nurses.

During same time in America there was outbreak of civil war but there were no nurses to give nursing care; family members of military staff or volunteers were taking care of sick and this had laid down the foundation of nursing in America. In 1872, first School of nursing was established for formal training of nurses. After 10 years in 1883 many new training schools were established

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in America by laypersons as physicians were not in support of opening more formal education institutions for nurses. On the other hand, hospital and physician realized the economic advantages of student nurses under the banner of clinical training; as care provided by the students was cost effective, cheap and good. They worked for 12 hours without supervision and their classes were irregularly planned as they had to provide care to patients in the hospital in place of qualified staff. After graduation few were offered job in hospital, mostly worked in home doing private duties. In US in the beginning of 19th century during industrialization and urbanizations, hospitals were built in urban areas. By 1990s many new School of Nursing were opened with own hospital or affiliated to hospitals.

In 1860 in England, District nursing originated to provide care to sick poor person at home. In 1886, in America, two district nurse associations were established. In 1912, Public Health Nursing was recognized as a field to provide health care services to people at home and in community.

In the 1890s, nurses organized two major professional associations: the American Society of Superintendents of Training Schools for Nurses later renamed the National League of Nursing Education and the Associated Alumnae of the United States, later renamed the American Nurses Association. Other major organizations, the National Association of Coloured Graduate Nurses and the National Organization for Public Health Nursing formed in the early twentieth century. State nurses' associations also organized and were instrumental in passing state nurse registration acts which regulated and provided a licensing system for nursing practice. The successful passage of nurse registration acts, considered a significant legislative accomplishment at a time when women held little political power, also provided nurses with their modern legal title, registered professional nurses (RN).

Employment conditions for nurses also presented challenges. In the early part of the twentieth century, hospitals employed only a few graduate nurses, mainly in supervisory positions. They relied instead on student nurses for the bedside care to patients. Most nurses, once they graduated from their educational program, entered the field of private duty nursing. Private duty nurses were employed by individual patients primarily in their homes. But for nurses, private duty often did not provide regular and dependable employment; nurses were hired on an ad hoc basis by patients and they were often without a regular source of income. The cost of private duty was also quite high, limiting the number of patients employing private duty nurses. It was not until the mid-twentieth century that hospitals hired nurses as regular staff on a permanent basis, providing full professional nursing services to all hospitalized patients. By 1960, approximately 172 college-based nursing education programs awarded Bachelors of Science in Nursing degrees. Experts believed baccalaureate educated nurses would be better prepared to care for the complex needs of late-twentieth-century patients and would be able to take on more advanced roles in the delivery of health care. Beginning in the 1960s, new types of nurses, who specialized in different hospital settings such as intensive care units, and nurse practitioners who were trained to deliver a variety of primary care services were available. Availability of

trained “advanced practice nurses” enabled hospitals and other health care facilities to deliver more efficient, less costly, and safer health care services. Today, nurse practitioners, clinical nurse specialists, and other specialty-area nurses are well established to provide cost effective quality care.

Research in nursing began with Florence Nightingale. Her landmark publication, Notes on Nursing (1859), described her early interest in environmental factors that promote physical and emotional well-being.

Most studies in the early 1900s were concerned with nurses’ education. For example, in 1923, a group called the Committee for the Study of Nursing Education studied the educational preparation of nurse teachers and administrators and the clinical experiences of nursing students. The committee issued the Goldmark Report (for its author, Josephine Goldmark), which identified educational inadequacies and concluded that advanced educational preparation was essential. As more nurses received university-based education, studies concerning nursing students their characteristics, problems, and satisfactions became more numerous. The American Journal of Nursing, first published in 1900, began to publish a few studies in the 1930s. By the 1970s, the growing number of nursing studies and discussions of theoretical and contextual issues created the need for additional journals. The 1980s brought nursing research to a new level of development. An increase in the number of qualified nurse researchers, the widespread availability of computers for the collection and analysis of information, and an ever-growing recognition that research is an integral part of professional nursing led nursing leaders to raise new issues and concerns. More attention was paid to the types of questions asked, the methods of collecting and analyzing information, the linking of research to theory, and the utilization of research findings in practice. In 1986 National Centre for Nursing Research (NCNR) at the National Institutes of Health (NIH) was established. In 1993, the National Institute of Nursing Research (NINR) was launched. NINR has helped put nursing research into the mainstream of research. Several journals were established in the 1990s in response to the growth in clinically oriented research and interest in EBP, including Clinical Nursing Research and Journal of Clinical Nursing.

B. Nursing in India

In the ancient times, until 17th century, formalized nursing was not traceable in India. Every village had a dais/traditional birth attendant to take care of maternal and child health needs of the people. Military nursing was introduced by the Portuguese in the 17th century. In 1664, East India Company started a hospital for soldiers at Fort St. Geroge, Madras. In 1797, a lying-in-hospital (Maternity) for the poor in Madras was built. Some of the other earliest hospitals were the first hospital in Calcutta in Fort William (1708), Calcutta medical college hospital and London mission hospital at Neyyoor (1838), Jamsetjee Jeejeebhoy (J.J) group in Mumbai (1843), Thomasan hospital at Agra (1853), Holy Family Hospital, Delhi (1855), Civil hospital Amritsar (1860), CMC, Ludhiana, Punjab (1881), 1892 Miraj medical school and hospital, Maharashtra (1892) and Bowring hospital in Bangalore (1895).

Florence Nightingale influenced nursing in India and brought reforms in military and civilian hospitals in 1861. St. Stevens Hospital at Delhi was the first one to begin training Indian women as nurses in 1867. In 1871, the government General Hospital at Madras was started with the first school of nursing for midwives with four students. Many nursing schools were started in different states of India between 18th and 19th century mostly by mission hospitals, which trained nurses in India. At this time there was no uniform educational standards followed in nursing schools. In 1907-1910, in North India, United Board of Examiners for mission hospitals was set up which formulated training standards and rules. Later Mid India (1926) and South India (1913) boards (boards of CMAI) were set up which conducted examination and gave diplomas. The first school of Health visitors was started in 1918 by Lady Reading Health School, Delhi. The first four-year Basic B.Sc. program was established in 1946 at Rajkumari Amrit Kaur College of Nursing in Delhi and CMC College of Nursing in Vellore. In 1960, M.Sc. was established in RAK College of Nursing, Delhi. In 1951, a two-year ANM course was established in St. Mary's Hospital at Punjab.

Bombay Presidency Nursing Association was the first state nursing association established in 1890. Professionalization of nursing in India began in 1905 when nine European nurse superintendents formed an organization which then got expanded and the Trained Nurse Association of India (TNAI) was established in 1909. Through sustained efforts from the TNAI, the Indian Nursing Council Act was passed in 1947 and the first college of nursing affiliated to the University of Delhi was established which was a step towards professionalization of nursing in India. TNAI established three sub associations or leagues within TNAI; Health Visitors' League (1922), Midwives and Auxiliary Nurse-Midwives Association (1925) and Student Nurses Association (1929). In 1949, Indian Nursing Council (INC) was established to maintain a uniform standard of training for nurses, midwives and health visitors and regulate the standards of nursing in India. INC act was passed in 1947 that was amended in 1950 and 1957.

The nursing scenario at the time of independence was not good and there were about 7000 nurses for the population of 400 million. The hospitals were grossly understaffed, nursing lacked professional and social status, and the working and living conditions of nurses were not satisfactory. The low status attributed to the low socio-economic status of women and nursing is primarily a women's profession. In the fifties, a greater number of girls from different parts of the country joined nursing and slowly there are more entrants from better socioeconomic status.

Nursing profession in India developed and 'midwifery' integrated constituting of antenatal, natal and postnatal care. Nurses were regarded as General Nurses and were rotated in all departments equally (including midwifery). Since the health demands were high and with limited nurses available especially in the rural area, the Auxiliary Nurse Midwives (ANMs) were introduced at the community level to cater to the growing MCH needs. The increase in their services ranged from MCH to additional responsibilities of immunization, family planning and other National Health Programmes, this diluted the very important midwifery component.

