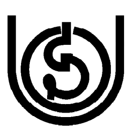

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Indira Gandhi National Open University
School of Health Sciences

MHH-103
Organization and Management of Hospital & Health Services

Block

5

HEALTH SYSTEM IN INDIA

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BLOCK INTRODUCTION

In the previous block you learnt about Community Health and related concepts. Carrying the topic forward, we will discuss health system in India.

For the convenience of understanding, the Block have been classified into five units which are as under:

Unit 18: Overview of Health Care Delivery System

Unit 19: Holistic Approach to Health

Unit 20: Health and Population, Policy and Strategies

Unit 21: District Health Organization

Unit 22: Regionalization of Health Care

We will start our unit by learning the basic concept of Health Care Delivery System in India, its evolution and how it is being practically implemented. It will be followed by holistic approach to health in which we will learn various sciences of healing including AYUSH ,its evolution and some points about the alternative systems of medicine. This will be followed by Population, Policy and Strategies related to Health in which the focus would be on various policies and guidelines which have been implemented keeping the goal 'health for all' in mind. The national health and the population policies will be discussed in detail. You will also get to know some of the important concepts related to District health organisation. The structure and functioning and the concept of decentralisation will be discussed in this unit along with district health information system. The block ends with the Unit on Regionalization of health care in which the purpose and the concept of regionalism will be discussed in detail. You will be expected to understand the advantages and the disadvantages of regionalism in this unit.

In every unit there is check your progress for your own self-assessment. See that you attempt those after you read every section. Maps and diagrams are given at appropriate places to ease the understanding of the topic.

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UNIT 18 OVERVIEW OF HEALTH CARE DELIVERY SYSTEM

Structure

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18.2 Evolution of Health Care Delivery System

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18.0 OBJECTIVES

After going through this unit, you should be able to:

- describe briefly how the health care delivery system has evolved over a period of time;
- list the recommendations of important health committees
- describe the health care infrastructure at various levels;
- specify the services provided at various levels; and
- relate the infrastructure to requirements of health services.

18.1 INTRODUCTION

In the previous block of this course, you have learnt about the basics of health, health for all and primary health care. In this unit, you will learn about the overview of health care delivery system in the country. In the beginning of the unit, you will learn about the evolution of health care delivery system including the

recommendations of various committees. Thereafter you will learn about the health care infrastructure at various levels. Towards the end of this unit, you will learn about the role of voluntary organisations, private practitioners and indigenous system of medicine in the health delivery system of the country.

18.2 EVOLUTION OF HEALTH CARE DELIVERY SYSTEM

18.2.1 History of Evolution of Health Services

Health is a positive state of well-being and not a mere absence of diseases. Health, further implies complete adjustment of the individual to his total environment, physical and social. Factors like social, economic and education have an intimate bearing on the health of the community. Health is thus, a vital part of a concurrent and integrated programme of development of all aspects of community life.

India has a rich, millennia old heritage of medical and health sciences. The Indus Valley Civilisation (3000 – 2500 BC) had well-developed environmental sanitation programmes like underground drains, public baths etc. Almost all households had bathrooms, latrines, water-closets and carefully built wells. Marshall (1931) remarked that public health facilities of Mohenjodaro city were superior to those of all other communities of the ancient orient states.

Vedic medicine took the momentous step from magico-religious therapeutics to rational therapeutics (Chattopadhyaya, 1977). Charak Samihita and Susruta Samihata displayed the highly developed medical science. India was the first country to build hospitals not only for humans but also animals and perform surgery on the operation table.

Health Status and Health System till Independence

There were three major indigenous systems of medicine (ISM) in the early period i.e. Ayurveda-the Hindu system; Unani-the Greek System , Siddha system which prevailed in Tamil Nadu and some other parts of South India.

During the middle of the 18th Century, the British Government in India established medical services. Allopathy was introduced primarily to look after the health needs of British armies, their civil servants and labour employed in colonial enterprises and industries. General public was given the lowest priority. Indigenous systems of medicine were totally neglected and allowed to languish. The state of public health in British India was low as evident by wide prevalence of diseases like Malaria, Tuberculosis, Cholera, plague etc. In the forties the death rate was 22.4 per 1000 inhabitants and infant mortality of 162 per 1000 live births (Bhore Committee, Vol. 1, 1946). Services which were available in general hospitals located in big cities and commercial centres were largely curative in nature and meant for the care of the sick and injured. Later on, some preventive measures were provided for the control of epidemics and dispensaries were also opened in some remote villages. Medical services were scattered inadequately, not only in number but in the kind of medical care they delivered. Rural population in particular were starved of services. In the United Provinces, one institution served a population of about 1,05,626 people inhabiting about 202 villages.

An important feature of health policies, plans and programmes in India is that they started taking shape prior to Independence along with the growing national movement. The National Planning Committee (NPC) of the Indian National Congress was set up in 1938. This Committee set up a sub-committee on National Health chaired by Colonel Santok Singh Sokhey which made a penetrating assessment of then health situation and health services in the country and recommended measures for their improvement in the interim report submitted in 1940. The integration of curative and preventive functions in a single state agency was urged and it was stressed that the maintenance of the health of the people was the responsibility of state. Thus, even as early as 1940, India's leaders had already envisaged a people-oriented health service.

Growth of Health Care Services After Independence

On achieving Independence, India embarked upon a planned effort for raising the standard of living of the masses. Health planning in Independent India was made an integral part of the overall planning for socio-economic development. A major landmark in the development of health services in India was the establishment of the first Primary Health Centre (PHC) in October, 1952. The PHC, as part of the Community Development Programme signified the putting into practice of the concept of community participation and inter-sectorial development for health care. National Health Programmes like malaria control programme, Tuberculosis control programme etc. were initiated so that the rural people have access to important communicable diseases. Sub centres were established to take health care services near the people.

18.2.2 Salient Features of Various Committees

Bhore Committee (1943-46)

In 1943, the then British Government appointed the **"Health Survey and Development Committee"** with Sir Joseph Bhore as Chairman to make a survey of the existing health conditions and health organisations and to make recommendations for future development. The recommendations and guidance provided by the Bhore Committee formed the basis for organisation of basic health services in India. The report was submitted to the Government in 1946. The Bhore Committee emphasised the need for social orientation of medical practice, a high level of public participation to lay special emphasis on preventive work and consequent development of environmental health.

The Bhore Committee made two types of recommendations: -

(a) A comprehensive blue print for the distant future (20 to 40 years) the smallest service unit was to be a Primary Health Unit, serving a population of 10,000 to 20,000; and

(b) A short-term scheme covering 2 to 5 years period-the emphasis would be on setting up 30 bedded hospitals, one for every two Primary Health Units.

Mudaliar Committee

It recommended (a) Upgrading and strengthening of PHUs. (b) Strengthening of District Hospitals (c) Mobile Service teams for rural areas (d) Levying of small fee for those availing hospital facilities except for poor, (h) National Programmes

in regard to Malaria Eradication, Small Pox, Cholera, Leprosy, Tuberculosis and Filariasis.

Chadha Committee (1963)

The Committee considered that the maintenance was the responsibility of the general health system which should be adequately strengthened, particularly the rural health services. Vigilance through medical institutions (government or non-government) must be developed. Multipurpose domiciliary health services should be developed for all health programmes including malaria, small-pox, control of other communicable diseases, health education etc.

Mukherjee Committee (1966)

The Committee recommended the strengthening of the administrative set up at different levels from the Primary Health Units up to the State Headquarters, delinking of malaria maintenance activities from Family Planning Programme.

Jain Committee (1966-67)

Reviewed (a) working of different classes of hospitals in the country to improve the standards of medical care and develop sound guidelines for the future expansion of the hospital services. (b) Review of the working of the Central Government Health Scheme (CGHS)

Kartar Singh Committee (1972-73)

Recommended a) Multipurpose workers for the delivery of health, family planning and nutrition

services to the rural communities with one Male Health Worker (Multipurpose) for a population of six to seven thousand and one Female Health Worker (ANM) a population of ten to twelve thousand. (b) Training for all workers engaged in the field of health, family planning and nutrition should be integrated.

Shrivastava Committee (1974-75)

The Committee recommended (a) Organisation of the basic health services (including nutrition, health education and family planning) within the community itself and training the personnel needed for the purpose, (b) bridge the community with the first level referral centres, viz., the PHC,

18.2.3 Changing Trends in Evolution of Health Care Delivery System

At the time of Independence, the country's health care infrastructure was mainly urban and clinic based., Central and State Governments made efforts to build up primary, secondary and tertiary care institutions and tried to link them through an appropriate referral system. The private and voluntary sectors also tried to cater to the health care needs of the population. Efforts to train adequate number of medical, dental and paramedical personnel were also taken up. National Programmes for combating major public health problems were evolved and implemented. Efforts to further improve the health status of the population by optimizing coverage and quality of care by identifying and rectifying the critical gaps in infrastructure, manpower, equipment, essential diagnostic reagents, drugs and enhancing the efficiency of the health systems are underway.

The National Health Policy was formulated and adopted in 1983 by providing comprehensive framework for planning, implementation and monitoring of health services. Successive Plans have evolved various health programmes to achieve the goals set in the National Health Policy. Alma Ata Declaration of WHO adopted by India, envisaged availability of Health for All by Year 2000 AD.

Shifts in Thrusts under Various Five Year Plans

In the First Five Year Plan (1951-56) programmes for the control of communicable diseases such as malaria, filaria, tuberculosis, leprosy etc. were instituted. Health and medical care infrastructure facilities and water supply and sanitation were expanded. The subsequent Five Year Plans (2nd 3rd and 4th) aimed at extending health and family planning services within the reach of all the people for improving their health status. In the Fifth Five Year Plan supplementary feeding programmes for the children and expectant mothers were initiated on a country-wide basis. The family planning programme was integrated with the MCH and nutrition programmes. Sixth Five Year Plan (1980-85) envisaged a long term perspective for achieving the HFA goals and National Health Policy formulated. Health for mothers and children were to be strengthened through the Primary Health Care approach which includes integrated comprehensive MCH Care, suitable strengthening of referral services and logistic support.

Check Your Progress 1

1) List two types of recommendations made by Bhore Committee (1946).
2) Which committee recommended multipurpose worker for delivery of primary health care?
3) Which committee recommended levying of small fee for availing hospital facilities?

18.2.4 National Rural Health Mission (NRHM)

The National Rural Health Mission was launched to carry out necessary architectural correction in the basic health care delivery system. The Mission adopted a synergistic approach by relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water. It also aimed at mainstreaming the Indian systems of medicine to facilitate health care. The Plan of Action included increasing public expenditure on health, reducing regional imbalance in health infrastructure, pooling resources, integration of organizational structures, optimization of health manpower, decentralization and district management of health programmes, community participation and ownership of assets, induction of management and financial personnel into district health system, and operationalizing community health centers into functional hospitals meeting Indian Public Health Standards in each Block of the Country. The Goal of the Mission is to improve the availability of and access to quality health care by people, especially for those residing in rural areas, the poor, women and children.

Implementation Framework & Plan of Action for NRHM

The key features in order to achieve the goals of the mission include making the Public Health delivery system fully functional and accountable to the community,

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human resource management, community involvement, decentralization, rigorous monitoring & evaluation against standards, convergence of health and related programmes from village level upwards, innovations and flexible financing and also interventions for improving the health indicators. The diagrammatic representations of the 5 Main approaches of NRHM is illustrated in Fig.18.1.

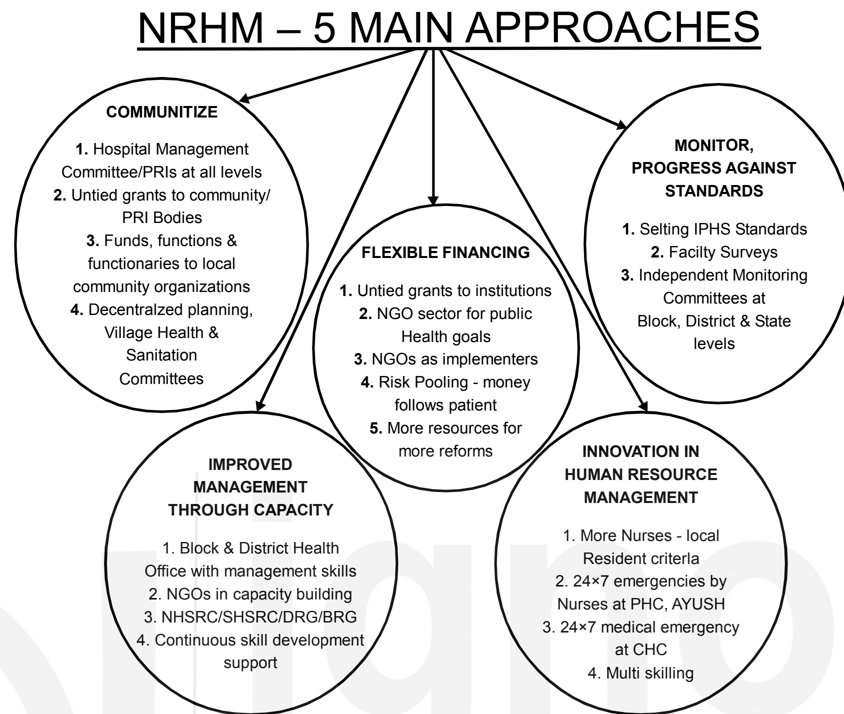

Fig18.1: NRHM Approaches

A) Improving the Public Health Delivery System

Given the status of Public Health Infrastructure in the country, particularly in the EAG, and the North Eastern States, it will not be possible to provide the desired services till the infrastructure is sufficiently upgraded. The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels. This involves simultaneous corrections in manpower planning as well as infrastructure strengthening. The Mission would provide priority to both these aspects.

B) Public Health Infrastructure

The Central Govt has so far supported only the construction/ upgradation of sub centres. Because of their difficult financial conditions, the States have usually not provided sufficient funds for construction / upgradation of Primary Health Centres (PHC) / Community Health Centre (CHC) / District Hospitals etc. As a result, infrastructure is in poor condition in most of the states. NRHM allows the expenditure for construction subject to the condition that it should not be more than 33 % of the total NRHM outlay in the case of high focus States. NRHM also provides for upgradation of District Hospitals.

As per original Cabinet approval, untied grants were to be made available only to sub-centres. However, the Mission now proposed provisions for untied funds at PHC/ CHC/ district levels. A provision for funds for taking up innovative

schemes at district/ State/ Central level has also been made. It is proposed to improve outreach activities in un-served and underserved areas especially inhabited by vulnerable sections through provision of Mobile Medical Units (MMU) in every district under their proposal. The MMUs would also cover Anganwadi centres.

C) Improving Availability of Critical Manpower

The issue of availability of critical manpower in the rural areas is proposed to be addressed through initiatives like introduction of a trained voluntary community health worker (ASHA) in every village of the 18 High Focus states, additional ANM at each sub centre, three staff nurses at the Primary Health Centres (PHCs) to make them operational around the clock and additional specialists and paramedical staff at the Community Health Centres (CHC).

D) Capacity Building

In order to provide managerial support for tracking funds and monitoring activities under the Mission provision has been made setting up Programme Management Units at the State/ District level. Capacity building at all levels is a huge challenge under NRHM. In order to provide technical support to the Mission for achieving this objective, it is proposed to set up National Health Systems Resource Centre (NHSRC) at the central and state levels (SHSRC). The NRHM also emphasises the setting up of fully functional block and district level Health Management systems as under NRHM 70 % of the resources would be utilised at Block and Block levels and 20 % at the district level.

Given the large army of ASHAs, ANMs, Nurses, Rural Medical Practitioners continuous skill development s needed. Strengthening nursing institutions, linking medical colleges for providing skill development support to rural health workers, involving the involuntary sector in skill development are few key interventions to be taken up.

E) Community Health Workers

One female Accredited Social Health Activist (ASHA) is to be provided for every village with a population of 1000 (with provision for relation in the eight EAG states, Jammu and Kashmir and Assam) in each of the high focus states. She would be the link between the community and the health facility and would be the first port of call for any health-related demand. Now under the Mission, it is proposed to have ASHAs in all the 18 high focus States.. ASHA along with Anganwadi workers (AWW) & Auxiliary Nurse Midwife (ANM), Self-help Groups & community based organisations, & through combined organisation of monthly Village health, Nutrition & Sanitation day at the Anganwadi Centres would be expected to bring about perceptible changes in the health status of the community.

F) Convergent Action on Other Determinants of Health

The PRIs and a large range of community-based organisations like Self Help groups, School water, health nutrition & Sanitation Committees Mahila Samkhya Groups, Zila Saksharta Samitis provide an opportunity for seeking local levels accountability in the delivery of social sector programmes. School and Anganwadi would form the base of these activities. NHRHM provides for School Health

Check-ups and School Health Education to be worked out in consultation with at the village and facility levels.

G) Decentralisation

As the indicators of health depend so much on drinking water, nutrition, sanitation, female literacy, women's empowerment as they do on functional facilities, NRHM seeks to adopt a convergent approach for interventions under the umbrella of the district plan which seeks to integrate all the related initiatives at the village, block, and district levels. The district Health Action Plan would be the main instrument for planning, inter sectoral convergence, implementation and monitoring of the activities under the Mission. Rather than funds being allocated to the states for implementing programmes designed and approved at the GOI level, the states would be encouraged to prepare their perspective and annual plan which is turn be based on the district plans. Even though village is envisaged as the Primary unit for planning The District Health Mission under the Zila Parishad would get the district plan prepared covering health as well the other determinants of health. Household and facility Surveys would define the baseline. Periodic surveys would thereafter be taken up on annual basis to track the improvements in the facilities as well as in the reduction in health indicators. The District Plans would be collated into a Sate Plan which would be appraised and approved by the Mission at the National level. As far as the other determinants of health are concerned, the funds for them would continue to flow through the existing channels but the District Plan would clearly bring out the convergent action being taken at the district level. NRHM recognises that delegation of financial and administrative powers at various levels would be necessary for the successful implementation of the decentralised plans.

H) Mainstreaming of AYUSH

Provision has been made for State specific proposals for mainstreaming AYUSH, including appointment of AYUSH doctors/ paramedics on contractual basis providing AYUSH wings in PHCs and CHCs. As envisaged under NRHM vision and goals, efforts will be made to integrate AYUSH in Primary health delivery.

I) Flexible Financing

Under the implementation Framework, from the Eleventh Plan onwards, it is proposed to have a single budget head from the activities under the Mission. This would provide the states much needed flexibility to direct the funds to those areas where they are needed the most. However, a minimum amount would be earmarked for various disease control programmes to ensure that the national objectives and commitments are met. The funds under the NRHM budget head would flow though the integrated health society at the State and District levels. The norm under which the funds would be allocated by the Centre to the States and by the State to districts on the basis of Integrated State/ District health activity Plans have been clearly spelt out in the Implementation Framework.

J) Normative Framework

The District Health Action Plans would be prepared based on a Normative Framework. The cost norms have been derived from three sources. First existing norms of the schemes brought under the umbrella of the NRHM. Secondly, norms

developed by the NCMH. Thirdly, norms developed and approved as new interventions under NRHM.

K) Monitoring and Accountability Framework

The NRHM framework is based on a rights-based approach. The framework proposes accountability at every level through a three-pronged process of Community based monitoring, external surveys (SRS, DLHS household surveys by ASHA, facility surveys in the district level) and stringent internal monitoring. The process of community involvement of the health institutions itself would enhance accountability and the NRHM would facilitate this process by wide dissemination of the results. For effective monitoring a strong MIS is being put in place. The citizen charter would help the public to know their rights and entitlements at each facility. Monitoring also would be in terms of service guarantees provided by each facility, utilisation of such services by the community (especially weaker sections)) changes in their health seeking behaviour, etc. The facilities survey is expected to create a baseline for each health facility and assist in monitoring annual progress against the baseline in terms of services guaranteed.. Independent evaluation would ensure midcourse corrections.

L) Pro People Partnerships with the Voluntary Sector

Investments by voluntary organizations are critical for the success of NRHM. The Mission provides for partnerships with the voluntary groups/ organizations for advocacy, building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services and working together with community organizations. It is proposed to provide people friendly regulatory framework that promotes ethical practice through accreditation, standard treatment protocols and training and upgradation of skills of non-government health providers. 5% of the total NRHM outlay is proposed to be the resource allocation to voluntary organizations on the basis of approved guidelines & norms.

The Vision of the Mission

- To provide effective healthcare to rural population throughout the country with special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
- 18 special focus states are Arunachal Pradesh, Assam, Bihar, Chattisgarh, Himachal Pradesh, Jharkhand, Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh.
- To raise public spending on health from 0.9% GDP to 2-3% of GDP, with improved arrangement for community financing and risk pooling.
- To undertake architectural correction of the health system to enable it to effectively handle increased allocations and promote policies that strengthen public health management and service delivery in the country.
- To revitalize local health traditions and mainstream AYUSH into the public health system.
- Effective integration of health concerns through decentralized management at district, with determinants of health like sanitation and hygiene, nutrition, safe drinking water, gender and social concerns.

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- Address inter State and inter district disparities.
- Time bound goals and report publicly on progress.
- To improve access to rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.

Goals, Strategies and Outcomes of the Mission

The National Rural Health Mission (NRHM) has been launched with a view to bringing about dramatic improvement in the health system and the health status of the people, especially those who live in the rural areas of the country. The Mission seeks to provide universal access to equitable, affordable and quality health care which is accountable at the same time responsive to the needs of the people, reduction of child and maternal deaths as well as population stabilization, gender and demographic balance. In this process, the Mission would help achieve goals set under the National Health Policy and the Millennium Development Goals. To achieve these goals NRHM will: -

- Facilitate increased access and utilization of quality health services by all.
- Forge a partnership between the Central, state and the local governments.
- Set up a platform for involving the Panchayati Raj institutions and community in the management of primary health programmes and infrastructure.
- Provide an opportunity for promoting equity and social justice.
- Establish a mechanism to provide flexibility to the states and the community to promote local initiatives.
- Develop a framework for promoting inter-sectoral convergence for promotive and preventive health care.

The Objectives of the Mission

- Reduction in child and maternal mortality
- Universal access to public services for food and nutrition, sanitation and hygiene and universal access to public health care services with emphasis on services addressing women's and children's health and universal immunization
- Prevention and control of communicable and non-communicable diseases, including locally endemic diseases.
- Access to integrated comprehensive primary health care.
- Population stabilization, gender and demographic balance.
- Revitalize local health traditions & mainstream AYUSH.
- Promotion of healthy life styles.

The core strategies of the Mission

- Train and enhance capacity of Panchayati Raj Institutions (PRIs) to own, control and manage public health services.

- Promote access to improved healthcare at household level through the female health activist (ASHA).
- Health Plan for each village through Village Health Committee of the Panchayat.
- Strengthening sub-centre through better human resource development, clear quality standards, better community support and an untied fund to enable local planning and action and more Multi-Purpose Workers (MPWs).
- Strengthening existing (PHCs) through better staffing and human resource development policy, clear quality standards, better community support and an untied fund to enable the local management committee to achieve these standards.
- Provision of 30-50 bedded CHC per lakh population for improved curative care to a normative standard. (IPHS defining personnel, equipment and management standards, its decentralized administration by a hospital management committee and the provision of adequate funds and powers to enable these committees to reach desired levels).
- Preparation and implementation of an inter sector District Health Plan prepared by the District Health Mission, including drinking water, sanitation, hygiene and nutrition.
- Integrating vertical Health and Family Welfare programmes at National, State, District and Block levels.
- Technical support to National, State and District Health Mission, for public health management
- Strengthening capacities for data collection, assessment and review for evidence-based planning, monitoring and supervision.
- Formulation of transparent policies for deployment and career development of human resource for health.
- Developing capacities for preventive health care at all levels for promoting healthy life style, reduction in consumption of tobacco and alcohol, etc.
- Promoting non-profit sector particularly in underserved areas.

The supplementary strategies of the mission

- Regulation for Private sector including the informal Rural Medical Practitioners (RMP) to ensure availability of quality service to citizens at reasonable cost.
- Promotion of public private partnerships for achieving public health goals.
- Mainstreaming AYUSH – revitalizing local health traditions.
- Reorienting medical education to support rural health issues including regulation of medical care and medical ethics.
- Effective and visible risk pooling and social health insurance to provide health security to the poor by ensuring accessible, affordable, accountable and good quality hospital care.

The Special Focus States

While the Mission covers the entire country, it has identified 18 States for special attention. These states are the ones with weak public health indicators and/or weak health infrastructure. These are Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. While all the Mission activities are the same for all the States/UTs in the country, the high focus States would be supported for having an Accredited Social Health Worker (ASHA) in all villages with a population of 1000 and also in having Project Management Support at the State and District level. It also articulated a need for including the health needs of the urban poor while planning for health through District 19 Health Plans. The Mission is to be implemented over a period of seven years (2005- 2012). The NRHM District Health Plans will cover District and Sub Divisional/Taluk Hospitals as well as they cater to rural households as well.

18.3 HEALTH CARE INFRASTRUCTURE

18.3.1 National Level

Constitutionally public health, sanitation, hospitals and dispensaries fall in the state list. Population control and family planning, medical education, adulteration of food stuffs and other goods, drugs, cornpilation of vital statistics including registration of births and deaths are in the concurrent list, while international health comes under union list.

Ministry of Health and Family Welfare (MoHFW) is the apex executive organisation dealing with the issue of health and family welfare in the country. It is headed by a Cabinet Minister , deputy minister ans a Minister of State who may have an independent charge.

Currently, it has following two departments:-

- Department of Health & Family Welfare
- Department of Health Research

Department of Health and Family Welfare

The Secretary to the Government of India in MoHFW heads the department and is assisted by special secretaries, additional secretaries, joint secretaries etc. Being the execucutive arm it implements the decisions taken by the legislative. It also is responsible for the financial matters.

Department of Health Research (DHR)

Headed by a secretary 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.

Directorate General of Health Services

The Directorate General of Health Services (Dte.GHS) is the technical arm of MoHFW and is a repository of technical knowledge concerning Public Health, Medical Education and Health Care. The Dte.GHS is headed by Director General of Health Services (DGHS), an officer of Central Health Services, who renders 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.

The Indian Council of Medical Research (ICMR)

ICMR, the apex body in India for the formulation, coordination and promotion of biomedical research, is one of the oldest medical research bodies in the world.

The ICMR has always attempted to address itself to the growing demands of scientific advances in biomedical research on the one hand, and to the need of finding practical solutions to the health problems of the country, on the other.

The Council's research priorities coincide with the National health priorities such as control and management of communicable diseases, fertility control, maternal and child health, control of nutritional disorders, developing alternative strategies for health care delivery, containment within safety limits of environmental and occupational health problems; research on major non-communicable diseases like cancer, cardiovascular diseases, blindness, diabetes and other metabolic and haematological disorders; mental health research and drug research (including traditional remedies). All these efforts are undertaken with a view to reduce the total burden of disease and to promote health and well-being of the population.

18.3.2 State Level

The state is the ultimate authority responsible for all the health services operating within its jurisdiction.

Like in the centre there is a Department of Health and Welfare headed by the State Minister of Health and Family Welfare and a Deputy Minister. The executive arm is headed by Principal Secretary of Health and Family welfare assisted by joint secretaries etc. Directorate of Health and Family Welfare is the technical arm headed by the Director of Health Services. He is the chief technical advisor to the state government on all matters relating to medical and public health including MCH. He is also responsible for the organisation and direction of all health activities including family welfare activities. He is assisted by Programme officers designated as Additional and Joint Directors etc.

The Regional Directors are at divisional level and are classified on the basis of geographical distribution. They inspect all the branches of public health within their jurisdiction, irrespective of their speciality.

In some states the area on medical education is integrated with the State Directorate of Health Services but in other states (e.g. Uttar Pradesh) medical education

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remains a separate identity. Regional Director, Govt. of India is responsible for coordinating between State and Centre.

18.3.3 District Level

The district level structure of health services is a linkage system between the state as well as regional structure on one side and the peripheral level structure such as primary health centres and sub-centres on the other side. It receives information from the state level and transmit the same to the periphery by suitable modifications to meet the local needs.

The district officer with the overall control is designated as the Chief Medical and Health Officer (CM&HO) or as the District Medical and Health Officer (DM&HO). These officers are popularly known as CMOs or DMOs. They are responsible for implementing health and family welfare programmes according to the policies laid down and finalised at higher levels i.e. state and centre. DMOs/ CMOs are assisted by 3-4 Deputy CMOs.

You will learn in detail about the District Health Organisation in Unit 4 of this block.

18.3.4 Block and CHC Level

Rural areas of the district have been organised into blocks, known as Community Development Blocks. The block is a unit of overall planning and development and comprises of approximately 100 villages and about 80,000 to 1,20,000 population, and under charge of a Block Development Officer.

To provide effective services and referral support to primary health care programme, one Community Health Centre (CHC) is being established in each block. The CHCs can be framed by upgrading some of the block level PHC if new centres are not created. The officer in-charge of CHC is known as superintendent CHC or medical officer in-charge block PHC. It is intended to be a first level referral institution. Normally one CHC should have 4 Medical Officers who are either qualified or specially trained to work as Surgeon, Obstetrician, Physician and Pediatrician. One CHC should have 30 beds. The CHCs are currently provided on the population norm of 1 per 1,20,000 population in general areas and 1 per 80,000 population in tribal / desert areas

Lack of accountability in the CHCs has been the main reason for patients preferring private facilities over them. To bring in quality accountability in the health services, Indian Public Health Standards (IPHS) have been set up for the CHCs. These standards have been fixed by a high powered task group through a consultative process with the states and other experts. IPHS is a novel concept to fix benchmarks of infrastructure including building, manpower, equipments, drugs, quality assurance through introduction of treatment protocols. Most important they also define the level of services that a CHC would be expected to provide.

18.3.5 Primary Health Centre (PHC) Level

The PHCs are currently provided on the population norm of 1 per 30,000 population in general areas and 1 per 20,000 population in tribal / desert areas. The PHCs are expected to have two doctors. The PHC should be a 24 hour facility

with nursing facilities. Select PHCs, especially in large blocks where the CHC is over one hour of journey time away, may be upgraded to provide 24 hour emergency hospital care for a number of conditions by increasing number of Medical Officers. It will be for the States to decide on the configuration of PHCs to meet IPH Standards and offer 24X7 services including safe delivery.

The PHC is supposed to provide curative care but the prime responsibility is to provide primary health care services and the implementation of the National Health Programmes.

18.3.6 Sub-Centre Level

The Sub-Centres are currently provided on the population norm of 1 per 5000 population in general areas and 1 per 3000 population in tribal areas. There is one ANM and a Health Worker Male posted at a sub-centre. Sub centres co-ordinate outreach activities specially to underserved areas.

The Task Force for Comprehensive Primary Health Care (CPHC) endorsed the establishment of Ayushman Bharat - Health & Wellness Centres (AB-HWCs) and committed that two thirds of the budget be allocated towards primary health care. The AB-HWCs Programme is a set of multiple reforms, spanning all aspects of the health care systems such as service medicines and diagnostics, community participation, and ownership and governance.

To ensure delivery of CPHC, existing Sub Health Centres (SHCs) covering a population of 3,000 - 5,000 are being transformed to Health and Wellness Centres (AB-HWCs). CPHC is complemented by outreach services, Mobile Medical Units and Home and Community based care, enabling a seamless continuum of care. The AB-HWCs at the Sub Health Centre (SHC) level would be equipped and staffed by an appropriately trained Primary and comprising of multi-Purpose Workers (male & female) & ASHAs.

18.3.7 Village level

A trained female community health worker – ASHA – is being provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norm could be relaxed for one ASHA per habitation depending on the workload. ASHA must be a primary resident of the village with formal education upto Class VIII and preferably in the age group 25-45. Though she would not be paid any honorarium, she would be entitled for performance-based compensation. It is expected that on an average an ASHA working with reasonable efficiency would be able to earn Rs. 1000 per month

ASHAs would reinforce community action for universal immunization, safe delivery, newborn care, prevention of water-borne and other communicable diseases, nutrition and sanitation. She will also help the villagers promote preventive health by converging activities of nutrition, education, drinking water, sanitation etc. In order that ASHAs work in close coordination with the AWW, she would be fully anchored in the Anganwadi system

At present Health Days are organized every month at the Anganwadi level in each village in which immunization, ante / post-natal check ups and services related to mother and child health care including nutrition are being provided.

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18.3.8 Institutional Arrangement

The biggest challenge for the success of any programme is to establish accountable and effective implementation arrangements. Clarity regarding tasks, teams, roles, functions, powers at all levels of the system will facilitate effective action. Every state will have to carry out detailed analysis of the implementation arrangements required to implement NRHM. The most important requirement for the success of the NRHM is to be able to develop a block level health management team along with a strong District Health Mission. Decentralized district health action plan is the key corner stone of NRHM and all efforts to build capacities and develop appropriate implementation arrangements at these levels are a priority for NRHM. Accordingly, State and National level structures have to be reoriented to be able to provide guidance and support to the functional areas identified for blocks and districts. The biggest challenge of NRHM is to establish an effective implementation arrangement at block and district level as without it all the efforts at decentralized public health action will remain difficult to operationalize.