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As far as nursing manpower is concerned there is great imbalances in the situation. In comparison to the developed countries, the nurse population ratio in India is far from satisfactory. In 2004, the ratio was 1:2250 in India and 1:100-150 in Europe. The ratio in African countries, Sri Lanka and Thailand is 1:1400, 1:1100 and 1:850, respectively. Many states in India face a shortage of nurses and midwives (Dilip Kumar, 2005). In the Western countries, there are, on an average, 2 to 3 nurses to a doctor.

Report of the various committees and their recommendations are discussed in the next sections.

4.3 RECOMMENDATIONS OF VARIOUS COMMITTEES

The various committees such as Bhore Committee (1943), Shetty Committee (1954), Mudaliar Committee (1959-61), Kartar Singh Committee (1973), Srivastava Committee (1974), High Power Committee (1987) and five-year plans have brought about a transition in the status of nursing and midwifery. The recommendations made were in relation to staffing in hospital nursing service, public health settings, and schools/colleges, working and living conditions, infrastructure and equipment, regulations, and intensification of training programmes to meet the staff shortage. The reports mentioned above and the committees and National Health Policy (NHP, 2002) have put forward many recommendations for nursing management and capacity building. The NHP laid emphasis on improving the skill of nurses and on increasing the ratio of degree-holding nurses vis-à-vis diploma-holding nurses. It also recognized the need for establishing training courses for super-speciality nurses required for tertiary care institutions. However, gap existed in actual implementation and this required a strong support at the policy level to ensure implementation of key recommendations.

Different committees since 1946 emphasized the importance of nurse in health care delivery system. The Health Survey and Development Committee (Bhore Committee, 1946), was the most progressive in terms of its broad perspective and long-term vision for health in the country. It is relevant to mention here that the Committee had aimed at a target of one nurse to a 500 population. Most of the recommendations of the Bhore Committee are relevant even today. However, majority of the recommendations have not been taken up for implementation. The Shetty Committee (1954) was setup on the recommendation of Central Committee of Health to review the then prevailing training and service conditions for nurses. The committee recommended that hospital nursing service staff and public health nursing service staff should be combined into a single cadre. The Mudaliar Committee (1961), recommended streamlining of nursing personnel to three grades of nurses: basic nurse with four years of training (including six months midwifery and six months Public Health Nursing). The Kartar Singh Committee (1972) had the greatest impact in terms of quality and long-term changes. This committee recommended the introduction of Multi Purpose Workers under Health and Family Planning Programme. The Shrivastav Committee (1975) further consolidated the recommendations of the Kartar Singh Committee. The Bajaj Committee

(1986) strongly recommended that the health-related vocational courses should be for ANMs. In 1983, the National Health Policy emphasised on 'Health for all' principles and strategies were incorporated for strengthening and expansion of three-tier primary health care infrastructure - the subcentre, PHC and CHC. However, there was no qualitative difference in the job of any of the public health nursing personnel. Emphasis was given on orientation training to nursing personnel for implementing the new strategies.

The working and living conditions of nursing personnel have a direct bearing on the status of nursing services. The quality of nursing care depends on the number and quality of nursing manpower. It is also related to working conditions, equipment and supplies in the work place. The quality of nursing service also depends on the opportunities available for enhancement of professional education and incentives for promotions, etc. Taking a serious note of this, a High-Power Committee on Nursing was appointed by the Government of India, Ministry of Health and Family Welfare in July 1987 to review the role, functions, status and preparation of nursing personnel; nursing services and other issues related to the development of the profession and to make suitable recommendations to the government. The committee observed that nurses are generally not involved in making policies that govern their status and practice. The committee made several recommendations related to working conditions, nursing education, continuing education and staff development, norms for nursing services and education. Structural changes at administrative level, job descriptions for all nursing positions, working hours not more than 40 hours a week, opportunity for higher education after 5 years of service, accommodation and transportation facility for safety and security of nursing personnel, nurses to be relieved from the non nursing duties etc. The National Health Policy, 2002 quotes "The ratio of nursing personnel in the country vis-à-vis doctor/bed is very low according to professionally accepted norms. There is also an acute shortage of nurses trained in super-speciality disciplines for deployment in tertiary care facilities The policy while emphasizing the need for an improvement in the ratio of nurses vis-à-vis doctor/bed lays focuses on improving the skill -level of nurses, and on increasing the ratio of degree holding nurses vis-à-vis diploma-holding nurses. It recognizes need for the central government to subsidize the setting up, and the running of, training facilities for nurses on a decentralized basis. Also, the policy recognizes the need for establishing training courses for super-speciality nurses required for tertiary care institutions.

Present Status of Nursing Practice and Education in India

A. Nursing Practice and Nursing Education

- Currently India has only 1.7 nurses (Global is 2.5/1000) available per thousand population. In 2024, India had a nurse-to-population ratio of approximately 1.96 nurses per 1,000 people. This falls short of the World Health Organization (WHO) recommendation of 3 nurses per 1,000 people. While there are over 3.3 million registered nursing personnel in India, this number is insufficient to meet the country's healthcare needs.

- The ratio of hospital beds to population in 0.98/1000 against the global average of 3.5 beds/1000 population (WHO).
- India stands at 75th rank with respect to number of nurses. The country needs 2.4 million nurses to meet the growing demand (FICCI report, 2016). The HLEG (High Level Expert Group) group report on UHC (Universal health coverage India) 2011 is increased reliance on a cadre of well- trained nurses, which will allow doctors to focus on complex clinical cases.
- Nurses can undertake research to find evidence to support new nursing interventions. Nurses can contribute towards strengthening systems to work efficiently in interdisciplinary teams.
- They can effectively participate and influence policies related to nursing at local, state and national levels. There is a rising demand in terms of manpower for tertiary care, which requires specialized and highly skilled resources including doctors, nurses and other paramedical staff, this is also emphasized in NHP 2017. As a result, the demand for trained manpower, will continue to increase every year. The number of registered nurses/midwives was 6.7 lakhs in 1998 and has reached 17,91,285 nurses/midwives in 2014.
- In India, nursing educational programs such as Auxiliary Nurse Midwifery, General Nursing and Midwifery, BSc(N), MSc(N), MPhil and PhD(N) exist. INC prescribes uniform standards and syllabi for every educational program to be implemented across the country.
- From 2000 to 2016, ANM schools have increased from 298 to 1927, GNM schools from 285 to 3040, B.Sc colleges from 30 to 1752, and M.Sc colleges from10 to 611. Although the increase is significant still there is gap between demand and supply. The 12th five-year plan suggested establishing 24 centers of excellence in nursing. The HR efforts included up gradation of schools to colleges, strengthening of existing schools, faculty development, and establishment of 6 AIIMs like institutions.
- Some of the INC initiatives and achievement include capacity building of 55 nursing educational institutions, training of 1,20,000 nurses and 3500 faculty in HIV/AIDS & TB through GFATM project. E Learning module was developed as a result of this project. A Live register is being developed for all categories of nurses.
- Every registered nurse will be provided with a nurse unique ID (NUID). The register will lead to development of a nurse tracking system across the country and aid in reciprocal registration alongside renewal of license linked with CNE. INC has become a member of ICN. A national consortium for PhD in nursing was constituted by INC in 2006 in collaboration with Rajiv Gandhi University of Health Sciences.
- The main objective is to promote research activities in various fields of nursing.

- There is a scope for improving living and working conditions of nurses in the future. Through the efforts and representation by TNAI, Supreme Court has recommended minimum salary of 20,000 per month as starting salary of a staff nurse in private hospitals.
- Some states have developed mechanism to conduct and record CNE through State nursing councils. Integration of service and education model that is practiced in CMC Vellore is also introduced in a few more institutions particularly in St Johns College of Nursing, Bangalore.
- Some of the top nursing colleges in India today are established in the earliest days and are continuing to maintain standards and quality of education. AIIMS College of Nursing Delhi, CMC College of Nursing Vellore, RAK College of Nursing Delhi, SNDT College of Nursing Mumbai, NIMHANS Bangalore, Manipal College of Nursing Manipal, PGI College of Nursing Chandigarh, AFMC College of Nursing Pune, , BM Birla College of Nursing, Kolkata, , St John's Bangalore, Govt College of Nursing Thiruvananthapuram, CMC College of Nursing Ludhiana, Father Muller College of Nursing Mangalore, Sri Ramachandra Medical University College of Nursing Chennai, and Apollo College of Nursing, Chennai are some of the top colleges of Nursing today. Many universities are running PhD programmes in nursing and many colleges have been recognized as research departments.