The proposed institutional mechanisms of the Mission

- Village Health and Sanitation Committee (at village level) comprising of Panchyat representatives, ANM/MPW, Aanganwadi Worker, teacher, ASHA, Community Health Volunteers.
- Gram Panchayat/Sub Health Centre level Committee of Panchayat.
- PHC/Cluster of Panchayat level PRI committee.
- Block level PRI Committee for approval of Block Health Plan.
- Zila Parishad for approval of District Health Plan.
- Independent monitoring committees at Block, district and national levels.
- Hospital Management Committee /Rogi Kalyan Samiti for community management of public hospitals.
- District Health Mission, under the leadership of Zila Parishad with District Health Head as Convenor and all relevant departments, NGOs, private professionals, etc represented on it.
- State /Health Mission chaired by Chief Minister and co-chaired by Health Minister and with the State Health Secretary as Convenor – representation of related Departments, NGOs, private professionals, etc.
- Integration of Department of Health and FW at National and State level.
- National Mission Steering Group Chaired by Union Minister for Health and Family Welfare with Deputy Chairman Planning Commission, Minister of Panchayati Raj , Rural Development, Human Resource Development and Public Health professionals as members, to provide policy support and guidance to the Mission.
- Empowered Programmed Committee chaired by Secretary Health & Family Welfare to be the Executive Body of the Mission.
- National Programme Consultative Committee under AS & Mission Director.

- Standing Mentoring Group shall guide and oversee the implementation of ASHA initiative.
- Task Group for selected tasks (time bound).

National level management of NRHM

In order to carry out the functions under the Mission, the Mission requires an empowered structure, The Mission Steering Group (MSG) and the Empowered Programme Committee (EPC) has already been established under the respective Chairmanship of the Health and Family Welfare Minister and the Union Health and Family Welfare Secretary. To carry out the functions mandated by MSG/ EPC, the Mission Directorate has been established in the Ministry of Health and Family Welfare. The Directorate is headed by a Mission Director who is of the level of Additional Secretary to Govt. of India. Under the Mission Directorate, there would be 5 Joint Secretary level officers, the roles and functions of whom would be clearly articulated to ensure that their tasks and responsibilities are clearly defined. Besides, the technical divisions like Maternal Health (MH) and Child Health (CH), Immunization etc. would also be reporting to the Mission Director through the Joint Secretary concerned.

A National Health Systems Resource Centre (NHSRC) is set up to serve as an Apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the Centre and the States in the Programme. The NHSRC would provide necessary technical assistance to the Mission Directorate. The Mission Directorate would not only handle the day-to-day administrative of the Mission but also will be responsible for Planning, Implementation and Monitoring of the Mission activities. Adequate administrative financial powers would be delegated to the Mission Directorate to enable it to function in Mission mode.

Check your progress 2

1. Which is the most peripheral health institutional facility provided by the government.?
2. Which is the most peripheral institution providing secondary care?

18.4 ROLE OF NON-GOVERNMENTAL ORGANIZATIONS (NGOS)

The National Health Policy has envisaged key role of voluntary organisations in the two most vital components of health and family welfare programmes i.e. population stabilisation and primary health care. NGOs have been playing a significant role in the provision of health care services including medical care. They also play an important role in educating and motivating the people to adopt the small family norm.

Efforts are being made to involve NGOs at all levels of the health delivery system. Besides advocacy, NGOs would be involved in building capacity at all levels, working together with community organizations and Panchayti Raj institutions, and contributing to monitoring the right to health care and service guarantees from the public health institutions.

18.5 MINISTRY OF AYUSH

The Ministry of Ayush was formed on the 9th of November 2014 with a vision of reviving the profound knowledge of our ancient systems of medicine and ensuring the optimal development and propagation of these systems of healthcare. Earlier, the Department of Indian System of Medicine and Homoeopathy (ISM&H) was responsible for the development of these systems. It was then renamed as the Department of Ayurveda, Yoga, and Naturopathy, Unani, Siddha and Homoeopathy (Ayush) in November 2003 with focused attention towards education and research in Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homoeopathy.

Salient Objectivest

1. To upgrade the educational standard of the Indian Systems of Medicine and Homoeopathy colleges in the country.
2. To strengthen existing research institutions and to ensure time-bound research programmes on identified diseases for which these systems have an effective treatment.
3. To draw up schemes for cultivating, promoting, and regenerating medicinal plants that are used in these systems.
4. To evolve Pharmacopoeia standards of Indian Systems of Medicine and Homoeopathy drugs.

18.6 LET US SUM UP

Overview of Health Care Delivery System In this unit you have learnt about an overview of health care delivery system in the country. To start with, you learnt about the brief history of evolution of health services in the country both in pre and post-independence era. You learnt about salient features of various committees from time to time which formed the basis of present day health care delivery system of the country. You also learnt about the changing trends of health care delivery system across various Five Year Plans. Subsequently you learnt about the organisation of health infrastructure at various levels i.e. Central, State, District, Block and Village. Towards the end you learnt about the role which voluntary sector, private sector and ISM/ AYUSH can play in the delivery of health care services. You also learned about the NRHM, the National Health Mission and changes with regards the Public health care infrastructure, financing, risk pooling etc.

18.7 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1. (a) A comprehensive blue print for the distant future (20 to 40 years) the smallest service unit was to be a Primary Health Unit, serving a population of 10,000 to 20,000; and

   (b) A short term scheme covering 2 to 5 years period-the emphasis would be

on setting up 30 bedded hospitals, one for every two Primary Health Units.

2. Kartar Singh Committee
3. Mudaliar Committee.

Check Your Progress 2

1. Sub centre
2. CHC

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UNIT 19 HOLISTIC APPROACH TO HEALTH CARE

Structure

19.0 Objectives
19.1 Introduction
19.2 Evolution of Medicine
  19.2.1 Ayurveda
  19.2.2 Yoga
  19.2.3 Naturopathy
  19.2.4 Siddha Vaidya System
  19.2.5 Unani Medicine
  19.2.6 Homeopathy
  19.2.7 Traditional Chinese Medicine
  19.2.8 Acupuncture
  19.2.9 Reiki
19.3 Role of Alternate Systems of Medicine
19.4 Holistic Medicine
19.5 Need for Application in Indian Scenario
19.6 Training and Support
19.7 Let Us Sum Up
19.8 Answers to Check Your Progress
19.9 Further Reading

19.0 OBJECTIVES

After going through this unit, you should be able to:

- define and explain the need and the basis of holistic medicine;
- fulfil the needs of the concept for holistic medicine for people to adopt;
- prepare inputs required to develop the infrastructure for holistic medical care;
- demonstrate that holistic medicine makes a physician more effective; and
- develop comprehensive and efficient strategy to achieve ‘ Holistic Health for All’.

19.1 INTRODUCTION

Health has been the basic requirement essential for human survival, The WHO defines health as a STATE of mental, physical, social and spiritual wellbeing and not the absence of disease or infirmity

The holistic health aims at optimum synergistic health care concepts that could encompass a Health Systems with multidimensional approach in achieving sound

mind, in a sound body with a sound environment at family to the last man of the society at the grass root level. Therefore, the system must provide preventive, promotive, protective, curative and futuristic health approach universally with community partnership.

In this unit, you will learn about the concept and various aspects of the practice of Holistic Medicine for the physical, mental, emotional, social and spiritual wellbeing of the individual, family, community and each mankind as a whole.

You will also learn through the evolution of medicine including the principles and philosophy of various systems of medicine. Having understood the basic principles and philosophy of various systems of medicine, the need and demand as well as scope of integration of that health care delivery system. In today's world, healthy practices are not the first priority of the people, thus health hazards are increasing.

19.2 EVOLUTION OF MEDICINE

Holistic health or holistic healing is often defined as a form of healing that looks at the whole body, mind, and spirit. This kind of holistic healing often involves multiple complimentary medicines and alternative healthcare practices that can improve physical, Mental, Social, Spiritual, Emotional and environmental care. This may include all kinds of care like Ayurveda, Yoga, Siddha, Unani, Homeopathy and Modern medicine, since none of the system, individually, has the capability to heal all kinds of conditions and illness.

The history of medicine dates back to social changes approach to illness and disease from ancient early medical traditions of Babylon, China, Egypt and India. Sushruta, from India, introduced the concepts of medical diagnosis, surgery and prognosis. It has been the official policy of the Government of India to encourage all the systems of medicine, regardless of their origin. The initial recognition of Modern Medicine, Ayurveda, Unani, Homeopathy and Naturopathy, Yoga, Acupuncture etc. were extended by the Government of India to almost all the systems and sub-systems required for healthy living.

19.2.1 Ayurveda

Ayurveda is considered as a complete medical system that takes in to consideration physical, psychological, philosophical, ethical and spiritual wellbeing and lays great importance on living in harmony with nature and science. This system emphasizes the importance of maintenance of proper life style for keeping positive health.. Ayurvedic treatment focuses on the cure of the disease, not merely its symptoms by providing preventive and promotional applications also.

Ayurveda is based on the theory of 'Tri-dosha' and 'Pancha-Bhuta'.

There are eight specialities in Ayurveda**:**

1) Kayachikitsa (General Medicine)
2) Koumarabritya (Paediatrics)
3) Manasika Chikitsa (Psychiatry)

4) Salakya Chikiitsa (Surgery)

5) Salya Chikitsa (ENT and Ophthalmology)

6) Visha Chikitsa (Toxicology)

7) Rasayana (Geriatrics) and

8) Vajeekarama (Sexual dysfunction and sub-fertility

Further details are beyond the scope of this module..

19.2.2 Yoga

Yoga is a life of self-discipline based on the tenets of 'simple living and high thinking'. In a general sense, the word 'Yoga' is derived from the root 'yujir-yoge', which means union of the self with the Supreme Power. 'Yoga' is derived from another root 'yuj', which means a state of stability, peace and stillness**.** The Sutra of Patanjali' (second century B.C.), describes the 'Ashtanga' or eight-fold yoga, which includes outer and inner aspects of disciplining and training the mind and body.

The body is seen as a temple or vehicle for the soul, and has the following specific requirements for smooth functioning

a. Regulated Exercise:

b. Proper Breathing:. breathing techniques (Pranayama) releases energy for physical and mental rejuvenation.

c. Proper Relaxation or Cooling the system:

d. Proper Diet: Provides the correct fuel for the body.

e. Positive Thinking and Meditation:

f. Cleansing techniques or 'Shuddhi Kriyas': Clean the various internal organs of the body by using techniques such as Net**i,** Dhouli, Basti, Tratak**,** Nadi and Kapalbhati.

Yoga aims to bestow on an individual a state of perfect mental and physical health in which all the organs must perform effectively in a coordinated manner

19.2.3 Naturopathy

The philosophy of naturopathy is that the origin of all diseases is due to an accumulation of toxins in the body which it could not expel through its normal processes.

When a person adopts a life-style in disharmony with nature the natural balance of his body gets impaired and toxins begin to accumulate, as more toxins are produced than expelled by the body. Therefore, the first and the foremost step in the cure of a disease is to improve one's life-style and start living in harmony with nature. The basic ingredients of such a lifestyle are:

- Proper Diet.
- Proper Exercise

- Proper Rest
- Cleanliness

Therapeutic Measures

The principle behind the therapy is to affect an improvement in the blood circulation either to a particular part or to the whole body, so as to wash away the accumulated toxins. These techniques mainly involve various kinds of baths, packs and massages. Steam bath, sun bath, cold hip bath and mud pack are some of the examples of these techniques.

19.2.4 Siddha Vaidya System

Siddha Vaidya System is an ancient herbal medical system. These herbal remedies have a tangible solution for the various types of disorders.. It forms an ideal bridge between modem medicine and other complimentary systems of medicines

19.2.5 Unani Medicine

The Unani system of medicine recognizes the influence of surroundings and ecological conditions on the health of human beings. The essential factors that influence health and vitality are—air, food and drinks, bodily movements and repose, psychical movement and repose, sleep and wakefulness, excretion and retention. It aims at restoring the equilibrium of various elements of the human body and stresses on the maintenance of a proper ecological balance and keeping water, food. and air free from pollution.

The theoretical framework of Unani system is based on the teachings of Hippocrates. The principal, basis of diagnosis in Unani is the theory of Humorous. As per Unani system. There are mainly four Humorous in the body—Dum (blood), Balgham (Cough and sputum), Safra (yellow bile), and Sauda (black bile). According to the preponderance of these Humours, black bile & phlegm, yellow bile and sauda bile, the temperaments of persons are expressed by the words sanguine, phlegmatic, choleric, and melancholic respectively.

Every person is supposed to have a unique, hurnoral constitution, which represents his healthy state. To maintain this healthy state there is a power of self-preservation called *Quwwat-e-Mudabbira* (*Medicatrix Maturae*) in the body. When this power weakens, an imbalance in the humoral composition occurs and disease is resulted. The therapy in Unani medicine is aimed at restoring his humoral balance**.** Another distinctive feature of the Unani system is its emphasis on diagnosing a disease by feeling the pulse (nabz) by the fingers**.** Other methods of diagnosis include examination of baul(urine), baraz(stool), etc.

19.2.6 Homeopathy

Similia Similibus curentur or "let likes be treated with likes" forms the foundation of medicinal homeopathy.

The principle according to Hahnemann is "the order to discover the true curative powers of a remedy to the diseases one must ascertain the specific artificial disorder it develops in the healthy human body and then utilize it to treat similar morbid conditions. In order to radically cure chronic diseases, one must search

for the single remedy that may evoke a similar disease picture, the closer the similarity the better."

Homeopathy aims to restore the lost equilibrium of the sick person at the physical, mental and emotional levels by stimulating *and* regulating the intrinsic defence and curative mechanisms, called as vital forces. It is a non-invasive therapy, low cost, non-toxic, and supposedly safe.

19.2.7 Traditional Chinese Medicine

The basic concept of Traditional Chinese medicine (TCM) is that a vital force of life, called 'Qi' surges through the body. Any imbalance of Qi can cause disease. This imbalance is most commonly thought to be caused by an alteration in the opposite and complementary forces that make up the Qi. These are called 'yin' and 'yang'.

TCM seeks to restore this balance through treatment specific to the individual. It is believed that to regain balance, one must achieve the balance between the internal body organs and the external elements of earth, fire, water, wood, and metal. Treatment to regain balance may involve:

- Acupuncture
- Moxibustion (the burning of herbal leaves on or near the body)
- Cupping (the use of warmed glass jars to create suction on certain points of the body)
- Massage
- Herbal remedies
- Movement and concentration exercises (such as tai chi)

19.2.8 Acupuncture

Acupuncture involves the insertion of very thin needles through the skin at strategic points on the body. A key component of traditional Chinese medicine, acupuncture is most commonly used to treat pain. Increasingly, it is being used for overall wellness, including stress management. Sometimes the first acupuncture session will be more painful than the following session This could be because certain energy points on the body are being activated for the first time.

Acupuncture is a form of treatment that involves inserting very thin needles through a person's skin at specific points on the body, to various depths. Traditional Chinese medicine explains that health is the result of a harmonious balance of the complementary extremes of "yin" and "yang" of the life force known as "qi," pronounced "chi." Illness is said to be the consequence of an imbalance of the forces. It is said to flow through meridians, or pathways, in the human body. These meridians and energy flows are accessible through 350 acupuncture points in the body. **Inserting needles into these points with appropriate combinations is said to bring the energy flow back into proper balance.** There is no scientific proof that the meridians or acupuncture points exist but numerous studies suggest that acupuncture works for some conditions.

Moxibustion

Moxibustion is a form of therapy that entails the burning of mug wort leaves. This is a small, spongy herb that is believed to enhance healing with acupuncture. *Moxibustion* is a form of heat therapy in which dried plant materials called "moxa" are burned on or very near the surface of the skin.. Acupuncture and moxibustion are sometimes used in combination for the treatment of disease and for anaesthesia. From ancient times, the Chinese believed that burning or heating certain points on the body increased circulation "full-bloodedness" and relieved pain. Generally, points near large blood vessels, eyes, and ears are treated by moxa, because acupuncture at these points is deemed inadvisable.

In modern practice the herb is usually crushed, wrapped in special paper, and, when lit, held above the point to be warmed or placed on the skin and removed before overheating occurs.

Auriculotherapy

Auriculotherapy also known as auricular therapy or ear acupuncture or auriculoacupuncture, is a form of alternative medicine based on the idea that the ear is a micro system, which reflects the entire body, represented on the auricle, the outer portion of the ear. Auriculotherapy is a health care modality whereby the external surface of the ear, or auricle, is stimulated to alleviate pathological conditions in other parts of the body.

Sujok therapy is also a variation of acupressure, which used specific points on hands and feet to treat the ailments. It also makes use of seeds, semi-precious stones along with pressure stimulation that help relieve problem.

Relaxology is another variety of acupuncture or acupressure. Reflexology is a type of therapy that uses gentle pressure on specific points along your feet (and possibly on your hands or ears as well) to help you feel better. The theory is that these eases stress, and that helps your body work better. It's also known as zone therapy.

Reiki (−I, /Èrejki/) is a Japanese form of energy healing, which is a subset of alternative medicine, unapproved by Indian health system. Reiki practitioners use a technique called *palm healing* or *hands-on healing* through which a "universal energy" is said to be transferred through the palms of the practitioner to the patient in order to encourage emotional or physical healing. It is based on *qi* ("chi"), which practitioners say is a universal life force, although there is no empirical evidence that such a life force exists. Studies reporting positive effects have had methodological flaws.

Check Your Progress 1

1. Define Health and holistic health
2. What is Acupuncture?
3. What is the philosophy of naturopathy?

19.3 ROLE OF ALTERNATE SYSTEMS OF MEDICINE

Alternative medicine is any practice of medicine that aims to achieve the healing effects, but which lacks biological-plausibility. Complementary medicine (CM),

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complementary and alternative medicine (CAM), integrated medicine or integrative medicine (IM), and holistic medicine are among many names of the same phenomenon. Alternative therapies share in common that they are included outside of medical science . Some alternative practices, even some times, are based on theories that contradict the science of how the human body works. Research into alternative therapies often fails to follow proper research protocols (such as placebo-controlled trials, blind experiments and calculation of prior probability), providing invalid results.

Much of the perceived effect of an alternative practice arises from a belief that it will be effective (the placebo effect), or from the treated condition resolving on its own (the natural course of disease). This is further exacerbated by the tendency to turn to alternative therapies upon the failure of medicine, at which point the condition will be at its worst especially for diseases that are not expected to get better by themselves such as cancer or HIV infection etc. The alternative sector faces far less regulation over the use and marketing of unproven treatments. Its marketing often advertises the treatments as being "natural" or "holistic", in comparison to those offered by medical science

All the different types of medicines described in this chapter earlier pages fall under alternative medicine including Ayurveda and homeopathy or Yoga. Yoga principle are also included in Physiotherapy in today's Health sciences. Naturopathic medicine is based on a belief that the body heals itself using a supernatural vital energy that guides bodily processes . Nevertheless, their importance in health care delivery system cannot be denied. Similarly Homeopathy is a belief that a substance that causes the symptoms of a disease in healthy people by repeated dilution increases the power of medicine.

19.4 HOLISTIC MEDICINE

Holistic Medicine has been used in different people differently. It means total health care. Thus, Holistic medicine has mainly two types of connotations. The first is **womb to tomb care,** that is care of all persons from the conception till death. We have been trying to provide it, through antenatal care till geriatric care or even death.

The second connotation aims at providing care from all kinds of medicine from enchanting mantra to critical medical care.. In critical care units physio therapy improves the condition, similarly yoga has reduced mental stress and anxiety. Combination of ayurveda or homeopathic treatment along with modern medicine is also not uncommon. Thus, cases may be treated with all branches of medicine which ever suits them and the ultimate aim is patient's cure.

19.5 NEED FOR APPLICATION IN INDIAN SCENARIO

A basic principle behind many kinds of alternative medicine is keeping balance in treatment. Acupuncture, tai chi, and various forms of energy medicine are designed to bring the body into balance and help restore health.

Recently, the National Center for Complementary and Alternative Medicine (NCCAM) reported that about 38 percent of U.S. adults and about 12 percent of children are using some form of alternative medicine. Government of India have adopted Ayurveda, Unani, Homeopathy and Physiotherapy as acceptable alternative medicine under ministry of AYUSH.

Traditional medicine views disease as a distinct entity from the person who carries it. The growing trend toward specialization in modern medicine has led to many treatment advances, but a key difference between traditional and alternative medicine is that most forms of alternative medicine emphasize *whole-body* care. Practitioners of alternative medicine address not just the physical body but also the patient's emotional and spiritual health. According to the Osher Centre for Integrative Medicine, a growing interest in a more holistic approach to health is one of the main reasons alternative medicines is on the rise.

- Because of the belief of whole-body care, alternative medicine practitioners often offer patients a great deal of personal attention. Another draw to alternative medicine is its focus on prevention. Whereas traditional medicine tends to intervene once disease is present, many types of alternative medicine encourage patients to have "wellness," than only treatments of the patient.

In our country, components of Ayurveda, Yoga and Naturopathy perform various modalities may be introduced *at* the primary health care level Simultaneous availability of medicinal herbs and that of modem medicine, yoga and / homeopathy in appropriate proportion will probably optimise the primary health services. It will enable an enhanced level of primary health and ensure timely cure of most of illnesses, significantly, while relieving the tremendous burden on the secondary and tertiary health services, thus enhancing their performance too.

19.6 TRAINING AND SUPPORT

Training and practice in Modern Medicine, Ayurveda and homeopathy is undertaken in India under the guidance and supervision of their respective councils. However, such facilities are not available for acupuncture, although many organization perform acupuncture and yoga as per their norm.

Effective training programs create a positive, motivated, and competent workforce. This, in turn, improves patient satisfaction and profitability of the practice. Importance of training in an Organisation are: (i) Advantages of standardization (ii) Increasing organisational stability and flexibility (iii) Heightened morale (iv) Reduced supervision and direction (v) Economical use of resources (vi) Increase in productivity (vii) addressing future manpower needs. The skills needed for better performances apart from medical skills for diagnosis and treatment are:

- Communication skill.
- Problem- Solving attitude.
- Listening and Learning Skill
- Compassionate attitude

19.7 LET US SUM UP

The WHO defines health as a STATE of mental, physical, social and spiritual wellbeing and not the absence of disease or infirmity. The holistic health thus aims at optimum synergistic health care concepts that could encompass a Health Systems with multidimensional approach in achieving sound mind, in a sound body with a sound environment at family to the last man of the society at the grass root level. In today's world, health is not the first priority of the people, thus health hazards are increasing.

Holistic health or holistic healing is often defined as a form of healing that looks at the whole body, mind, and spirit. The approach to illness and disease emerged from ancient early medical traditions of Babylon, China, Egypt and India. The need of Primary Health Care was duly felt and expressed by Alma Ata declaration, in 1978, towards 'indigenisation' and 'de-professionalisation' of medicine whereby the Primary Health Care Approach through a primary health worker at the grassroot level. A series of Primary Health Care worker were created in India since then. The National Health Policy adopted by Government of India in 1983 covers almost all the systems and sub-systems required for Health for All by 2000 AD which was updated in 2002 and 2017.

Apart from Modern Medicine there are number of healing sciences and procedures followed by people. The Ayurveda and Siddha pertains to Indian medicine so as Yoga. The old Chinese medicine system is not followed except in China and a part of Japan. Homeopathy is popular in India and some part of the world. Most popular Chinese system is Acupuncture and its different variations subtypes such as Acupressure, Auriculotherapy, Reflexology and reiki etc. However, all these types are Alternative Medicine for approach to holistic health.

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19.8 ANSWERS TO CHECK YOUR PROGRESS

Check your Progress 1

1. Define Health and holistic health: Health is a state of physical mental, social and spiritual wellbeing and not merely absence of disease or infirmity. While Holistic health is a care from womb to tomb or may be care provided from all types of positive care.

2. What is Acupuncture?

   Acupuncture involves the insertion of very thin needles through your skin at strategic points on your body. A key component of traditional Chinese medicine, acupuncture is most commonly used to treat pain.

3. What is the philosophy of naturopathy? It is believed the origin of all diseases is an accumulation of toxins in the body which it cannot expel due to the person adopting a life-style in disharmony with nature.

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UNIT 20 HEALTH AND POPULATION POLICY AND STRATEGIES

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20.0 OBJECTIVES

After going through this unit, you should be able to:

- describe the need for the national health policy and population policy; and
- list the goal, objectives and strategies of national health policy and population policy.

20.1 INTRODUCTION

This unit describes the needs for National Health Policy (NHP). It gives in detail the various elements of NHP. It also deals with National Population Policy which was passed by the Parliament in 2000. It describes the population problem, existing population policies and various recommendations.

20.2 NATIONAL HEALTH POLICY- 2017

20.2.1 Introduction to National Health Policy

You will agree to that the policies provide framework for accomplishment of the objectives to be achieved. You must also be aware of that each country evolves

its policies in light of the problems to be tackled. In the absence of a well-designed policy tackling the problems become difficult and may result in the wastage of men, material and money. The policy prescribes the aims, objectives and the targets that would be used to achieve the objectives operationally. It specifies the expected results, the measures for achieving them and mechanisms or methods to be adopted. Succinctly, it refers to that aspect of administration, which is considered to define the objectives and determining the choice of action.

The fragmented approach in the sphere of health exposed many shortcomings and the problems like increasing rate of population growth, high mortality rate of women and children, low nutritional standards, widespread communicable diseases, poor sanitation and non-availability of potable to the majority of population. This prompted the government to formulate a comprehensive national health policy that could serve the actual health needs and priorities of the country. In this context the first national health policy was evolved by the government of India in the year 1983.

The first National Health Policy of 1983 and the second National Health Policy of 2002 have served well in guiding the approach for the health sector in the Five-Year Plans. The current context has however changed in four major ways. First, the health priorities are changing. Although maternal and child mortality have rapidly declined, there is growing burden on account of non-communicable diseases and some infectious diseases. The second important change is the emergence of a robust health care industry estimated to be growing at double digit. The third change is the growing incidences of catastrophic expenditure due to health care costs, which are presently estimated to be one of the major contributors to poverty. Fourth, a rising economic growth enables enhanced fiscal capacity. Therefore, a new health policy responsive to these contextual changes was formulated.

The current National Health Policy, 2017 (NHP, 2017) seeks to reach everyone in a comprehensive integrated way to move towards wellness. It aims at achieving universal health coverage and delivering quality health care services to all at affordable cost.

20.2.2 Goal and Objectives

Goal: The policy envisages as its goal the attainment of the highest possible level of health and wellbeing for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery.

Objectives: Improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

I. Progressively achieve universal health coverage.

II. Reinforce trust in public healthcare system.

III. Align the growth of private healthcare sector with public health goals.

Specific Quantitative Goals and Objectives

a) Health Status and Programme Impact

1) Life Expectancy and healthy life

   - Increase Life Expectancy at birth from 67.5 to 70 by 2025.
   - Establish regular tracking of Disability Adjusted Life Years (DALY) Index as a measure of burden of disease and its trends by major categories by 2022.
   - Reduction of TFR to 2.1 at national and sub-national level by 2025.

2) Mortality by Age and/ or cause

   - Reduce Under-Five Mortality to 23 by 2025 and MMR from current levels to 100 by 2020.
   - Reduce infant mortality rate to 28 by 2019.
   - Reduce neo-natal mortality to 16 and still birth rate to "single digit" by 2025.

3) Reduction of disease prevalence/ incidence

   - Achieve global target of 2020 which is also termed as target of 90:90:90, for HIV/AIDS i.e. - 90% of all people living with HIV know their HIV status, - 90% of all people diagnosed with HIV infection receive sustained antiretroviral therapy and 90% of all people receiving antiretroviral therapy will have viral suppression.
   - Achieve and maintain elimination status of Leprosy by 2018, Kala-Azar by 2017 and Lymphatic Filariasis in endemic pockets by 2017.
   - To achieve and maintain a cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.
   - To reduce the prevalence of blindness to 0.25/ 1000 by 2025 and disease burden by one third from current levels.
   - To reduce premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 25% by 2025.

b) Health Systems Performance

1) Coverage of Health Services

   - Increase utilization of public health facilities by 50% from current levels by 2025.
   - Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.
   - More than 90% of the newborn are fully immunized by one year of age by 2025.
   - Meet need of family planning above 90% at national and sub national level by 2025.

- 80% of known hypertensive and diabetic individuals at household level maintain “controlled disease status by 2025.

2) Cross Sectoral goals related to health

- Relative reduction in prevalence of current tobacco use by 15% by 2020 and 30% by 2025.
- Reduction of 40% in prevalence of stunting of under-five children by 2025.
- Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).
- Reduction of occupational injury by half from current levels of 334 per lakh agricultural workers by 2020.
- National/ State level tracking of selected health behaviour.

c) Health Systems strengthening

1) Health finance

- Increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025.
- Increase State sector health spending to > 8% of their budget by 2020.
- Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.

2) Health Infrastructure and Human Resource

- Ensure availability of paramedics and doctors as per Indian Public Health Standard (IPHS) norm in high priority districts by 2020.
- Increase community health volunteers to population ratio as per IPHS norm, in high priority districts by 2025.
- Establish primary and secondary care facility as per norms in high priority districts (population as well as time to reach norms) by 2025.

3) Health Management Information

- Ensure district-level electronic database of information on health system components by 2020.
- Strengthen the health surveillance system and establish registries for diseases of public health importance by 2020.
- Establish federated integrated health information architecture, Health Information Exchanges and National Health Information Network by 2025.

20.2.3 Strategies

i) Policy thrust

a) Ensuring Adequate Investment - The policy proposes a potentially

achievable target of raising public health expenditure to 2.5% of the GDP in a time bound manner.

b) Preventive and Promotive Health - The policy identifies coordinated action on seven priority areas for improving the environment for health:

- The Swachh Bharat Abhiyan
- Balanced, healthy diets and regular exercises.
- Addressing tobacco, alcohol and substance abuse
- Yatri Suraksha – preventing deaths due to rail and road traffic accidents
- Nirbhaya Nari – action against gender violence
- Reduced stress and improved safety in the work place
- Reducing indoor and outdoor air pollution

c) Organization of Public Health Care Delivery - The policy proposes seven key policy shifts in organizing health care services:

- In primary care – from selective care to assured comprehensive care with linkages to referral hospitals
- In secondary and tertiary care – from an input oriented to an output based strategic purchasing
- In public hospitals – from user fees & cost recovery to assured free drugs, diagnostic and emergency services to all
- In infrastructure and human resource development – from normative approach to targeted approach to reach under-serviced areas
- In urban health – from token interventions to on-scale assured interventions, to organize Primary Health Care delivery and referral support for urban poor. Collaboration with other sectors to address wider determinants of urban health is advocated.
- In National Health Programmes – integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency.
- In AYUSH services – from stand-alone to a three-dimensional mainstreaming

ii) National Health Programmes

- **RMNCH+A services**

The policy strongly recommends strengthening of general health systems to prevent and manage maternal complications, to ensure continuity of care and emergency services for maternal health. In order to comprehensively address factors affecting maternal and child survival, the policy seeks to address the social determinants through developmental action in all sectors.

- **Child and Adolescent Health**

  The policy endorses the national consensus on accelerated achievement of neonatal mortality targets and “single digit” stillbirth rates. District hospitals must ensure screening and treatment of growth-related problems, birth defects, genetic diseases and provide palliative care for children. The policy envisages school health programmes as a major focus area as also health and hygiene being made a part of the school curriculum. The scope of Reproductive and Sexual Health should be expanded to address issues like inadequate calorie intake, nutrition status and psychological problems inter alia linked to misuse of technology, etc.

- **Interventions to Address Malnutrition and Micronutrient Deficiencies**

  The policy declares that micronutrient deficiencies would be addressed through a well-planned strategy on micronutrient interventions. Focus would be on reducing micronutrient malnourishment and augmenting initiatives like micro nutrient supplementation, food fortification, screening for anemia and public awareness. The present efforts of Iron Folic Acid (IFA) supplementation, calcium supplementation during pregnancy, iodized salt, Zinc and Oral Rehydration Salts/Solution (ORS), Vitamin A supplementation, needs to be intensified and increased.

- **Universal Immunization**

  Priority would be to further improve immunization coverage with quality and safety, improve vaccine security as per National Vaccine Policy 2011 and introduction of newer vaccines based on epidemiological considerations.

- **Communicable diseases**

  - **Control of Tuberculosis**

    The policy acknowledges HIV and TB co infection and increased incidence of drug resistant tuberculosis as key challenges in control of Tuberculosis. The policy calls for more active case detection, with a greater involvement of private sector supplemented by preventive and promotive action in the workplace and in living conditions.

  - **Control of HIV/AIDS**

    While the current emphasis on prevention continues, the policy recommends focused interventions on the high-risk communities (MSM, Transgender, FSW, etc.) and prioritized geographies.

  - **Leprosy Elimination**

    To carry out Leprosy elimination the proportion of grade-2 cases amongst new cases will become the measure of community awareness and health systems capacity, keeping in mind the global goal of reduction of grade 2 disability to less than 1 per million by 2020.

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- **Vector Borne Disease Control**

  The policy recognizes the challenge of drug resistance in Malaria, which should be dealt with by changing treatment regimens with logistics support as appropriate. New National Programme for prevention and control of Japanese Encephalitis (JE)/Acute Encephalitis Syndrome (AES) should be accelerated with strong component of inter-sectoral collaboration.

- **Non-Communicable Diseases**

  The policy recommends to set-up a National Institute of Chronic Diseases including Trauma, to generate evidence for adopting cost effective approaches and to showcase best practices. This policy will support an integrated approach where screening for the most prevalent NCDs with secondary prevention would make a significant impact on reduction of morbidity and preventable mortality. This would be incorporated into the comprehensive primary health care network with linkages to specialist consultations and follow up at the primary level. Emphasis on medication and access for select chronic illness on a 'round the year' basis would be ensured. Screening for oral, breast and cervical cancer and for Chronic Obstructive Pulmonary Disease (COPD) will be focused in addition to hypertension and diabetes.

- **Mental health**

  This policy will take into consideration the provisions of the National Mental Health Policy 2014 with simultaneous action on the following fronts:

  - Increase creation of specialists through public financing and develop special rules to give preference to those willing to work in public systems.
  - Create network of community members to provide psycho-social support to strengthen mental health services at primary level facilities and
  - Leverage digital technology in a context where access to qualified psychiatrists is difficult.