B. Public Health Nursing

- According to the Indian Nursing Council (2016), 789,740 ANMs and 56,096 LHVs are registered in the different state nursing councils of the Country. About 2.00 lakh ANMs and thousands of female health supervisors and public health nurses are working in the public health sector alone. They are responsible for implementing all national and state health programmes at ground level. Critical activities related to maternal and child health, disease control, immunization, epidemic management and health promotion are carried out by peripheral public health nursing personnel.
- The scope of public health nursing is wide in India and their potentials are not fully utilized in our country. Currently, public health nurses at PHC, block and district levels plan, monitor, and mentor peripheral health staff to implement programmes on health promotion and disease prevention. The Bhore Committee gave a strong recommendation for introduction of public health nurses and the Mudaliar Committee reiterated this. Rather than moving forward into a professional cadre, public health nursing in India became stagnant at the lowest level of ANM due to the political and economical reasons. Under Ayushman Bharat Scheme nurses are given 6 months training to work in Health and Wellness Centres and Community Health Officers.
- Shortage of nurses and its impact on the Indian health care delivery system remains a major concern to this day. Adding to the above problem, there is an undersupply of competent public health nurses who are willing to serve in the resource-limited community health

care settings.

Till now we have discussed about various committees and their recommendations. In next section you will learn about the nursing structure at centre, state and district level.

4.4 NURSING STRUCTURE

The major lacuna in nursing is not involving the nursing professionals in policy framing and decision-making but for decades, nursing professionals have not played any role in planning and policy formulation for the nursing and midwifery workforce. All the decision-making related to the nursing workforce, viz. services and education, is with the medical directorates, with the result that nursing issues are diluted at all levels. There is a leadership crisis of the nursing and midwifery workforce across India. Though it has immense potential for decision-making, the nursing workforce has not been allowed to emerge as an independent professional body.

Various committees and reports such as the High-Power Committee on Nursing have put forward recommendations for strengthening the nursing management capacity; however, there is a gap between producing policy documents and their actual implementation. This requires strong support at the policy level to ensure implementation of the key recommendations. It is important to identify the best practices and innovations across various states of India in order to develop a mechanism for their sharing and replication in other states.

As per study by Bagga (2015), some states have created the posts of DD/JD Nursing for looking after nursing teaching and nursing services' issues, it is important to critically evaluate the authority that these positions actually have in decision-making on policy matters pertaining to nursing and midwifery issues. There is also a need to assess the leadership role of these posts in taking initiatives for bringing about desirable changes to achieve the SDGs.

It was observed, that in most of the states, either the DHS or DHFW directly looks after matters related to nursing. It was surprising to observe that despite the increasing awareness and leadership among nursing professionals in the country, a separate Nursing Division did not exist in any of the State Directorates except WB and there also the separate nursing divisions is under the supervision of Director, Health Services and in Orissa nursing Directorate was established. In few other States 1-2 post were created at State level. Moreover, due to the slow pace of filling up senior level nursing posts, these posts are lying vacant. In some states, for example in UP, the JD level post for nursing is held by the medical professional.

With regard to nursing positions in the organizational set-up of the state health directorates, there is a lack of uniformity across different states. There are senior level posts of JD Nursing in UP, Assam, Manipur, TN and Kerala as compared to the post of DD Nursing in WB, Orissa and Rajasthan and Gujarat. However, this does not reflect in their involvement in the decision-making process. Not only does the level of posts differ but also their job responsibilities, e.g. the JD Nursing in TN looks after nursing education in the State, whereas in UP, JD Nursing is the overall in charge of nursing affairs

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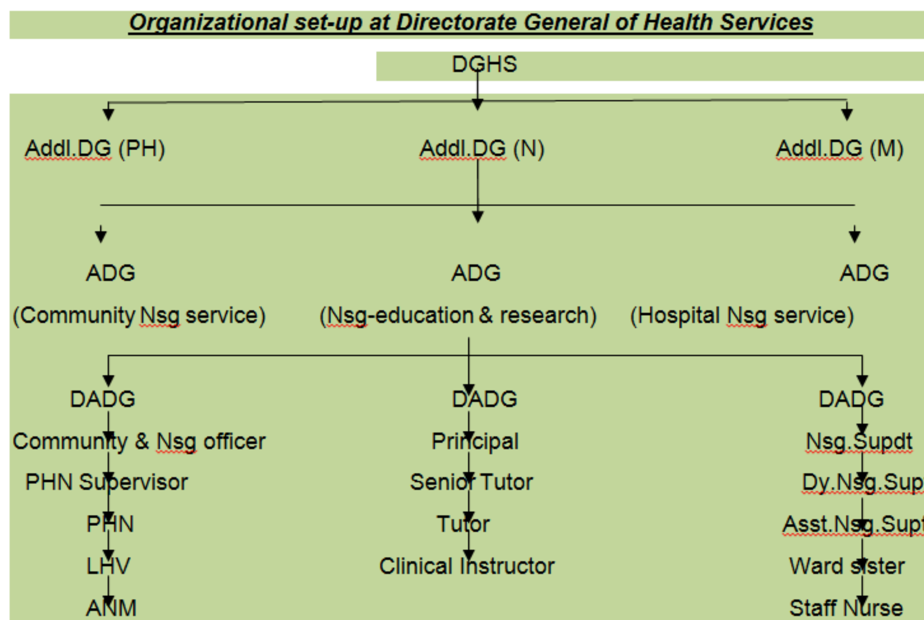
in the State. In the State of Manipur, the post of JD Nursing is only concerned with nursing education in the State. The best nursing setup is in WB which has a separate nursing division within the State Health Directorate and sanctioned posts of nursing administrators in comparison to only two such posts in UP and three in TN. In Kerala, there are three nursing posts under Director Health Services and one under Director Medical Education. In TN, a unique organizational setup exists whereby nursing issues are taken care of by three directorates: DME, Directorate of Medical and Rural Health Services and Directorate of Public Health and Preventive Medicine, indicating a positive impact on better rural health care services. On the other hand, Bihar has no nursing position at the state level. There is also discrepancy in the pay scales for the JD level posts in various states, e.g. JD Nursing, UP is drawing lower pay in comparison to DD Nursing in WB.

The High-Power Committee of the Govt. in 1989 had reviewed the principal challenges faced by the nursing workforce and indicated reforms for developing the directorates of nursing in the states. This committee recommended that a single directorate of nursing should be created in each state with a structure for clinical nursing, public health nursing and nursing education, with the intention of bringing about better governance and accountability to key functions. However, in the last two decades, these policy directions have not been translated into action. This calls for strong leadership and political will at the top.

The states, which have had the post of JD/DD Nursing, over the last many years have attempted to initiate more nursing development issues in comparison to the other states. For example, in WB the post of DD Nursing came into existence in 1975, and this state was the first to start the nurse practitioner in midwifery (NPM) course along with strengthening nursing education.

Organizing Nursing Service at various levels

You have learnt about organisation structure of nursing at Centre and State level as recommended by High Power Committee in Unit 2 of this Module. Let us review again.



Organizational set-up of Nursing Service at Centre Level

Secretary, Health

Director Nursing Service

Joint/Deputy Director Nursing services

ADNS (Community Nsg service) | ADNS (Nsg-education & research) | ADNS (Hospital Nsg service)

DADNS (Community Nsg service) | DADNS (Nsg-education & research) | DADNS (Hospital Nsg service)

DADNS	DADNS	DADNS
Dist. Nsg officer	DADNS	Nsg.Supdt
PH. Nsg officer	Principal	Dy.Nsg.Supt
PHN at PHC	Senior Tutor	Asst.Nsg.Supt
LHV	Tutor	Ward Sister
ANM	Clinical Instructor	Staff Nurse

Organizational set-up of Nursing Service at State Level

Director Nursing Services

Deputy Director Nursing Services

Assistant Director Nursing Services

Deputy Assistant Director Nursing Services

DMO | DNO | DHO

ADNO (Hosp&Nsg.Edu) | ADNO (Community)

Nsg Supt/Dy.Nsg.Supt	Principal tutor	Dist.PNO
Asst.Nsg.Supt	Tutor	PHN Supervisor (CHC)
Ward Sister	Clinical Instructor	PHN (PHC)
Staff Nurse		LHV
		ANM

Check Your Progress 1

1. Describe the recommendations of High Power Committee.

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2. Draw Nursing Structure at State level.

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1.5 FUTURE OF NURSING IN INDIA

The Future of Nursing: Leading Change, Advancing Health: This major initiative began in 2008, with the formation of a committee to assess and transform the nursing profession. As nurses, you can and should play a fundamental role in health care.

Recommendations:

1. Remove scope-of-practice barriers.
2. Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
3. Implement nurse residency programs.
4. Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020.
5. Double the number of nurses with a doctorate by 2020.
6. Ensure that nurses engage in lifelong learning.
7. Prepare and enable nurses to lead change to advance health.
8. Build an infrastructure for the collection and analysis of inter-professional health care workforce data.

Future Perspectives

Nursing today has endorsed several changes, success and challenges through a lot of strikes and movement. Nurses have widened their scope of their work, however while the role and responsibilities have multiplied, there are still concerns with regards to development of nursing, workforce, selection and recruitment and placement as per specialization, pre-services, in services training and human resource issues and career growth.

NHP 2017 recommends setting up new Medical Colleges, Nursing Institutions and AIIMS in the country by the government, standardization quality of clinical training, revisiting entry policies into educational institutions,

ensuring quality of education, continuing nursing education and on the job support to providers, especially those working in rural areas.

The policy also recommends the use of mid-level service providers to provide comprehensive primary care to the rural community through Health and Wellness centres/Sub centres. Nurses had undergone a six months bridge course and are posted as Community Health Officers in Ayushman Arogya Mandir.

INC has prepared curriculum for Nurse Practitioner (NP) programmes in Critical Care and primary care. NP in Critical Care (NPCC) programme is commencing from 2017 and NP in Primary Health Care (NPPHC) and many other programmes. These are residency programs aimed at providing clinical training at the real practice settings. The regulation of nursing education and practice will be strengthened through Nursing Practice Act (NPA) for which INC at the direction of the MOH &FW has started the preparation and soon it will be ready. National license exit exam for entry into practice, periodic renewal of license linked with continuing nursing education, and maintenance of live register are some of the future activities.

Evidence based practices helps nurses provide high quality patient care based on knowledge and research rather than because "this is the way we have always done it" or based on tradition myths advises of colleagues or outdated textbooks. EBP important to nursing practice because it results in better patient outcome, contribute to the science of nursing, increase confidence in decision making.

Transcultural nursing is another important futuristic approach and helpful in assessing the organization's strengths and limitations.

In India, NITI AAYOG has also recommended the revamping the regulatory system of nursing education to ensure quality training in nursing schools and also stressed on developing COEs in Nursing to enhance the stature of Government Nurses.

State of the World's Nursing - Investing in education, jobs and leadership by WHO (2020 and 2025), report highlighted that all over the world political commitment to universal health coverage and preparedness and response capacity is being tested during the COVID pandemic. During these situations nurses provide care to people and it was realised that nurses should work to their full capacity and extent of their training and education. WHO report emphasised on investment in nursing education, jobs and leadership.

Investment in education, jobs and leadership:

Nursing Education - Invest in large scale in nursing **education** – faculty, infrastructure and students to address global needs, meet domestic demand, and respond to changing technologies and advancing models of integrated health and social care.

Nursing Jobs - Create at least 6 million new nursing **jobs** by 2030, primarily in low- and middle-income countries, to take care of the shortages and address the inequitable distribution of nurses across the world.

Nursing Leadership - Strengthen nurse **leadership** – both current and future leaders to ensure that nurses have an influential role in health policy formulation and decision-making, and contribute to the effectiveness of health and social care systems.

4.6 ISSUE AND CHALLENGES IN NURSING IN INDIA

Nurses are struggling hard to keep up expectation but still they don't have recognition both from hospitals and society. There are numerous problems faced by nurses in hospitals such as staff shortage which led to more work pressure for staff nurse. Nurses are working day and night but their salary package is very poor compared to western countries**.**

Shortage of Staff Nurse

Shortage of staff nurse in most of the hospital, even in multispecialty hospitals, the numbers of staff nurse is less. Staff nurses are not placed in wards as per SIU norms, thus lead to stress and burnout. Attrition rate of nurses in private sector is high as nurses are leaving job and go abroad. Nurse are over-worked as they have to perform nursing job responsibilities with non-nursing responsibilities.

Working Hours

Working hours for nurses is fixed but they spend more hours as handing-over takes time and in emergency cannot leave the patient in-between the treatment process.

Assigning Duties

Although there are job responsibilities prescribed by each hospital but still non-nursing activities are given to nurses. Many a times nurses with experience in ICU / OT are not posted there but due to shortage of staff they are posted in other departments. In these cases, hardly any induction training is conducted for these nurses. Even it is important to organise induction training for new nurses who are appointed by respective hospital.

Lack of recognition

Nurses lack professional recognition by public and health system.

Lack of autonomy

India a nurse has limited autonomy and authority to take decisions.

Societal challenges

Nurses are skilled professional who undergo training and undertake professional course to attain professional status but still social status in not given.

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Financial Issues

In private sector, pays structure is very low that is why attrition rate is very high.

State of the World's Nursing - Investing in education, jobs and leadership by WHO (2020), report suggested the nursing role in 21st century health system. Keeping in view issues and challenges in India are we ready to train nurses, provide jobs and have nursing leaders in India who can lead nursing in 21st century and especially to achieve universal health coverage. WHO report highlighted that Cochrane review have shown that nurses can deliver effectively primary health care and provide wide range of services to take care of communicable, non-communicable diseases, health education and prevention of diseases. Report also highlighted that purpose of nursing education is to prepare nurses to meet the demands of health system. The intake of students and output of nursing education institutions should be as per needs and demands of the system. Number of students enrolling in and completing nursing programme are affected by many micro and macro factors including gender, socio-economic factors at various levels. Report also highlighted that nurses should be prepared for speciality or advance practice at masters level and at PhD level for advance clinical speciality or research work.

New Initiatives in India

Under **Ayushman Bharat Scheme, MOHFW, GOI, in Health and Wellness Centres (HWCs)** nurses are appointed as Community Health Officers (CHO). CHO is the first point of care or source of information for health related issues to the people and provide basic health care services in out-patient clinic, provide services for health promotion, prevention of disease and disease surveillance. The HWCs provide expanded range of services along with selective package of health care for pregnant women, children, reproductive health and communicable diseases. HWCs also deliver Preventive, Promotive, Curative, Rehabilitative and Palliative care for wider range of services close to communities. Maintaining record of inflow and outflow of nurses is very essential.

Ministry of Health and Family Welfare, Government of India, Strengthening Pre-Service Education for Nursing Midwifery Cadre in India, guidelines (2017) one of the major focus areas of this national health policy 2017, was to develop the capacities of healthcare professionals, especially nurse midwives by developing and conductive specialized nursing training courses and curriculum, establishing nursing schools and centres of nursing, for a force of Nurse Practitioners and Public Health Nurses and increasing their availability in most needed areas and to achieve SDGs and UHC; various programmes and schemes are launched to achieve the targets but due to failure to reach the desired level of quality of care, acute shortage of trained human resources, especially the nurse midwives, low level of competency of service providers there are many challenges. Therefore, an increase in capacity of the states to produce sufficient number

of competent and skilled nurses is crucial for the success of the various GoI programs. Availability of competent nurse midwives in the country is a critical determinant to accessibility of quality RMNCH+A services. In order to ensure availability of adequate number of skilled nurse midwives, MoHFW in collaboration with the Indian Nursing Council (INC), undertook a comprehensive initiative to strengthen the quality of pre-service education (PSE) for nursing-midwifery cadre in India. It is envisaged that the efforts in this direction will ensure availability of a highly skilled and competent nursing workforce and steer India towards its commitment to Universal Health Coverage.