- **Population stabilization**

  The National Health Policy recognizes that improved access, education and empowerment would be the basis of successful population stabilization. The policy imperative is to move away from camp-based services with all its attendant problems of quality, safety and dignity of women, to a situation where these services are available on any day of the week or at least on a 14 fixed day. Other policy imperatives are to increase the proportion of male sterilization from less than 5% currently, to at least 30%.

iii) Women's health & Gender Mainstreaming

There will be enhanced provisions for reproductive morbidities and health needs of women beyond the reproductive age group (40+). This would be in addition to package of services covered in the previous paragraphs.

iv) Gender based violence

This policy notes with concern the serious and wide-ranging consequences of GBV and recommends that the health care to the survivors/ victims need to be provided free and with dignity in the public and private sector.

v) Supportive Supervision

For supportive supervision in more vulnerable districts with inadequate capacity, the policy will support innovative measures such as use of digital tools and HR strategies like using nurse trainers to support field workers.

vi) Emergency Care and Disaster Preparedness

The policy envisages creation of a unified emergency response system, linked to a dedicated universal access number, with network of emergency care that has an assured provision of life support ambulances, trauma management centers–

- o one per 30 lakh population in urban areas and
- o one for every 10 lakh population in rural areas

vii) Mainstreaming the Potential of AYUSH

For persons who so choose, this policy ensures access to AYUSH remedies through co-location in public facilities. The policy recognizes the need to standardize and validate Ayurvedic medicines and establish a robust and effective quality control mechanism for AUSH drugs.

viii) Tertiary care Services

The policy affirms that the tertiary care services are best organized along lines of regional, zonal and apex referral centers. It recommends that the Government should set up new Medical Colleges, Nursing Institutions and AIIMS in the country following this broad principle. Regional disparities in distribution of these institutions must be addressed. The policy supports periodic review and standardization of fee structure and quality of clinical training in the private sector medical colleges. To expand public provisioning of tertiary services, the Government would additionally purchase select tertiary care services from empaneled non-government sector hospitals to assist the poor.

ix) Human Resources for Health

There is a need to align decisions regarding judicious growth of professional and technical educational institutions in the health sector, better financing of professional and technical education, defining professional boundaries and skill sets, reshaping the pedagogy of professional and technical education, revisiting entry policies into educational institutions, and ensuring quality of education.

- **Medical Education:** The policy recommends strengthening existing medical colleges and converting district hospitals to new medical colleges to increase number of doctors and specialists. The policy supports expanding the number of AIIMS like centers for continuous flow of faculty for medical colleges, biomedical and clinical research.
- **Attracting and Retaining Doctors in Remote Areas:** Policy proposes financial and non-financial incentives, creating medical colleges in rural areas; preference to students from under-serviced areas, realigning pedagogy and curriculum to suit rural health needs, mandatory rural postings, etc.
- **Specialist Attraction and Retention:** Proposed policy measures include - recognition of educational options linked with National Board of Examination & College of Physicians and Surgeons, creation of specialist cadre with suitable pay scale.
- **Mid-Level Service Providers:** For expansion of primary care from selective care to comprehensive care, complementary human resource strategy is the development of a cadre of mid-level care providers. This can be done through appropriate courses like a B.Sc. in community health and/or through competency-based bridge courses and short courses.
- **Nursing Education:** The policy recognizes the need to improve regulation and quality management of nursing education. Other measures suggested are - establishing cadres like Nurse Practitioners and Public Health Nurses to increase their availability in most needed areas.
- **ASHA:** This policy supports certification programme for ASHAs for their preferential selection into ANM, nursing and paramedical courses.
- **Paramedical Skills:** Training courses and curriculum for super specialty paramedical care (perfusionists, physiotherapists, occupational therapists, radiological technicians, audiologists, MRI technicians, etc.) would be developed.
- **Public Health Management Cadre:** The policy proposes creation of Public Health Management Cadre in all States based on public health or related disciplines.

x) Financing of Health Care

The policy advocates allocating major proportion (upto two-thirds or more) of resources to primary care followed by secondary and tertiary care. Inclusion of cost-benefit and cost effectiveness studies consistently in programme design and evaluation would be prioritized.

xi) Collaboration with Non-Government Sector/Engagement with private sector:

The policy suggests exploring collaboration for primary care services with 'not-for-profit' organizations having a track record of public services where critical gaps exist, as a short-term measure. Private providers, especially those working in rural and remote areas or with under-serviced communities, could be offered encouragement through provision of appropriate skills to meet

public health goals, opportunities for skill up-gradation to serve the community better, participation in disease notification and surveillance efforts, sharing and supporting certain high value services.

xii) Regulatory Framework

The regulatory role of the Ministry of Health and Family Welfare- which includes regulation of clinical establishments, professional and technical education, food safety, medical technologies, medical products, clinical trials, research and implementation of other health related laws- needs urgent and concrete steps towards reform.

xiii) Vaccine Safety

Vaccine safety and security would require effective regulation, research and development for manufacturing new vaccines in accordance with National Vaccine Policy 2011.

xiv) Medical Technologies

India is known as the pharmacy of the developing world. However, its role in new drug discovery and drug innovations including bio-pharmaceuticals and bio-similars for its own health priorities is limited. This needs to be addressed in the context of progress towards universal health care.

xv) Public Procurement

Quality of public procurement and logistics is a major challenge to ensuring access to free drugs and diagnostics through public facilities. An essential pre-requisite that is needed to address the challenge of providing free drugs through public sector, is a well-developed public procurement system.

xvi) Availability of Drugs and Medical Devices

The policy accords special focus on production of Active Pharmaceutical Ingredient (API) which is the back-bone of the generic formulations industry. Recognizing that over 70% of the medical devices and equipments are imported in India, the policy advocates the need to incentivize local manufacturing to provide customized indigenous products for Indian population in the long run.

xvii) Aligning other policies for medical devices and equipment with public health goals

xviii) Improving Public Sector Capacity for Manufacturing Essential Drugs and Vaccines

xix) Anti-microbial resistance

The problem of anti-microbial resistance calls for a rapid standardization of guidelines, regarding antibiotic use, limiting the use of antibiotics as Over-the-Counter medication, banning or restricting the use of antibiotics as growth promoters in animal livestock.Pharmaco-vigilance including prescription audit inclusive of antibiotic usage, in the hospital and community, is a must in order to enforce change in existing practices.

xx) Health Technology Assessment

Health Technology assessment is required to ensure that technology choice is participatory and is guided by considerations of scientific evidence, safety, consideration on cost effectiveness and social values. The National Health Policy commits to the development of institutional framework and capacity for Health Technology Assessment and adoption.

xxi) Digital Health Technology Eco – System

Recognizing the integral role of technology (eHealth, mHealth, Cloud, Internet of things, wearables, etc) in the healthcare delivery, a National Digital Health Authority (NDHA) will be set up to regulate, develop and deploy digital health across the continuum of care. The policy advocates extensive deployment of digital tools for improving the efficiency and outcome of the healthcare system.

xxii) Health Surveys

The scope of health, demographic and epidemiological surveys would be extended to capture information regarding costs of care, financial protection and evidence-based policy planning and reforms. The policy recommends rapid programme appraisals and periodic disease specific surveys 26 to monitor the impact of public health and disease interventions using digital tools for epidemiological surveys.

xxiii) Health Research

The National Health Policy recognizes the key role that health research plays in the development of a nation's health. In knowledge-based sector like health, where advances happen daily, it is important to increase investment in health research

xxiv) Governance

One of the most important strengths and at the same time challenges of governance in health is the distribution of responsibility and accountability between the Centre and the States. The policy recommends equity sensitive resource allocation, strengthening institutional mechanisms for consultative decision-making and coordinated implementation, as the way forward.

xxv) Legal Framework for Health Care and Health Pathway

Excellent health care system needs to be in place to ensure effective implementation of the health rights at the grassroots level. Right to health cannot be perceived unless the basic health infrastructure like doctor-patient ratio, patient-bed ratio, nurses-patient ratio, etc are near or above threshold levels and uniformly spread-out across the geographical frontiers of the country.

20.2.4 Way forward

A policy is only as good as its implementation. The National Health Policy envisages that an implementation framework be put in place to deliver on these policy commitments. Such an implementation framework would provide a roadmap with clear deliverables and milestones to achieve the goals of the policy.

Check your progress 1

1) What are the objectives of NHP-2017?

20.3 NATIONAL POPULATION POLICY - 2000

20.3.1 Introduction to National Population Policy

India's population reached 100 crores on May 11, 2000 and as per the latest World Population Prospects report released by United Nations (revision 2019), the estimated population of India is expected to exceed China's population, by 2027 and it would become the most populous country in the world. Few important reasons of high Population growth in India are: The large size of the population in the reproductive age-group, Higher fertility due to unmet need for contraception, High wanted fertility due to the high infant mortality rate, and Early age marriage of girls resulting in a typical reproductive pattern of "too early, too frequent, too many".

Stabilizing population is an essential requirement for promoting sustainable development with more equitable distribution.

The population strategies adopted after independence went through many changes and the major milestones are:

- India became the first country in the world to launch a national family planning program in 1952, emphasizing family planning to the extent necessary for reducing birth rates to stabilize the population at a level consistent with the requirement of national economy.
- A National Population Policy statement was released by the Government of India in 1976.
- Approach and name of the family planning programme was changed into family welfare programme in 1977.
- The age of marriage for girls at 18 years and for boys at 21 years was implemented by the Child Marriage Restraint (Amendment) Act, in 1978.
- National health policy of 1983 emphasized the need for securing the small family norm.
- In 1993, a report of population committee of national development council recommended that a national policy of population should be formulated by the government and adopted by parliament.
- National Population Policy was announced by Government of India in 2000.

The National Population Policy formulated in the year 2000 provides a policy framework for advancing goals and prioritizing strategies towards voluntary and informed choice, target free approach and achievement of replacement level of fertility by simultaneously addressing the issues of contraception, maternal health and child survival. It envisages development of one-stop integrated and coordinated service delivery at the village level on these two parameters. This involves partnership of the government with non-government voluntary organizations.

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20.3.2 Objectives of National Population Policy

a) **Immediate objective:** To address the unmet needs for contraception, strengthen health care infrastructure, and health personnel and provide integrated service delivery for basic reproductive and child health care.

b) **Medium-term objective:** To bring the TFR to replacement levels by 2010 and vigorous implementation of inter-sectoral operational strategies

c) **Long-term objective**: To achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

20.3.3 National Socio-Demographic Goals

The following National Socio-demographic goals to be achieved by 2010 are formulated:

1) Address the unmet needs for basic reproductive and child health services, supplies and infrastructure.

2) Make school education up to age 14 free and compulsory, and reduce drop outs at primary and secondary school levels to below 20 percent for both boys and girls.

3) Reduce infant mortality rate to below 30 per 1000 live births.

4) Reduce maternal mortality ratio to below 100 per 100,000 live births.

5) Achieve universal immunization of children against all vaccine preventable diseases.

6) Promote delayed marriage for girls, not earlier than age 18 and preferably after 20 years of age.

7) Achieve 80 percent institutional deliveries and 100 percent deliveries by trained persons.

8) Achieve universal access to information, Counselling and services for fertility regulation and contraception with a wide basket of choices.

9) Achieve 100 percent registration of births, deaths, marriages and pregnancies.

10) Contain the spread of Acquired Immuno Deficiency Syndrome (AIDS), and promote greater integration between the management of RTI and STI.

11) Prevent and control communicable diseases.

12) Integrate Indian System of Medicine (ISM) in the provision of RCH services, and in reaching out to households.

13) Promote vigorously the small family norm to achieve replacement level of TFR.

14) Bring about convergence in implementation of related social sector programmes so that family welfare becomes a people centered programme.

20.3.4 Strategies in National Population Policy

a) Strategic themes

Twelve strategic themes have been identified which must be simultaneously pursed in standalone or inter-sectoral programmes in order to achieve the national socio-demographic goals:

1) Decentralized Planning and Program Implementation.
2) Convergence of Service Delivery at Village Levels.
3) Empowering Women for Improved Health and Nutrition.
4) Child health survival interventions
5) Meeting the Unmet Needs for Family Welfare Services.
6) Focus on Under-Served Population Groups. - Urban Slums - Tribal communities, hill areas, displaced/migrant populations – Adolescents. Involvement of men in Planned Parenthood.
7) Action through diverse Health Care Providers.
8) Collaboration with and Commitments from Non-Government Organizations and the Private Sector.
9) Mainstreaming Indian System of Medicine and Homeopathy.
10) Contraceptive Technology and Research on Reproductive and Child Health.
11) Providing healthcare and economic support for the Older Population.
12) Information, Education and Communication.

b) Operational Strategies

i) Decentralized Planning, Program Implementation and Convergence of Service Delivery at Village Levels:

- Utilize village self-help groups to organize and provide basic services for reproductive and child health care, combined with the ongoing ICDS scheme.
- Implement, at village levels, a one-stop integrated and coordinated service delivery package for basic health care, family planning and maternal and child health related services, provided by the community and for the community.
- Wherever these village self-help groups have not developed for any reason, community midwives, practitioners of ISM, retired school teachers and ex-defence personnel may be organized to perform similar functions.
- At village levels, the Anganwadi centre may become the pivot of basic health care activities, contraceptive counseling and supply, nutrition education and supplementation, as well as preschool

activities. The Anganwadi centres can also function as depots for ORS/basic medicines and contraceptives.

- A maternity hut should be established in each village to be used as the village delivery room with storage space for supplies and medicines. It should be adequately equipped with kits for midwifery, ante-natal care, and delivery; basic medication for obstetric emergency aid; contraceptives, drugs and medicines for common ailments.
- Trained birth attendants as well as the vast pool of traditional dais should be trained and made familiar with emergency and referral procedures.
- Provide wider basket of choices in contraception, through innovative social marketing schemes to reach household levels.

ii) Empowering Women for Improved Health and Nutrition

- Improve district, sub-district and panchayat-level health management with coordination and collaboration between district health officer, sub-district health officer and the panchayat for planning and implementation activities.
- Strengthen Community Health Centres (CHCs) and PHCs to provide comprehensive essential and emergency obstetric and neo-natal care.
- Strengthening skills of health personnel and health providers through classroom and on-the-job training.
- Create an enabling environment for women and children to benefit from products and services disseminated under the reproductive and child health programme.
- Open more child care centres in rural areas and in urban slums, where a woman worker may leave her children in responsible hands.
- To empower women, pursue programmes of social afforestation to facilitate access to fuelwood and fodder. Similarly, pursue drinking water schemes for increasing access to potable water
- Ensure adequate transportation at village level, subcentre levels, zila parishads, primary health centres and at community health centres. Identifying women at risk is meaningful only if women with complications can reach emergency care in time.
- Improve the accessibility and quality of maternal and child health services through: Deployment of community mid-wives and additional health providers at village levels; and Strengthen the capacity of primary health centres to provide basic emergency obstetric and neo-natal health care.
- Support community activities such as dissemination of IEC material, including leaflets and posters, and promotion of folk jatras, songs and dances to promote healthy mother and healthy baby messages.

- Expand the availability of safe abortion care.
- Develop maternity hospitals at sub-district levels and at community health centres to function as FRUs for complicated and life-threatening deliveries.
- Formulate and enforce standards for clinical services in the public, private, and NGO sectors.
- Focus on distribution of non-clinical methods of contraception (condoms and oral contraceptive pills) through free supply, social marketing as well as commercial sales.
- Create a national network consisting of public, private and NGO centres, identified by a common logo, for delivering reproductive and child health services free to any client. The provider will be compensated for the service provided.

iii) Child health and Survival

- Support community activities, from village level upwards to monitor early and adequate antenatal, natal and post-natal care.
- Pursue compulsory registration of births in coordination with the ICDS Programme.
- After the birth of a child, provide counseling and advocacy about contraception.
- Improve capacities at health centres in basic midwifery services, essential neo-natal care.
- Sensitize and train health personnel in the integrated management of childhood illnesses.
- Strengthen critical interventions aimed at bringing about reductions in maternal malnutrition, morbidity and mortality, by ensuring availability of supplies and equipment at village levels, and at sub centres.
- Pursue rigorously the pulse polio campaign to eradicate polio.
- Ensure 100 percent routine immunisation for all vaccine preventable diseases, in particular tetanus and measles.
- Explore the feasibility of a national health insurance covering hospitalisation costs for children below 5 years, whose parents have adopted the small family norm, and opted for a terminal method of contraception after the birth of the second child.

iv) Meeting the Unmet Needs for Family Welfare Services

- Strengthen, energise and make publicly accountable the cutting edge of health infrastructure at the village, subcentre and primary health centre levels.
- Address on priority the different unmet needs.