Indian Nursing Council initiated many programme like Nurse Practitioner programme in Critical Care and various Post Basic Diplomas like in operation room nursing, cadio-thorasic nursing, neurology nursing, midwifery nursing, psychiatry nursing, critical care nursing, disaster and emergency nursing, ortho nursing, geriatric nursing etc.

Nurse Registration and Tracking System (NRTS) - Government of India has launched the Ayushman Bharat Digital Mission to create a national digital health ecosystem and bridge the existing gap amongst different stakeholders of healthcare ecosystem through digital highways. One of the key components of this Mission is preparation of a nationwide Health Professional Registry. The Indian Nursing Council and State Nursing Councils (SNCs) have started implementing the Nurse Registration and Tracking System (NRTS) to maintain the Live Register of Nurses, which will form a part of the Health Professional Registry under Ayushman Bharat Digital Mission. Although the majority of already registered Nurses' data have been enrolled / ported to the NRTS integrated web portal (https://nrts.indiannursingcouncil.gov.in). Indian Nursing Council (Nurses Registration & Tracking System) Regulations, 2019.

Check Your Progress 2

1. Discuss the future of nursing in India.

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2. Describe the issues and challenges in nursing in India.

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4.7 LET US SUM UP

You have learnt the detailed history of nursing in India, about various committees and their recommendations. Organization structure of Nursing at various levels in India, future aspects of Nursing in India and issues faced by Nursing Profession. Highlights of State of Nursing report by WHO (2020) are also given and some of the new initiatives in India are briefed.

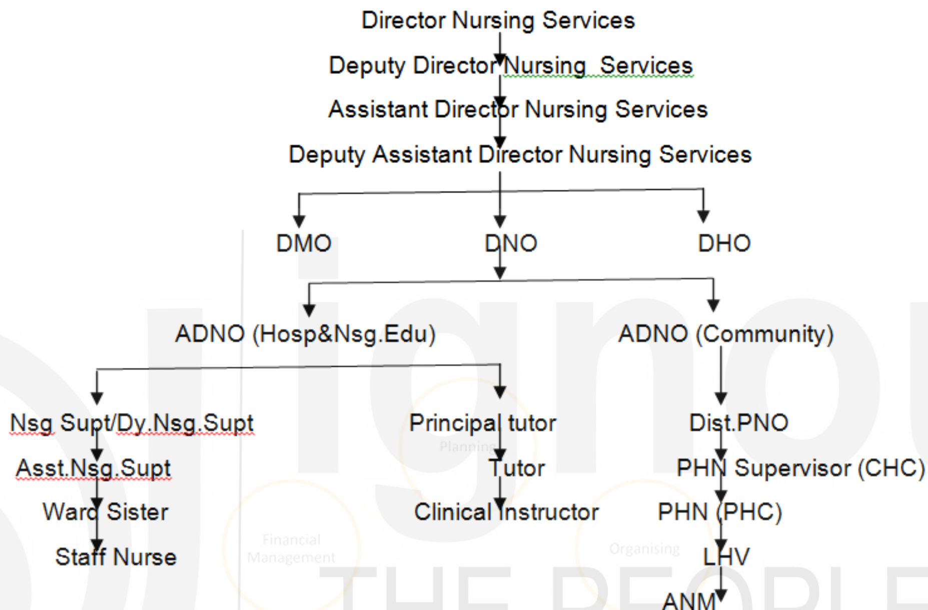
4.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. High Power Committee on Nursing was appointed by the Government of India, Ministry of Health and Family Welfare in July 1987 to review the role, functions, status and preparation of nursing personnel; nursing services and other issues related to the development of the profession and to make suitable recommendations to the government. The committee observed that nurses are generally not involved in making policies that govern their status and practice. The committee made several recommendations related to working conditions, nursing education, continuing education and staff development, norms for nursing services and education. Structural changes at administrative level, job descriptions for all nursing positions, working hours not more than 40 hours a week, opportunity for higher education after 5 years of service, accommodation and transportation facility for safety and security of nursing personnel, nurses to be relieved from the non nursing duties etc. The National Health Policy, 2002 quotes "The ratio of nursing personnel in the country vis-à-vis doctor/bed is very low according to professionally accepted norms. There is also an acute shortage of nurses trained in super-speciality disciplines for deployment in tertiary care facilities The policy while emphasizing

the need for an improvement in the ratio of nurses vis-à-vis doctor/ bed lays focuses on improving the skill -level of nurses, and on increasing the ratio of degree holding nurses vis-à-vis diploma-holding nurses. It recognizes need for the central government to subsidize the setting up, and the running of, training facilities for nurses on a decentralized basis. Also, the policy recognizes the need for establishing training courses for super-speciality nurses required for tertiary care institutions.

2. Nursing structure at State Level



Check Your Progress 2

1. The future of healthy India lies in mainstreaming the health agenda in the framework of the sustainable development and strengthening primary, secondary and tertiary care services to serve the rural (70%) and urban (30%) population. NHP 2017 recommends setting up new Medical Colleges, Nursing Institutions and AIIMS in the country by the government, standardization quality of clinical training, revisiting entry policies into educational institutions, ensuring quality of education, continuing nursing education and on the job support to providers, especially those working in rural areas using digital tools and other appropriate training resources, strengthening human resource governance, regulation of practice, establishing cadres like Nurse Practitioner and Public Health Nurses, specialty training for tertiary care, nursing school/ college for 20-30 lakh population, HR policy for faculty, centres of excellence in nursing in each state, career progression to nursing cadre and posting of regular nurses to sub-centre in the state where adequate nursing institutions are present. The policy also recommends the use of mid-level service providers to provide comprehensive primary care to the rural community through Health and Wellness centres/Sub centres. Nurses can assume this role provided they undergo a six month bridge course. Nursing education

2. **Issues and challenges**

Shortage of Staff Nurse

Shortage of staff nurse in most of the hospital, even in multispecialty hospitals, the numbers of staff nurse is less. Staff nurses are not placed in wards as per SIU norms, thus lead to stress and burnout. Attrition rate of nurses in private sector is high as nurses are leaving job and go abroad. Nurse are over-worked as they have to perform nursing job responsibilities with non-nursing responsibilities/

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Assigning Duties

Although there are job responsibilities prescribed by each hospital but still non-nursing activities are given to nurses. Many a times nurses with experience in ICU / OT are not posted there but due to shortage of staff they are posted in other departments. In these cases, hardly any induction training is conducted for these nurses. Even it is important to organise induction training for new nurses who are appointed by respective hospital.

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Nurses lack professional recognition by public and health system.

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India a nurse has limited autonomy and authority to take decisions.

Societal challenges

Nurses are skilled professional who undergo training and undertake professional course to attain professional status but still social status in not given.

Financial Issues

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UNIT 5 COUNCILS COMMISSION AND NURSING ASSOCIATIONS

Structure

5.0 Introduction

5.1 Objectives

5.2 International Council of Nursing and Indian Nursing Council

5.3 National Nursing and Midwifery Commission Act of India

5.4 Professional Associations of Nursing in the World and India

5.5 Let us Sum up

5.6 Answers to Check Your Progress

5.7 Practical Activity and Guidelines

5.0 INTRODUCTION

In the previous unit you have learnt about nursing history and future of nursing in India. It is important for you to learn about nursing councils and nursing association's role for quality nursing services, education and welfare of nurses. We will review the role vision and mission of International Nurses Council; Indian Nursing Council Act; professional associations' world over and in India and establishment of National Nurses and Midwife Commission in India on lines of National Medical Commission.

5.1 OBJECTIVES

After completion of this unit you will be able to:

1. describe the vision and position statement of International Council of Nurses;
2. analyse Indian Nursing Council (INC) Act and need for amendment;
3. explain the need for various nursing programmes in India;
4. analyse the future strategies and activities of INC;
5. analyse the need for National Nursing and Midwifery Commission Act in India
6. list the professional nursing associations in the world; and
7. critically analyse the role of Trained Nurses Association of India (TNAI).

5.2 INTERNATIONAL COUNCIL OF NURSING AND INDIAN NURSING COUNCIL

A. International Council of Nursing

Let us first review about International Council of Nursing.

The International Council of Nurses (ICN) is a federation of more than 130 national nurses associations (NNAs), representing the more than 20 million nurses worldwide. Founded in 1899, ICN is the world's first international organisation for health professionals. ICN works to ensure quality nursing care for all, sound health policies globally, the advancement of nursing knowledge, and the presence worldwide of a nursing profession. ICN's works with many international agencies e.g. United Nations agencies, World Health Organization, International Labour Organisation and the World Bank.

Vision of ICN - The global community recognises, supports, and invests in nurses and nursing to lead and deliver health for all.

Mission - To represent nursing worldwide, advance the nursing profession, promote the wellbeing of nurses, and advocate for health in all policies.

ICN has identified three key programme areas as crucial to the betterment of nursing and health. These are known as ICN's Pillars and they are:

Professional Practice, Regulation, and Socio-economic welfare. The association's activities are focused in these areas.

The International Classification for Nursing Practice (ICNP) – a common code language for data globally.

Leadership for Change are two significant ICN projects which come under the professional practice pillar. Leadership in Negotiation is a project which comes under the socio-economic welfare pillar.

ICN Strategic Priorities

ICN explicitly seeks to align and integrate nursing with global health priorities. For the period 2017-2020, they identified several specific health topics priorities for a global focus and advancement. Work to influence the World Health Organization, and other high-level decision making bodies to ensure that nurses are part of the decision-making, policy-setting and implementation of national and international policies and strategies.

1. Universal Health Coverage - As the largest heath profession in the world, nurses are critical to achieving Universal Health Coverage. UHC is an overarching topic that is addressed in many ICN projects and policy initiatives.

2. Non-Communicable Diseases - In 2018, the International Council of Nurses (ICN) is reiterating its commitment and highlighting the importance of 'Health as a Human Right.' After 70 years of the sentiment being adopted in the WHO constitution, still about 50% of the world's population do not have full coverage of essential health services and more than 100 million people are still being pushed into extreme poverty because they have to pay for health care (World Health Organization, 2017).

3. Primary Health Care - Primary health care is of particular importance to ICN because the millions of nurses we represent are its backbone. PHC is the cornerstone of health systems for every nation on this planet and,

thus, equity and access to primary health care services are essential to improving the health and wellbeing of all people.

4. Human Resource for Health - The world cannot help to achieve the Sustainable Development Goals, Universal Health Coverage and other health goals without looking at the Human resources for health. Investing in the workforce is a vital part of health system strengthening and patient safety.

5. Person Centred Care - The philosophical basis of nursing is a person-centred approach to health. A person-centred approach, a functional health system, the availability of an appropriately skilled workforce and addressing the issues of access are the critical building blocks for Universal Health Coverage.

6. Patient Safety - The delivery of safe, high-quality patient care is of utmost importance to nurses. As nursing care spans all areas of care delivery, nurses are well placed to prevent harm to patients and improve the quality and safety of healthcare delivered across all settings. As such, nurses should be central to the design and operation of all health providers' patient safety systems and processes.

7. Antimicrobial Resistance - ICN, in conjunction with our partner organisations, has identified several specific health topics priorities for a global focus and advancement in the 2017-2020.

8. Mental Health - WHO estimates that nearly two-thirds of people with a known mental health problem never seek help from a health professional. Stigma, discrimination and neglect prevent care and treatment from reaching people with mental disorders. ICN is concerned about the lack of recognition of the health workforce role in the care, advocacy and leadership in dealing with mental health. ICN is also concerned about the absence of consumers and the community in the development of policies, strategies or legislation related to mental health. People-centred care and community engagement need to be front and centre in any future implementation plans.

9. Immunization - Immunisation is a proven tool for controlling and eliminating life-threatening infectious diseases worldwide. It is estimated to prevent up to 3 million deaths each year and is considered to be one of the most successful and cost effective health investments. With the right strategies, even the hardest to reach and vulnerable populations can receive the benefits of immunisation.

10. Sustainable Development Goals - Nurses, as the primary providers of healthcare to all communities in all settings, are key to the achievement of the Sustainable Development Goals (SDGs). In fact, if investment in the nursing profession is not made by governments and world leaders, we cannot succeed.

Definition of Nursing – ICN

Nursing encompasses autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well and in all settings.

Nursing includes the promotion of health, prevention of illness, and the care of ill, disabled and dying people. Advocacy, promotion of a safe environment, research, participation in shaping health policy and in patient and health systems management, and education are also key nursing roles. (ICN, 2002)

Long definition

Nursing, as an integral part of the health care system, encompasses the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages, in all health care and other community settings. Within this broad spectrum of health care, the phenomena of particular concern to nurses are individual, family, and group "responses to actual or potential health problems" (ANA, 1980, P.9). These human responses range broadly from health restoring reactions to an individual episode of illness to the development of policy in promoting the long-term health of a population.

The unique function of nurses in caring for individuals, sick or well, is to assess their responses to their health status and to assist them in the performance of those activities contributing to health or recovery or to dignified death that they would perform unaided if they had the necessary strength, will, or knowledge and to do this in such a way as to help them gain full of partial independence as rapidly as possible (Henderson, 1977, p.4). Within the total health care environment, nurses share with other health professionals and those in other sectors of public service the functions of planning, implementation, and evaluation to ensure the adequacy of the health system for promoting health, preventing illness, and caring for ill and disabled people. (ICN, 1987)

Definition of a Nurse

The nurse is a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country. Basic nursing education is a formally recognised programme of study providing a broad and sound foundation in the behavioural, life, and nursing sciences for the general practice of nursing, for a leadership role, and for post-basic education for specialty or advanced nursing practice. The nurse is prepared and authorized (1) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (2) to carry out health care teaching; (3) to participate fully as a member of the health care team; (4) to supervise and train nursing and health care auxiliaries; and (5) to be involved in research. (ICN, 1987).

1.3 INDIAN NURSING COUNCIL

Indian Nursing Council

The Indian Nursing Council (INC) will be replaced by National Nursing and Midwifery Commission (NNMC) as NNMC Act was passed by Parliament in August, 2023. But it is important for you to know about INC also.

INC is an autonomous organisation of Ministry of Health & Family Welfare,

Government of India. It was constitution under Section 3 (1) of the Indian Nursing Council Act 1947.

An INC Act was to constituted in order to establish a uniform standard of training for nurses, midwives and health visitors in India.

Recognition of qualifications.—(1) For the purposes of this Act, the qualifications included in 1 [Part I of] the Schedule shall be recognised qualifications, and the qualifications included in Part II of the Schedule shall be recognised higher qualifications. (2). You can go through the link for details http://www.indiannursingcouncil.org/pdf/inc-act-1947_New.pdf

The Council shall cause to be maintained in the prescribed manner a register of nurses, midwives, auxiliary nurse-midwives and health visitors to be known as the Indian Nurses Register, which shall contain the names of all persons who are for the time being enrolled on any State register.

Various nursing programmes for which standard guidelines are provided by INC are Nurse Practitioner (Critical Care) Programme, M.Sc. Nursing, B.Sc. Nursing, Post Basic B.Sc. Nursing, General Nursing and Midwifery Diploma, ANM, Post Basic Diploma Specialised programmes.

Initiatives by INC

- Initiating Nurse Practitioner (Critical Care) programme.
- Roll out Nurse Practitioner Midwifery programme as per MOHFW, GOI, guidelines.
- One of the key initiatives taken by Indian Nursing Council is up-gradation of School of Nursing to College of Nursing i.e. single entry level for nursing for quality of nursing education.
- Another initiative taken up by INC is maintaining Nurses Registration and Tracking System (NRTS). Software is developed by INC for maintenance and operation of Indian Nurses Register. For details link is given http://www.indiannursingcouncil.org/pdf/cirular_of_nrts.pdf
- Nursing Now campaign was launched in India by INC during an international conference on Nurses and Midwives for Universal Health Coverage in 2018. To celebrate 2020 as the Year of the Nurse and the Midwife, the Nightingale Challenge aims to equip and empower the next generation of nurses and midwives as leaders, practitioners and advocates in health. The Nightingale Challenge asks every health employer around the world to provide leadership and development training for a group of their young nurses and midwives during 2020. We aim to have at least 1,000 employers accepting the Nightingale Challenge, benefiting over 20,000 nurses and midwives aged 35 and under during 2020.
- Revision of B.Sc. Nursing syllabus.
- Added various modules related to disaster management, climate change, air pollution and heat wave and their impact of health, integration of MLHP in B.Sc. N and Post Basic B.Sc. N and added elective modules in B.Sc. Nursing.