- Formulate and implement innovative social marketing schemes to provide subsidised products and services
- Improve facilities for referral transportation at panchayat, zilla parishad and primary health centre levels.
- Encourage local entrepreneurs at village and block levels to start ambulance services through special loan schemes.
- Provide special loan schemes and make site allotments at village levels to facilitate the starting of chemist shops for basic medicines and provision for medical first aid.

v) Under-Served Population Groups

(a) Urban Slums

- Finalise a comprehensive urban health care strategy.
- Facilitate service delivery centres in urban slums to provide comprehensive basic health, reproductive and child health services by NGOs and private sector organisations.
- Initiate specially targeted information, education and communication campaigns for urban slums on family planning, immunization, ante-natal, natal and post-natal check-ups and other reproductive health care services.
- Promote inter-sectoral coordination between departments/ municipal bodies dealing with water and sanitation, industry and pollution, housing, transport, education and nutrition, and women and child development.
- Streamline the referral systems and linkages between the primary, secondary and tertiary levels of health care in the urban areas.

(b) Tribal Communities, Hill Area Populations and Displaced and Migrant Populations

- Many tribal communities are dwindling in numbers, and may not need fertility regulation. Instead, they may need information and counseling in respect of infertility.
- The NGO sector may be encouraged to formulate and implement a system of preventive and curative health care that responds to seasonal variations in the availability of work, income and food for tribal and hill area communities and migrant and displaced populations.

(c) Adolescents

- Ensure for adolescents access to information, counseling and services, including reproductive health services, that are affordable and accessible.
- Provide for adolescents the package of nutritional services available under the ICDS programme.

- Enforce the Child Marriage Restraint Act, 1976, to reduce the incidence of teenage pregnancies.
- Provide integrated intervention in pockets with unmet needs.

(d) Increased Participation of Men in Planned Parenthood

- Focus attention on men in the information and education campaigns to promote the small family norm, and to raise awareness by emphasising the significant benefits of fewer children, better spacing, better health and nutrition, and better education.

vi) Diverse Health Care Providers

- At district and sub-district levels, maintain block-wise data base of private medical practitioners whose credentials may be certified by the Indian Medical Association (IMA) and assign to each a satellite population, for whom they may provide reproductive and child health services. The private practitioners would be compensated for the services rendered.
- Involve the non-medical fraternity in counseling and advocacy.
- Modify the under/post-graduate medical, nursing, and paramedical professional course syllabi in order to reflect the concepts and implementation strategies of the reproductive and child health programme and the national population policy.

vii) Collaboration with and Commitments from the Non-Government organizations and private sector

- Collaboration with and commitments from NGOs to augment advocacy, counseling and clinical services, while accessing village levels.
- Collaboration between the voluntary sector and the NGOs will facilitate dissemination of efficient service delivery to village levels.
- The corporate sector and industry could, for instance, take on the challenge of strengthening the management information systems in the seven most deficient states, at primary health centre and subcentre levels.
- Help promote transportation to remote and inaccessible areas up to village levels. This will greatly assist the coverage and outreach of social marketing of products and services.

viii) Mainstreaming Indian Systems of Medicine and Homeopathy

- Provide appropriate training and orientation in respect of the RCH programme for the institutionally qualified ISMH medical practitioners, and utilize their services to fill in gaps in manpower at appropriate levels in the health infrastructure, and at subcentres and primary health centres, as necessary.
- Utilise the ISMH institutions, dispensaries and hospitals for health and population related programmes.

ix) Contraceptive Technology and Research on RCH

- Government will encourage, support and advance the pursuit of medical and social science research on reproductive and child health, in consultation with ICMR and the network of academic and research institutions.
- A committee of international and Indian experts, voluntary and non-government organisations and government may be set up to regularly review and recommend specific incorporation of the advances in contraceptive technology and, in particular, the newly emerging techniques, into programme development.

x) Providing for the Older Population

- Sensitize, train and equip rural and urban health centres and hospitals towards providing geriatric health care.
- Encourage NGOs and voluntary organizations to formulate and strengthen a series of formal and informal avenues that make the elderly economically self-reliant.
- Tax benefits could be explored as an encouragement for children to look after their aged parents.

xi) Information Education and Communication

- Converge IEC efforts across the social sectors. The two sectors of Family Welfare and Education have coordinated a mutually supportive IEC strategy.
- Involve departments of rural development, social welfare, transport, cooperatives, education with special reference to schools, to improve clarity and focus of the IEC effort, and to extend coverage and outreach.
- Demonstration of support by elected leaders, opinion makers, and religious leaders with close involvement in the reproductive and child health programme greatly influences the behaviour and response patterns of individuals and communities.
- Utilise radio and television as the most powerful media for disseminating relevant sociodemographic messages.
- Utilise dairy cooperatives, the public distribution systems, other established networks like the LIC at district and sub-district levels for IEC and for distribution of contraceptives and basic medicines.
- Sensitise the field level functionaries across diverse sectors to the strategies, goals and objectives of the population stabilization programmes.
- Involve civil society for disseminating information, counseling and spreading education about the small family norm, the need for fewer but healthier babies, higher female literacy and later marriages.

20.3.5 Legislation

For pursuing the agenda for population stabilization of NPP-2000, the 42nd Constitutional Amendment has frozen the number of seats in Lok Sabha and Rajya Sabha till 2026, with the 1971 Census as the base.

20.3.6 Public support

Demonstration of strong support to the small family norm, as well as personal example, by political, community, business, professional and religious leaders, media and film stars, sports personalities, and opinion makers, will enhance its acceptance throughout society. The government will actively enlist their support in concrete ways.

20.3.7 New structures

For management and implementation of NPP following structures are recommended:

(i) **National Commission on Population:** A National Commission on Population, presided over by the Prime Minister, will have the Chief Ministers of all states and UTs, and the Central Minister in charge of the Department of Family Welfare and other concerned Central Ministries and Departments, will oversee and review implementation of policy.

(ii) **State / UT Commissions on Population:** Each state and UT may consider having a State / UT Commission on Population, presided over by the Chief Minister, on the analogy of the National Commission, to likewise oversee and review implementation of the NPP 2000 in the state / UT.

(iii) **Coordination Cell in the Planning Commission:** The Planning Commission will have a Coordination Cell for inter-sectoral coordination between Ministries for enhancing performance. In place of a coordination cell, a policy convergence has been set up.

(iv) **Technology Mission in the Department of Family Welfare:** Technology Mission in the Department of Family Welfare will be established to provide technology support in respect of design and monitoring of projects and programmes for reproductive and child health, as well as for IEC campaigns. In place of a Technology Mission in the Department of Family Welfare, an Empowered Action Group (EAG) has been created.

20.3.8 Promotional and Motivational Steps for Adopting Small Family Norm in NPP

1) Rewards for Panchayats and Zila Parishads for exemplary performance.

2) Balika Samridhi Yojana - A cash incentive of Rs 500 is awarded at the birth of the girl child of birth order 1 or 2 to promote survival and care of girl child.

3) Maternity Benefit Scheme - A cash incentive of Rs 500 is awarded to mothers who have their first child after 19 years of age for the birth of first or second child only.

4) Family Welfare - linked Health Insurance Plan.
5) Couples below the poverty line, who marry and produce two children after age of 21 are rewarded.
6) Opening/Establishing creches and child care centres in rural areas and urban slums, to promote participation of women in paid employment.
7) Provision of wider and affordable choices of contraceptives.
8) Strengthening and expansion of safe abortion facilities.
9) Increased vocational training schemes for girls leading to self-employment.
10) Villagers will be provided soft loans and encouraged to run ambulance services for referrals.
11) A revolving fund will be set up for income-generating activities by village-level self-help groups, who provide community-level health care services.
12) Products and services will be made affordable through innovative social marketing schemes.
13) Strict enforcement of Child Marriage Restraint Act, 1976.
14) Strict enforcement of the Pre-Natal Diagnostic Techniques Act, 1994.
15) Soft loans to ensure mobility of the ANMs will be increased.
16) The 42nd Constitutional Amendment has frozen the number of representatives in the Lok Sabha (on the basis of population) at 1971 Census levels.

20.3.9 Way Forward

Population problem is not just an issue of lack of awareness or education. It is intrinsically linked to poverty, societal norms and cultural preferences like preference for the male child, larger families, etc. A mere focus on contraception and sterilization will not render the population control measures successful, and so will not the coercive and top-bottom approach help either. The focus must be on a basket of issues such as poverty alleviation, women empowerment, education & awareness, access to reproductive healthcare facilities, changing mindset and societal norms, etc. Also, adequate measures must be taken to take advantage of the demographic dividend of the country so that population is not a burden but a resource in the rapid economic development of the country.

The National Population Policy 2000 is uniformly applicable to the whole country. In pursuance of this policy, Government has taken a number of measures under Family Planning Programme and as a result, the percentage decadal growth rate of the country has declined significantly from 21.5% for the period 1991-2001 to 17.7% during 2001-2011 and Total Fertility Rate (TFR) has declined from 3.2 (in year 2000) to 2.2 as per Sample registration Survey (SRS) 2017.

Check your progress 2

1) What are the major objectives of the National Population Policy-2000?
2) What are the new structures recommended by National Population Policy-2000?

3) Fill in the blanks:

   (i) National family planning programme was launched in the year……. ?

   (ii) National population policy was announced by government in the year …… ?

20.4 LET'S SUM UP

The primary aim of the National Health Policy, 2017, is to inform, clarify, strengthen and prioritize the role of the Government in shaping health systems in all its dimensions- investments in health, organization of healthcare services, prevention of diseases and promotion of good health through cross sectoral actions, access to technologies, developing human resources, encouraging medical pluralism, building knowledge base, developing better financial protection strategies, strengthening regulation and health assurance.

The roadmap of the new policy is predicated on public spending and provisioning of a public healthcare system that is comprehensive, integrated and accessible to all. One of the key principles of the Policy is to reduce inequity which would mean affirmative action to reach the poorest and minimizing disparity on account of gender, poverty, caste, disability and other forms of social exclusion and geographical barriers. The policy also recognizes the special health needs of tribal and socially vulnerable population groups and recommends situation- specific measures in the provisioning and delivery of services. It advocates allocating major proportion of resources to primary care followed by secondary and tertiary care.

20.5 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) What are the objectives of National health policy-2017?

   Answer: The major objective of NHP-2017 is to improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality.

   - Progressively achieve universal health coverage.
   - Reinforce trust in public healthcare system.
   - Align the growth of private healthcare sector with public health goals.

Check Your Progress 2

1) What are the major objectives of the National Population Policy-2000?

   Answer: The National Population Policy 2000 has laid down objectives at three-time frames: immediate, medium term, and long term.

   Immediate objective: To address the unmet needs for contraception, strengthen health care infrastructure, and health personnel and provide integrated service delivery for basic reproductive and child health care.

Medium-term objective: To bring the TFR to replacement levels by 2010 and vigorous implementation of inter-sectoral operational strategies

Long-term objective: To achieve a stable population by 2045, at a level consistent with the requirements of sustainable economic growth, social development, and environmental protection.

2) What are the new structures recommended by NPP-2000?

Answer: Four new structures, the National Commission on Population, State/ UT Commissions on Population, Coordination Cell in the Planning Commission, and Technology Mission in the Department of Family Welfare were proposed to be established under the NPP-2000.

3) Fill in the blanks:

(i) National family planning programme was launched in the year…….1952

(ii) National population policy was announced by government in the year …… 2000

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UNIT 21 DISTRICT HEALTH ORGANISATION

Structure

21.0 Objectives

21.1 Introduction

21.2 District Level Health System

- 21.2.1 Organisational Structure of District Health Care System
- 21.2.2 Functions of District Health Office

21.3 District Level Planning and Management

- 21.3.1 CMO's Role
- 21.3.2 Decentralised District Planning: Concept and Machinery
- 21.3.3 Designing the District Health Plan

21.4 District Health Information System

- 21.4.1 Sources of Health Information
- 21.4.2 Flow of Routine Health Information

21.5 Let Us Sum Up

21.6 Answers to Check Your Progress

21.7 Further Readings

21.0 OBJECTIVES

After going through this unit, you should be able to:

- describe the structure and functions of district health organisation;
- explain the concept, machinery and process of decentralised district planning for health and development; and
- discuss about the district health information system and its utility.

21.1 INTRODUCTION

District health care delivery system is the default system of health and family welfare services and all related health care programmes of India. The purpose of this unit is to give you an insight of the District Health Organisation in terms of its structure and function. While Health system concept was mooted in 1946 by Bhore committee.

The National Rural Health Mission (NRHM) was launched on 12thApril, 2005 and National Urban Health Mission (NUHM), on 1st May, 2013 and both the programmes were combined as National Health Mission which aimed at affordable and quality health care to the rural population, especially the vulnerable groups with regional and social inequities in health care.

Before the launch of NRHM, it was found that there were striking poverty in Government funds towards Health Sector. The government's allocation to

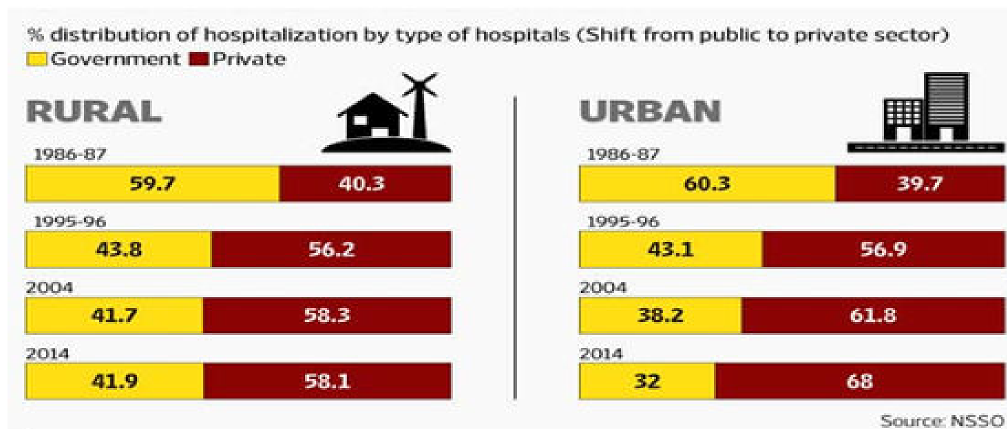
healthcare as a percentage of the country's gross domestic product (GDP) has fallen down 1.05% in 2015-16 from 1.47% in 1986-87. Unfortunately, health was not a priority for the government nor the people.. The comprehensive health care approach was fragmented and disease specific. National health programmes were ill supervised. The country ran the maternal & health programme and initiating Child Survival and Safe Motherhood (CSSM). IMR did fall to 41 per 1,000 live births in 2013 from 88 in 1990, according to a United Nations report 'Levels and Trends in Child Mortality' released in 2015. Similarly, according to a World Health Organization (WHO) report released in 2014, maternal mortality in India has declined from 560 deaths per 100,000 live births in 1990 to 190 in 2013.The out-of-pocket expenditure on health care was huge and disproportionately affected the poor. This called for a comprehensive restructuring of the prevailing strategies to improve the public health of the people.

Health surveys by the National Sample Survey Organisation (NSSO) show that since the 1990s, the dependence of Indians on private healthcare has risen sharply. In 1986-87 when 60% of people availed of public health services and the rest private healthcare, according to the 42nd NSSO report. But by 2014, this trend was reversed, with only 41% availing of public healthcare, according to the 71st NSSO report released last year. The decline in dependence on public healthcare is sharper in urban areas—from 60% in 1986-87 to almost 32% in 2014.

The evolution of healthcare in India over the past 25 years has been a mixed bag. While key health metrics such as the infant mortality rate (IMR) and maternal mortality ratio have come down substantially, healthcare expenses have shot up—a direct fallout of lower public health spending. The government's allocation to healthcare as a percentage of the country's gross domestic product (GDP) has fallen to 1.05% in 2015-16 from 1.47% in 1986-87.

IMR has fallen to 41 per 1,000 live births in 2013 from 88 in 1990, according to a United Nations report 'Levels and Trends in Child Mortality' released in 2015. Similarly, according to a World Health Organization (WHO) report released in 2014, MMR in India has declined from 560 deaths per 100,000 live births in 1990 to 190 in 2013.

However, National Sample Survey Organisation (NSSO) showed, since the 1990s, the dependence of people on private healthcare has risen sharply, in India. In 1986-87, 60% of people availed of public health services and the rest private healthcare, on the contrary, according to the 42nd NSSO report by 2014, this trend was showed only 41% availing of public healthcare. The decline in dependence on public healthcare is sharper in urban areas—from 60% in 1986-87 to almost 32% in 2014 (As shown in figure below)



The Public Health services, today has been much advanced and developed, particularly in post-COVID time. Most government hospitals have better beds, oxygen and ventilator support, even in primary health centres in Gonda, a remote district of UP has incubators in the post-natal wards, in spite the fact the per capita expenditure per hospital bed is too less and thus the increased hospital expenditure of patients. Let us know the district health System more clearly.

21.2 DISTRICT LEVEL HEALTH SYSTEM

By now, you would have become conversant that for the delivery of health care services in the country, health infrastructure F developed at different levels, from the national /central level to the village level. A detailed description of the health care delivery system has been given in Unit 1 of this block.