5.3 NATIONAL NURSING AND MIDWIFERY COMMISSION ACT OF INDIA

The planning commission has recommended the replacement of Medical Council of India (MCI) with National Medical Commission (NMC). The decision has been approved by most states and after its approval by the Prime Minister it was proposed as final bill in the parliamentary sessions. It was passed by both the houses of Parliament in 2019. President of India gives his nod to National Medical Commission Bill 2019 on 8 August 2019 and it became a law.

BILL to provide for a medical education system that improves access to quality and affordable medical education, ensures availability of adequate and high quality medical professionals in all parts of the country; that promotes equitable and universal healthcare that encourages community health perspective and makes services of medical professionals accessible to all the citizens; that promotes national health goals; that encourages medical professionals to adopt latest medical research in their work and to contribute to research; that has an objective periodic and transparent assessment of medical institutions and facilitates maintenance of a medical register for India and enforces high ethical standards in all aspects of medical services; that is flexible to adapt to changing needs and has an effective grievance redressal mechanism and for matters connected therewith or incidental thereto.

The Commission shall perform the following functions, namely:

a) lay down policies for maintaining a high quality and high standards in medical education and make necessary regulations in this behalf;

b) lay down policies for regulating medical institutions, medical researches and medical professionals and make necessary regulations in this behalf;

c) assess the requirements in healthcare, including human resources for health and healthcare infrastructure and develop a road map for meeting such requirements;

d) promote, co-ordinate and frame guidelines and lay down policies by making necessary regulations for the proper functioning of the Commission, the Autonomous Boards and the State Medical Councils;

e) ensure co-ordination among the Autonomous Boards;

f) take such measures, as may be necessary, to ensure compliance by the State Medical Councils of the guidelines framed and regulations made under this Act for their effective functioning under this Act;

g) exercise appellate jurisdiction with respect to the decisions of the Autonomous Boards;

h) lay down policies and codes to ensure observance of professional ethics in medical profession and to promote ethical conduct during the provision of care by medical practitioners;

i) frame guidelines for determination of fees and all other charges in respect of fifty per cent. of seats in private medical institutions and deemed to be universities which are governed under the provisions of this Act;

j) exercise such other powers and perform such other functions as may be prescribed.

Let us go through some of the news items from newspaper and analyze the need for National Nurses and Midwife Commission in India in place of Indian Nursing Council.

National Nurses and Midwife Commission

Government think-tank NITI Aayog has pitched for enactment of the National Medical Commission (NMC) Bill, 2017, observing that regulatory bodies the Medical Council of India and the Nursing Council of India have "failed" to ensure adequate availability and quality of health professionals. In its 'Strategy for New India @75', the Aayog has recommended revamp of the regulatory system of nursing education to ensure quality training in nursing schools and also stressed on developing centres of excellence in nursing and enhancing the stature of government nurses. The Aayog said the quality of health professional training and adherence to standards is sub-optimal, including in the private sector. "Workforce shortages and uneven distribution of doctors, nurses, specialists and allied health professionals plague the sector," the Aayog said while observing that urban areas have four times as many doctors and three times as many nurses as compared to rural areas. Medical and nursing colleges are concentrated in a few states like Andhra Pradesh, Karnataka, Tamil Nadu, Kerala, Gujarat and Maharashtra.

An National Nursing and Midwifery Commission Act to provide for regulation and maintenance of standards of education and services by nursing and midwifery professionals, assessment of institutions, maintenance of a National Register and State Registers and creation of a system to improve access, research and development and adoption of latest scientific advancement and for matters connected therewith or incidental thereto.

The National Commission shall consist of a Chairperson, sixteen ex officio Members and twelve Members as follows:

(a) a person having outstanding ability, proven administrative capacity and integrity and possessing a postgraduate degree in nursing and midwifery profession from any University with experience of not less than twenty years in the field of nursing and midwifery, out of which at least ten years shall be as a nursing and midwifery leader, to be appointed by the Central Government—Chairperson;

(b) one representative of the Department of Health and Family Welfare, Ministry of Health and Family Welfare, not below the rank of Joint Secretary to the Government of India who is in-charge of nursing and midwifery—Member, ex officio;

(c) one representative of the Ministry of Defence not below the rank of Additional Director General, Military Nursing Services to the Government of India in the Directorate General of Armed Forces Medical Services—Member, ex officio;

(d) one representative of the Directorate General of Health Services not below the rank of Additional Director General—Member, ex officio;

(e) one person representing the National Medical Commission not below the rank of Deputy Secretary to the Government of India—Member, ex officio;

(f) President of each of the Autonomous Boards constituted under section 11

Members, ex officio;

(g) three persons, not below the rank of Chief Nursing Officer or Nursing Superintendent of any of the hospitals or Dean or Principal of College of Nursing, as the case may be, to be nominated by the Central Government from Central Government hospitals or Nursing and Midwifery Institutions of repute in such manner as may be prescribed—Members, ex officio;

(h) one person from each of the six zones, as may be prescribed, not below the rank of Chairperson, who shall be a nursing and midwifery professional, representing the State Commissions, on biennial rotation in the alphabetical order as per the zonal distribution of States and Union territories, to be nominated in such manner as may be prescribed—Members, ex officio;

(i) six nursing members of eminence, one from each of the six zones, as may be prescribed, from nursing and midwifery profession of outstanding ability, proven administrative capacity and integrity, possessing a postgraduate degree in any discipline of nursing and midwifery from any University and having experience of not less than fifteen years in the field of nursing and midwifery, out of which at least seven years shall be as a nursing and midwifery leader, to be nominated by the State Governments in such manner as may be prescribed—Members:

Provided that the States and Union territories represented under clauses (h) and (i) shall be distinct;

(j) four nursing and midwifery members of eminence, of which at least two shall be midwifery professionals, of outstanding ability, proven administrative capacity and integrity, possessing a postgraduate degree in any discipline of nursing and midwifery from any University and having experience of not less than fifteen years in the field of nursing and midwifery, out of which at least seven years shall be as a nursing and midwifery leader, to be nominated by the Central Government in such manner as may be prescribed—Members;

(k) one person representing charitable institutions engaged in education or services in the field of nursing and midwifery and having such qualification and experience, to be appointed by the Central Government in such manner as may be prescribed—Member; and

(l) a person of eminence to be appointed by the Central Government, in such manner as may be prescribed, from amongst persons of ability, integrity and standing, who have special knowledge and professional experience in such areas including management, law, medical ethics,

health research, consumer or patient rights advocacy, science and technology and economics—Member.

You can click the links below for more information.

http://egazette.nic.in/WriteReadData/2019/210357.pdf

https://main.mohfw.gov.in/sites/default/files/Gazette%20%281%29.pdf

https://www.business-standard.com/article/current-affairs/niti-aayog-pitches-for-nmc-bill-enactment-to-improve-nursing-training-118122300119_1.html

https://theprint.in/india/governance/niti-aayog-pitches-for-enactment-of-national-medical-commission-bill-2017/167847/

After this add Check Your Progress short or long questions

Check Your Progress 1

1. Define the term Nurse.

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2. Describe need for NNMC Act.

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5.4 PROFESSIONAL ASSOCIATIONS OF NURSING IN THE WORLD AND INDIA

Professional nurse organizations gain strength through the collaborative exchange of ideas, and members benefit from a foundation built on shared professional experiences.

Nursing Associations World over

There are many professional organizations of nurses; below are given names of few nursing associations.