21.2.1 Organizational Structure of District Health Care System

The district level structure of the health care system is a middle level organisation and it is a linkage between the state on one side and the peripheral level structures. The medical colleges are the highest-level structures to provide specialist and super specialist care either for the cases referred from the different Primary health centres or Community health centres. The basic health unit at the periphery is the Primary health Centre. With the implementation of multipurpose health workers scheme, reorganisation of health care services structure has developed. Consequently, all the health and family welfare programmes in the district have been brought under a unified charge. This district officer with the overall control is popularly known as the CMO (Chief Medical Officer) / CDMO (Chief District Medical Officer) or even Civil Surgeon depending on the state, since health is "a state subject". The district chief is assisted by Deputy programme Officers or Deputy CMOs (Dy CMOs), whose numbers/specialisations and status in the cadre of state health services differ from state to state. Each state has adopted this broad pattern with modifications, suiting its own requirement and also depending upon the availability of resources of men, money and material. These Dy CMOs are given individual responsibility of Maternal Child health & Family welfare, Integrated Disease Surveillance Programme (IDSP) and Communicable disease control etc. For the District Health Education, there remains a District Education officer, who is not a medical professional and remains attached to the CMO. The basic Organization with manpower has been given in fig 21.1.

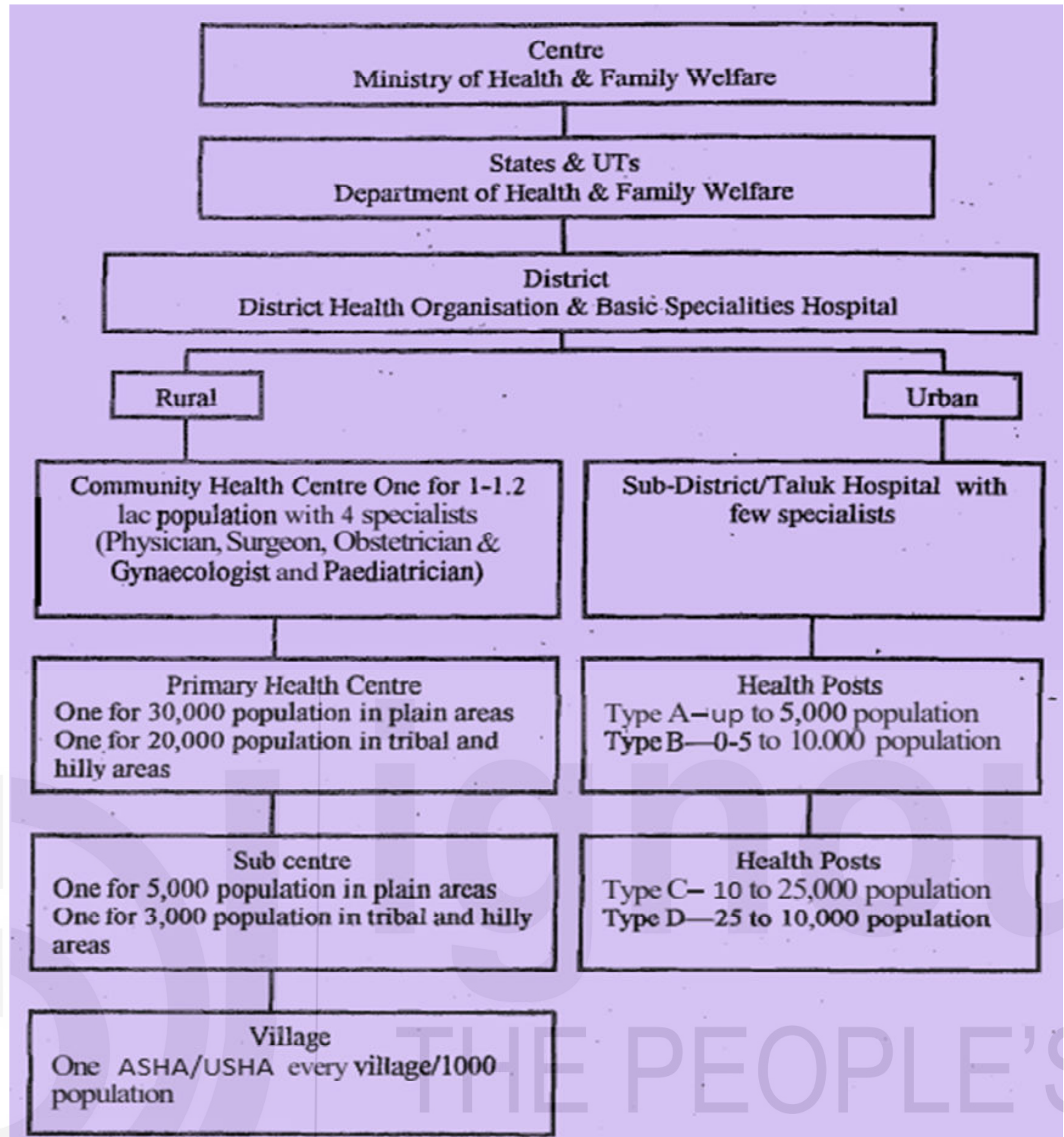


Fig 21.1: Basic Organization with manpower

21.2.2 Functions of District Health Office

The Chief Medical Officer (CMO) being the Supreme authority of district health care services translates the broad health policies and programmes according to the directive of the state. CMO directs, guides and supervises the peripheral health units. The Medical Officer in charge of the PHC further provides direction and supervision to the staff below till the ASHA (Accredited Social Health Activist). ASHA is an incentivised volunteer health worker from the community. At present there are 9 lakh such ASHAs working in the village. There are similar numbers of USHAs (Urban Social Health Activists) working as an interface between the public health system and the community at the Urban areas. They help the ANM or Health worker (female) to motivate people for organising immunization camps,family planning activities and COVID vaccination drive etc. The health worker male is monitored for the communicable disease control activities. Each health workers (male & female) work at the subcentre level for 5000 population. Each PHC has 6-7 such Subcentres. At the district level there is an IDSP unit with one data entry officer and a surveillance medical officer. They collect, compile and report all the disease condition / cases or epidemics to the CMO for perodic report to the state IDSP unit to report to the National Communicable Disease Control Centre. The major functions of district health unit are to effectively run:

i. Medical, surgical Care and other super specialist care

ii. Sterilization Facility

iii. Trauma Centre functioning

iv. MCH (Reproductive Health) units

v. Paediatric unit with Incubator facility

vi. COVID control Unit and oxygen plant

vii. Family welfare services

viii. IDSP Services.

ix. National health mission and all other National health progrmmes

x. Management of Biological waste (BMW) disposal system

xi. Medicolegal services

xii. Disaster and Epidemic control

xiii. Staff training Centre

xiv. Coordination system of extramural organization such as Panchayat Raj system etc.

You are supposed to Visit a district Health Unit with your Counsellor to study the details of the unit and also visit Urban Primary Health Centre (UPHC). This course, particularly the district health system, is based on "Learning by doing" method, thus you are supposed to give utmost importance to learn on the site visit and counselling programme.

Check Your Progress 1

1) The chief of the District Health Organisation may be designated differently in different states viz. ....

2) Tick the correct answer:

   The deputies to the chief of the district are often given:

   a) singular programme responsibilities

   b) responsibilities of supervising activities of all the programmes in specific areas of the district.

21.3 DISTRICT LEVEL PLANNING AND MANAGEMENT

21.3.1 CMO's Role

In order to perform the functions assigned to the District Health Organisation in an efficient and effective manner, the chief of the district has to resort to decentralised district level planning and management. The nomenclature varies from state to state. In most of the districts these managers are known as CMO or

Chief Medical Officer, while they are also known as CDMO or Chief District Medical officer. Earlier and still in some states they are known as Civil Surgeons. As a manager of the District Health Care Delivery System, the CMO has to perform three broad roles. These are:

1) Interpersonal Management

a) ***Figurehead:*** By the status of their office, CMOs are required to *carry* out a variety of social, legal and ceremonial roles e.g., make opening remarks at meetings, signs various government form and make themselves available for VIP visits.

b) ***Leader:*** The role that describes CMO's amicable interpersonal relations with his subordinates. CMOs need to motivate staff of work and give them responsibility according to their prescribed roles. As a guide his main duty aims at **"Getting the desired work done timely"** at the same time enhance the staff competence. The major tasks of a leader is given below (Adopted from A treatise of Health Management)

L	Liquidity of activities / tasks and events with low profile of the self (Do not use "Me", it's "WE" that energizes your team and helps you get more work per worker
E	Entrepreneurship in performance.
A	Active work productivity with Self involvement
D	Dependability (Distribute work as per the capabilities of each worker and believe them).
E	Educative towards workers and the acceptors.
R	Results oriented as per the desired output.
S	Supportive Supervision (as explained earlier)
H	Humane in approach to people at large.
I	Internally motivated and inform workers and initiate work by self-involvement.
P	Programme package perspective and attitude.

c) ***Liaison:*** CMOs are responsible for relations and official dealings with people outside the district health organization and general as well as public administration. CMOs develop a network of contacts with other development sectors, district collector, local political representatives and leaders in the community. The CMO may depute some of his deputies to any of the aforesaid organizations.

2) Information Management

a) ***Monitor:*** CMOs continually seek and receive information about their organisation and its services. Being the head of the health system of the district, the CMO is supposed to undergo all information, surveillance data of IDSOP, Immunization activity, Government circulars etc and even medicinal & Laboratory chemicals flow detail.

b) ***Disseminator:*** CMOs is a three-way communication disseminator. He shares information with subordinates according to their need and performance, meetings and the outcome in his office. He also has to attained number meetings and trainings at the state and national level and improves the work productivity. In case of achievement or disaster or even medicolegal crisis, he disseminates information to the people directly or via TV, for the need of the people at large; what they need.

3) District Health Implementor

a) ***Resource Allocator:*** CMOS determine the allocation of material, manpower and finances to is Deputies with instruction as to how will resources be utilized, which is normally as per state directives.

b) ***Innovator:*** CMOs adopt innovative alternate approaches to the efficient delivery of services to bring about positive changes in their organisation. CMO anticipates problems and take initiative action to solve them.

c) ***Disturbance Handler:*** CMOS take charge when the normal routine is disturbed e.g. during disaster, during intensive health campaigns, in case employees go on strike, or when there is a breakdown of the supply line or service.

d) ***Negotiator:*** CMOs may enter into negotiations with any one that affects thedelivery of health services ofthe district by any mean.

In short, the CMO is the district health system with multiple managerial activities. He is the

- Team leader
- Planner
- Supervisor
- Monitor
- Motivator
- Coordinator
- Facilitator
- Information processor
- Decision maker
- Promoter of inter-personal interactor
- Communicator (for staff, **community** and government)
- Evaluator
- Innovator
- Resource provider
- Community contact maker

In playing his role, a CMO needs to have such qualities of leadership such as social acceptance, empathy, capacity to inspire and motivate others particularly colleagues, subordinates, influential community groups and opinion leaders and to mobilise their commitment, ability to communicate, courage to take calculated risks. At times the CMO has to take bold decisions, take initiative and demonstrate for the benefit of the people.

21.3.2 Decentralised District Planning: Concept and Machinery

There has been a growing recognition of the fact that there is a need to supplement the national and state health plans with a more detailed introspection and modification of the problems, resource and potentials of local areas, so that health plans and Health Systems should be tailored to the particular needs of each district. For example, before CSSM Programme it was thought to have addressed to Maternal and Child health, while our actual problem was preventing Maternal & Child Death. Whose health were we talking of, when Maternal mortality was 4 and child mortality was 120 / thousand live birth? Further the problem was not medical in origin, rather it was lack of management. Thus, CSSM program was taken of which trained the health care provider in management and equipment care. The strategy based on Child Survival and prevention of Maternal Death by all means. Within some 5+ years Maternal Mortality and infant mortality came down which significantly reduced after the RCH and NRHM programmes.

The health need and demand of the people were never the felt need of the people as the priority of the people was kerosene, food- grain, fertilizer supplies at the government distribution centres. It was only later they realized the importance. The district health Unit and CMOs were the basic administrative units, for central services provision and financial reallocation.

While the PHCs were as a normal grass root meeting point for bottom-up community health planning, the top down central and state planning, the CMO office plays the pivotal road. In contrast to national or state level plans, the district plans present a multisectoral package of area specificity. District planning generates a popular enthusiasm for innovation and experimentation to formulate implementation of Participatory Health Programming. Further, it brings about involvement of peoples' representatives not only in the formulation of programme implementation strategies at the village level, but also in supporting with the village resources, in implementation and its follow-up, thereby ensuring a participative commitment. In the Sonbhadra district of UP, which is a hilly district in UP, the District Administration passed the orders that the government buses have to give free lift to the Auxiliary Midwifes (ANM) when they go for Immunization Programme. District Planning Board has emerged as an effective path to formulate schemes and getting them implemented he participatory approach. It provides a forum for all sectors and organisations engaged in development work including panchayats to pool their resources, efforts and assist in evolving a well-coordinated participatory health sector approach.

Any programmes inadequacy in achieving its goal can be attributed to only 3 causes such as: (1) Technical insufficiency, (2) Administrative and (3) Operational incapacity. Thus, the District Planning is undertaken by the CMO as the convener. One must clearly know that Panning has to be the Pragmatic Blue print of Action for the Health Sector Development.

The District Planning Board is a representative sub-committee at the district level comprising oft the district magistrate as its vice-chairman and the Zilla Panchayat president as its co-chairman with a Minister of the State Government is *the* chairman. The above members can also send their representatives as and when the CMO calls the meeting with the approved agenda. There could be15 other categories of members consisting of lady members of Zilla Parishad, Presidents of Taluka / Block Panchayat, MPs, MLA, Mayors or equivalent of municipal bodies; officials like District Development Officer etc. However most of these people do not find the time to attend the meeting and the CMO /CDMO manages the entire programme.

The District Planning Board generally meets every three months and has powers to formulate and sanction schemes. The Board also has at its disposal, the 'united funds' allocated by the state for 'Decentralised District Flaming'. About one-third of the total outlay under plan is allocated to district level schemes to be implemented through heads of departments of different sectors. There is also a special outlay for development of identified backward areas. With the enactment of Panchayati Raj Act, the process of decentralisation has got strengthened further. There is provision for transfer of powers, fundings and, devolution of finds to the representatives of people. In terms of activities, barring law and order, almost all other developmental activities come within its scope. It is the local government at the district level and 22 departments involved in developmental activities ideally fall within the governance of Panchayats. Thus, Panchayati Raj Institutions are expected to play a pivotal role in the decentralised district planning for health and development. Most often than not Panchayat Raj & Health system work independently.

21.3.3 Designing the District Health Plan

A plan is a blue print of implementable action. Planning is a document and verbal statement is never a plan. Planning needs to be done to prepare such a print for action. This by itself is a process. Thus, health planning can *be* defined as an orderly process of defining community health problems, identifying health needs of the community and implementing the method to meet the need of the people. This involves befitting the resources to meet the action, establishing priority goals that are realistic and feasible, and projecting administrative action to accomplish the purpose of the District Health Organisation.

The purpose of health planning is to:

1. match the limited resources with many problems to be tackled.
2. eliminate wasteful or duplication of expenditure, and
3. develop the best course of action to accomplish a defined objective.

Health of the people reflects on the success of all developmental efforts being undertaken in the district. Similarly, development has a positive effect on health too e.g. greater availability of nutritious food through organised developmental efforts have a bearing on health of the people. In turn, healthy people can contribute more effectively towards developmental efforts.

Districts are now recognising the need to strengthen their planning system. However, the actions required would depend upon the context of programmes.

Generally, the areas that support planning system had inherent weaknesses in them. These have been rectified to a greater extend

a) *Data* System *and its* Use: District *strong* data system after the IDSP has been included at the district office. They have all data available on any disease weakly, data entry operator and epidemiologists to study and give expert advice to the CMO.

b) Planning *Capabilities:* All CMOs down the line up to Primary Health centre doctor have been trained in Management, programme implementation, supervision etc more than once. Even the para medical staff, field level managers like ANMs and ASHA have also been trained in record keeping, supervision and work implementation.

The above considerations have reduced the weakness of the health and health related sectors. There have been excellent programmes like CSSM programme, Zinc Diarrhoea programme, Community Mobilization programme, Improved Laboratory and pharmacy services and many such activity including improving the technical know-how and equipment provision at grass root level. . You have to request your counsellor to take you to the PHC & District health units so that you practically learn effectively.

Follow the following steps to study the Health System & after the same discuss in your counselling hours.

Basic Steps	**Key Questions**
1) Situational analysis 2) Projection prediction of health status 3) Identification and action of problems	When are we now?
4) Selection of priorities 5) Establishment of goals and objectives	Where do we want to reach?
6) Listing key alternative strategies 7) Try to Examine strategies in relation to resources 8) Selection of feasible strategy/choosing options 9) Listing of activities 10) Making an implementation plan	How will we reach?
Monitoring and control of operations 12) Evaluation 13) Replanning	Are we going in the right direction? Have we reached?