1. The American Nurses Association (ANA)

   Founded in 1896, the American Nurses Association (ANA) serves as one of the oldest and largest professional nurse organizations in the country. Subsidiaries of the ANA include the American Academy of Nursing, the American Nurses Foundation, and the American Nurses Credentialing Center, making it one of the most comprehensive nurse organizations.

   ANA exists to advance the nursing profession by:

   - Fostering high standards of nursing practice;
   - Promoting a safe and ethical work environment;
   - Bolstering the health and wellness of nurses; and
   - Advocating on health care issues that affect nurses and the public.

2. Sigma Theta Tau International Honor Society of Nursing (Sigma)

   This organization has 135,000 members and 700 chapters in institutions of higher learning around the world. Sigma was the first organization in the United States to fund nursing research and continues to offer continuing education opportunities, career advice, and leadership development programs to its members.

3. The National League for Nursing (NLN)

   The NLN was founded in 1893 and is the oldest of the professional nurse organizations in the United States. The NLN represents nursing education in healthcare organizations and institutions of higher learning. The NLN offers extensive opportunities for networking, continuous education, and professional development.

Nursing Association in India

Trained Nurses Association of India

The Trained Nurses' Association of India (TNAI) is a national organization of nurse professionals. It was established in 1908 and was initially known as Association of Nursing Superintendents. The Government of India has recognized TNAI as a service organization in 1950. Objectives of TNAI are given below.

Objectives

- Dignity and honour of the nursing profession,
- Promoting a sense of espirit de corps among all nurses,
- To advance professional, educational, economic and general welfare of nurses

Functions of TNAI

- To enunciate standards of Nursing Education and implement these through appropriate channels.
- To establish standards and qualifications for nursing practice.
- To enunciate standards of Nursing Service and implement these through appropriate channels.
- To establish a code of ethical conduct for practitioners.
- To stimulate and promote research designed to enhance
- To stimulate and promote research designed to enhance the knowledge for evidence-based nursing practice.
- To promote legislation and to speak for Nurses in regard to legislative action.
- To promote and protect the economic welfare of Nurses.
- To provide professional counselling and placement service for Nurses.
- To provide for the continuing professional development of practitioners.
- To represent Nurses and serve as their spoke person with allied national and international organisations, government and other bodies and the public.
- To serve as the official representative of the Nurses of India as a member of the International Council of Nurses.
- To promote the general health and welfare of the public through the Association programmes, relationships and activities e.g. Disaster Management.
- To render care as per the changing needs of the society.

Membership

A life member is a person who is a registered Nurse and Midwife trained from an institution recognised by the Indian Nursing Council/State Nursing Councils.

Student Nurses Association

The Student Nurses' Association of India (SNAI) is an affiliated association of the student nurses under the umbrella of TNAI. The main purpose behind the establishment of SNAI was to uphold the dignity and to promote a team spirit among students with professional ethics. SNAI was established in 1929 during TNAI Annual Conference in Madras. The pioneer unit of SNA was

established in General Hospital, Madras. The first SNA annual Conference was held in Delhi during November 1932.

In 1970 with the reorganization of TNAI the designation of the SNAI Secretary was changed to SNAI Advisor. The office was re-designated as Assistant Secretary-cum-SNA Advisor and in 2005, again re-designated as Deputy Secretary General-cum-SNA Advisor.

Further the SNAI units are expanded gradually to many nursing institutions in India and started functioning. Now there are 900 SNAI units and 1,50,000 SNAI members in the country.

Objectives:

a) To help the students to uphold the dignity of the profession.

b) To promote team spirit among students for common goal.

c) To help the students to develop professional ethics.

d) To encourage students to gain positive attitude towards the nursing profession

e) To encourage the students to develop leadership quality and effective communication skills for overall development.

f) To encourage students to participate and compete in various events at state, regional and national conferences.

New Initiatives by TNAI

- **Established Elderly Care Home (Day Care Centre)**
- **Established Central Institute of Nursing and Research Centre**
- **Established Staff Accommodation and Guest house**
- National Skills Lab (Daksh)'at TNAI's Central Institute of Nursing, Research and Elderly Care Home, TNAI Greater Noida.
- TNAI a recruitment agency. Concerned at the exploitative, unethical and deceptive practices of certain unscrupulous agencies operating in this area, TNAI had long been contemplating to provide a safe and fair mechanism to the Nurses, who in increasing numbers, seek employment within the country or abroad.
  - o To maintain high standards and transparency in selection of candidates in keeping with track record to TNAI
  - o Data flow of each candidate before appearing for the interview or selection process of right candidate for the right post
  - o To avoid third party involvement other than foreign employer and TNAI
  - o To provide necessary training and orientation before departure
  - o A data bank of nurses who are willing to go abroad to be created for uninterrupted supply of nurses overseas

- o TNAI will research and resolve issues pertaining to employment of nurses abroad
- o Disseminate the correct information to nurses
- o No hidden charges to be incurred by the applicants other than these stipulated by the Ministry of External Affairs, Government of India.

- Health Education England is hiring nurses to United Kingdom through The Trained Nurses Association of India (TNAI).
- The Trained Nurses Association of India in collaboration with British Council and Health Education England is providing Free IELTS training at the British Council Centre at New Delhi.
- TNAI established Occupational English Test Centre (OET) in collaboration with Khaira Education Pvt Ltd, (Approved premium provider by OET) at TNAI Hqrs, L-17, Florence Nightingale Lane, Green Park Main, New Delhi.

After this add Check Your Progress short or long questions

Check Your Progress 2

1. List the functions of TNAI.

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2. Describe objectives of SNA.

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5.6 LET US SUM UP

In this unit you have learnt about Indian Nursing Council Act and its functions. Need for various programmes in nursing in India and future activities of INC. Review the various nursing associations in the world and critically analyse the role of Trained nurses association of India and its role for the welfare of the nurses. As per policy of Government of India need for National Nursing and Midwifery Commission on lines of National Medical Commission.

5.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. The nurse is a person who has completed a program of basic, generalized nursing education and is authorized by the appropriate regulatory authority to practice nursing in his/her country. Basic nursing education is a formally recognised programme of study providing a broad and sound foundation in the behavioural, life, and nursing sciences for the general practice of nursing, for a leadership role, and for post-basic education for specialty or advanced nursing practice. The nurse is prepared and authorized (1) to engage in the general scope of nursing practice, including the promotion of health, prevention of illness, and care of physically ill, mentally ill, and disabled people of all ages and in all health care and other community settings; (2) to carry out health care teaching; (3) to participate fully as a member of the health care team; (4) to supervise and train nursing and health care auxiliaries; and (5) to be involved in research. (ICN, 1987).

2. Need for NNMC

   An National Nursing and Midwifery Commission Act to provide for regulation and maintenance of standards of education and services by nursing and midwifery professionals, assessment of institutions, maintenance of a National Register and State Registers and creation of a system to improve access, research and development and adoption of latest scientific advancement and for matters connected therewith or incidental thereto.

Check Your Progress 2

1. Functions of TNAI

   - To enunciate standards of Nursing Education and implement these through appropriate channels.
   - To establish standards and qualifications for nursing practice.
   - To enunciate standards of Nursing Service and implement these through appropriate channels.
   - To establish a code of ethical conduct for practitioners.
   - To stimulate and promote research designed to enhance
   - To stimulate and promote research designed to enhance the knowledge

for evidence-based nursing practice.

- To promote legislation and to speak for Nurses in regard to legislative action.
- To promote and protect the economic welfare of Nurses.
- To provide professional counselling and placement service for Nurses.
- To provide for the continuing professional development of practitioners.
- To represent Nurses and serve as their spoke person with allied national and international organisations, government and other bodies and the public.
- To serve as the official representative of the Nurses of India as a member of the International Council of Nurses.

2. Objectives of SNA:

   a) To help the students to uphold the dignity of the profession.

   b) To promote team spirit among students for common goal.

   c) To help the students to develop professional ethics.

   d) To encourage students to gain positive attitude towards the nursing profession

   e) To encourage the students to develop leadership quality and effective communication skills for overall development.

   f) To encourage students to participate and compete in various events at state, regional and national conferences.

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