Chart 21.1: Steps for studying District Health Planning

Each of the steps have been briefly described below:

1) **Situational Analysis**: As a first step it is very necessary for a planner to how the health of the community, factors promoting *good* health and the risk

factors associated with ill health. Thus, for making a proper situational analysis, bath, the community as well the health aspects need to be looked into.

a) *Community level action*

   i) *Demographic Profile:* Total population of the district, its distribution, age-sex composition, etc.

   ii) *Socioeconomic Conditions:* Per capita income, housing conditions, etc.

   iii) *Socio-cultural Aspects:* Attitudes *and* beliefs of community.

   iv) *Education* Related: Literacy rate, source for imparting education etc.

b) *Health Aspects*

   i) *Health Status:* Morbidity (incidence and prevalence of various diseases), mortality pattern, etc.

   ii) *Health Facilities:* Governmental, Voluntary *as* well as Private.

   iii) *Resources:* Human Resources, financial resources, material resources, community resources.

   iv) *Training Centres:* Location, numbers being trained, their capabilities for imparting training etc.

2) **Projection/Prediction of Health Status**: After making a community diagnosis through a situational analysis, it should to be deliberated as to what would be the likely situation in future which can be predicted and what action needs to be done e.g. expected increase of population, migration of people, or depletion of community resources e.g. water availability etc.

3) **Setting of Priorities**: It may not be possible to redress all the problems at one go. In such a situation, health problems need to be cared for on a priority basis depending upon the:

   i) Number of affected and severity of the problem.

   ii) Diseases which are prevalent in the weaker sections of the community**.**

   iii) Health problems with which the vulnerable groups of the community are associated e.g. mothers and children, school going children, etc

   iv) Problems which have serious social and sociocultural in origin, e.g. leprosy, tuberculosis, blindness.

4) **Establishment of Goals and Objectives**; It is very necessary to find outthe ultimate state that is desired. The objectives set forth should be realistic to achieve and in measurable terms e.g. reduction in morbidity / mortality rate from 75 to 70 in a period of two years.

5) **Strategies**: There could be various ways to resolve the problem. However, one has to adopt a strategy which is acceptable, feasible and matches the available resources e.g. for control of diarrhoea there could be different

alternatives like health education on water supply and sanitation, medical care including developing ORT corner, availability of ORS packets etc.

6) **Communication for Listing of Programmes**; The activities could be categorised under preventive, promotive, curative and rehabilitative aspects. Besides that, the activities to be undertaken at various level also need to be defined.

7) **Strategic Implementation Plan**: Once the activities have been listed out (i.e., what needs to be done), for a proper implementation it is necessary to spell out as to how would it be done, where would it be done, who would do it and when it is required to be undertaken e.g. orientation of field workers by PHC Medical Officers. Explaining the activity, task, subtask in towards achieving the effective output is the best design to follow. Fortunately, all medical officers of all districts of the country are trained today on management and skill development.

8) **Monitoring and Control of Operations**: This is a continuous process of observing, recording and reporting of various activities in order to measure the level of performance, identify deviations if any, and taking corrective measures.

9) **Evaluation**: Evaluation is in terms of what has been set forth to understand the level of achievement. Periodic and midterm reviews are part of it and this has to be done at different levels in the district. Ideally evaluation should include aspects such as performance, accessibility, coverage, community participation, intra and intersectoral coordination, and quality of services delivered, as well as costing exercises etc.

Check Your Progress 2

1) List out the merits of decentralised planning.

2) What are the various modes of planning?

3) The first step for planning is ....

21.4 DISTRICT HEALTH INFORMATION SYSTEM

By now it would have become clear to you that information is vital for the district level managers for working a situational analysis and eventually preparing a plan of action. Health information is thus a basic tool of management and a key input for bringing about an improvement in community health. It is defined as "*a mechanism for the collection, processing, analysis and transmission of information required for organising and operating health services, and also for research and training"*

The primary objective of a health information system is to provide reliable, relevant, up-to-date, adequate, timely and reasonably complete information for health managers at all levels and to assist planners in studying their current functioning, demand and workload.

21.4.1 Sources of Health Information

As already indicated in the earlier days of this unit, the district had a weak data system. Now the detailed information of the community, morbidity situation, action undertaken and adequate surveillance and monitoring is very pragmatically available even at the Primary Health centres. These centres are provided S, P and L report and send them to the higher-level weakly, timely, including **NIL** report. S is the sub centre report indicating "Suspect", P is the PHC report indicating "Presentive "and L is the Laboratory confirm report Accordingly the action at the district level with two-way report both Top Down and Bottom-Up process. These are all undertaken under IDSP (Integrated Disease Surveillance Programme). At all district level there is an IDSP Unit with computer, Data entry operator, statistician and trained epidemiologist internet and data transmission facility. The information is collected from domestic to heath infra structure level by trained field staff. All staff of the health system are well equipped on Health Information collection and dissemination. This system helped very well in controlling COVID 19 pandemic in India. You should request your skill development counsellor to make you visit and learn IDSP unit of the district.

Integrated Disease Surveillance Project (IDSP) was launched by Hon'ble Union Minister of Health & Family Welfare in November 2004 for a period up to March 2010. The project was restructured and extended up to March 2012. The project continues with domestic budget as Integrated Disease Surveillance Programme under NHM for all States with Budgetary allocation of 640 Cr.

A Central Surveillance Unit (CSU) at Delhi, State Surveillance Units (SSU) at all State/UT headquarters and District Surveillance Units (DSU) at all Districts in the country have been established.

Objectives:

- To strengthen/maintain decentralized laboratory based IT enabled disease surveillance system for epidemic prone diseases to monitor disease trends and to detect and respond to outbreaks in early rising phase through trained Rapid Response Team (RRTs)

Programme Components:

- Integration and decentralization of surveillance activities through establishment of surveillance units at Centre, State and District level.
- Human Resource Development – Training of State Surveillance Officers, District Surveillance Officers, Rapid Response Team and other Medical and Paramedical staff on principles of disease surveillance.
- Use of Information Communication Technology for collection, collation, compilation, analysis and dissemination of data.
- Strengthening of public health laboratories.
- Inter sectoral Co-ordination for zoonotic diseases

Data Management:

Under IDSP data is collected on epidemic prone diseases on weekly basis (Monday–Sunday). The information is collected on three specified reporting

formats, namely "S" (suspected cases), "P" (presumptive cases) and "L" (laboratory confirmed cases) filled by Health Workers, Clinicians and Laboratory staff respectively. The weekly data gives information on the disease trends and seasonality of diseases.

Whenever there is a rising trend of illnesses in any area, it is investigated by the Rapid Response Teams (RRT) to diagnose and control the outbreak. Data analysis and actions are being undertaken by respective State/District Surveillance Units. In the month of June 2016, about 94% Districts have reported weekly disease surveillance data from districts.

The various other sources of health information are briefly described below:

1) Census: The census is an important source of health information. The census is conducted in India at the end of first quarter of the first year in each decade. Census Commissioner and Registrar General of India directs, guides and operates the census. Without census data, it is not possible to obtain quantified I health, demographic and socio-economic indicators. However, district-wise figures take some time to be made available to district authorities.

2) Civil Registration System: Whereas census is an intermittent counting of population, registration of vital events (e.g. births, deaths) keeps a continuous check on demographic changes. Registration agencies vary from state to state e.g.,

   (i) health agency in Kerala and West Bengal,

   (ii) panchayat agency in Pradesh, Rajasthan, Bihar and Madhya Pradesh,

   (iii) Police agency in Haryana, Punjab, Madhya Pradesh, Jammu &Kashmir and Assam; and

   (iv) Revenue agency in Gujarat, Maharashtra, Andhra Pradesh, Karnataka and Tamil Nadu. The extent of under registration makes this system as not too reliable a system for district health managers.

3) Sample Registration System: Since civil registration system is deficient in India, being operationalised by the Registrar General, to provide reliable estimates of birth rate, death rate and infant mortality rate.

4) Survey of Causes of Death: The Registrar General of India also undertakes survey of causes of death.

5) Notification of Diseases: List of notifiable diseases vary with in the country, between the states and between urban and rural areas.

6) Hospital and Health Centre Records: The main drawback is that such records only constitute a tip of the iceberg. Such sources could be governmental as well as non-governmental.

7) Epidemiological Surveillance: As part of the national health progmmmes, surveillance system is often set-up (e.g., malaria) to report the occurrence of new cases and on efforts to control diseases (e.g. spraying done).

8) Survey Data: In India the Central Statistical Organisation (CSO) and National Sample Surveys Organisation (NSSO) conduct various surveys, which also include certain aspects related to health

21.4.2 Flow of Routine Health Information

The Government of India has set-up National Informatics Centre (NIC) to promote informatics culture in the government departments and to develop computer-based management information system for decision support at various levels. NIC has setup a nation-wide satellite-based computer communication network (NICNET)covering all the *districts,* state capitals and the centre, in order to facilitate the development *of* Distinct Information System (DISNIC) at district level and data base for the states and central government departments. A computer compatible version of Health Management Information System (HMIS) version 2.0) has been developed for implementation all over the country. This version consists of the data input in the district computer system as shown in the fig 21.2.

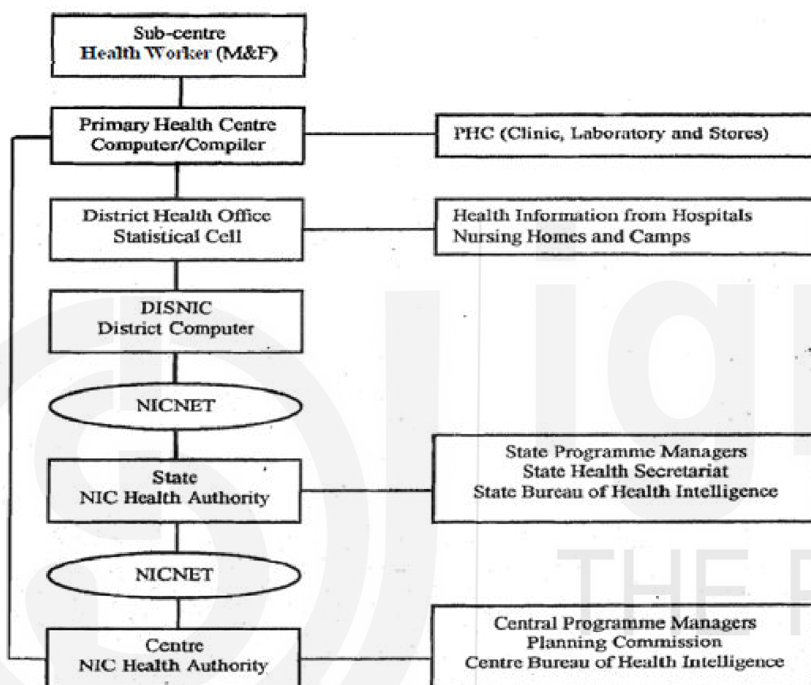


Fig.21.2 Information Flow in HMIS (Version 2.0)

Check Your Progress 3

1) Write True /False:

   a) Sample Registration System provides reliable estimates of birth, death and infant mortality rate. (T/F)

   b) District Computers are available at the CMO's Office. (T/F)

2) Write the fill form:

   a) NICNET..

   b) DISNIC..

   b) HIMS..

21.5 LET US SUM UP

In this unit you have learnt about the district health organisation with details about the organisational structure and functions of the district health office. It

would havebecome evident to you that district is the basic unit of administration in the country and how vital it is for the chief medical officer to play the role of a district level planner and a manager. You would have also got an insight into the procedure for developing a decentralised district health plan and the importance of a proper health information for the purpose. A district chief of health organisation (CMO) does not have to bank only on the programme sources of health information, but also on the non-programme sources.

21.6 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

1) Chief Medical Officer (CMO), Chief Medical and Health Officer (CMHO), District Medical and Health Officer (DMHO) or even Civil Surgeon.

2) a) F

   b) T

Check Your Progress 2

1) • It is realistic

   • There is participative commitment

   • Ensures better implementation

   • Involves meaningful utilisation of data collected

   • -Encourages creativity

2) i) Supply oriented

   ii) Strategically managed

   iii) Community centred

3) situational analysis.

Cheek Your Progress 3

1) a) True

   b) False

2) a) National Informatics Centre Network

   b) District Information System of National Informatics Centre

   c) Health Management Information System

21.7 FURTHER READINGS

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UNIT 22 REGIONALISATION OF HEALTH CARE

Structure

22.0 Objectives

22.1 Introduction

22.2 Concept and History of Regionalisation

22.3 Elements of Regionalisation

22.3.1 Structure

22.3.2 Demarcation of a Region

22.3.3 Hierarchy of Services

22.3.4 Primary Level

22.3.5 Secondary Level

22.3.6 Tertiary Level

22.4 Structuring of Authority and Responsibility

22.5 Disturbing Variables

22.6 The Regionalisation Process

22.6.1 Coordination within the Region

22.6.2 Monitoring

22.6.3 Basis of Regionalisation

22.6.4 Panchayat Raj

22.7 Let Us Sum Up

22.8 Answers to Check Your Progress

22.0 OBJECTIVES

After going through this unit, you should be able to:

- describe the concept of regionalisation;
- list the points in favour of demarcation of a region;
- describe the basis of hierarchy within the region;
- list the problems in implementation; and
- explain the overall benefits of regionalisation.

22.1 INTRODUCTION

In the earlier units of this block, you have learnt about health care delivery system in the country and also the district health organisation. In this unit you will learn about another concept of health *care* delivery system which aims at providing comprehensive health care services in a defined geographical area and this is known as regionalisation.

This unit will help you to understand the concept of regionalization as it applies to health care. It explains the basis and purpose of regionalization and also considers the other elements which have to be given weightage in regionalisation. The advantages and disadvantages of regionalisation have also been discussed briefly.

In this unit you will also learn about the basis of evolving of a region, the level of services provided within the region and also about the hierarchy of services necessary to ensure free flow-of information and services both up and down.

22.2 CONCEPT AND HISTORY OF REGIONALISATION

You must have studied in Geography that a country, a state or even a district may be divided into regions which are homogeneous areas. The same concept is applied to the provisions of health care. This process of regionalisation of health care in a region helps in assessing the requirements of health care in the region and then based on this a system is evolved, for providing the required health services considering the available resources too. It is of course necessary to exercise the greatest economy on the resources, as they are limited and should, therefore, be used optimally.

In the provision of healthcare, the district level is often taken as a region as it is administratively, functionally, structurally and geographically a distinct entity. Since Independence we have tried out many methods of bringing healthcare to the people who need it most and the three-tiered system of the Gram Panchayat, Taluk Panchayat (block level) and the Zilla Parishad has proved to be the best working system that has stood the test of tine so far.

You will also appreciate that vertical health programmes did not meet with the success which was expected over a period of time. This was because health is a matter which is closely linked with many other associated disciplines ordepartments. It is linked to food, water supply, forestry, environment, poverty removal, employment and so on. Many of these areas are handled by diverse departments. It has generally been found that the district is the region where all these departments and their activities interface. You must be knowing that the Zilla Parishad is the top tier of the Panchayat Raj Institutions (PRIs). This therefore forms a good homogeneous platform from which a region can be formed andcontrolled as all the lines of communication are established ones.

As a region, a district provides good scope for coordination and integration of services. This of course refers not only to health services but to all the allied services too. It is an established system and delivery of health care should also conform to these lives for effective, economical and successful implementation.

The concept of regionalisation of health care follows closely in the footsteps of the regionalisation process which took place in general administration. You must have heard the saying that India lives in its villages. This was true thousands of years ago and is true even today. The village Panchayat originally consisted of five members but that has been subject to change, in numbers, depending on the size of the village.

For a while after Independence there was a great deal of centralisation of power and therefore, all the decisions were taken at high levels. Plans were announced and implemented at the National level and at the State level. The implementation of many of these plans left much to be desired as the man in the village, the actual beneficiary was left out of the decision-making process. This realisation dawned on the planners when the expected results did not materialize out of so called well planned and well financed programmes. The basis for most of the early schemes on health planning as you how are the Health Survey and Development Committee Report (Bhore Committee) of 1946. The Community Development Programme was launched on 2nd October, 1952 and it was planned to set up a Primary Health Centre in every Community Development Block. The Mudaliar Committee in1961 recommended the reduction in the population covered by each PHC, among other things. In 1964 the Govt. of India reviewed the functioning of the PHC and strengthened the staff therein, while integrating Maternal and Child Health into the health services. Subsequently health care infrastructure was strengthened, based on the recommendations of various committees constituted from time to time and you have already learnt about this in the first unit of this block.

The first idea of local self-government was with the government resolution of Lord Rippon (1882). We have come a long way since then. Being a newly Independent country we have had to find the system which was most suitable to our setting and so, we have taken some time to establish this. As stated earlier, the concept of regionalisation of health care followed closely on the heels of regionalisation of the administrative machinery.

A change of Government in the centre in 1977 brought about a renewed interest in 'Panchayat Raj. However, it was only in1992 that the Constitution (73rd Amendment) Act, was enacted. This act envisages the establishment of panchayats as units of self-government. The gram panchayat was to be the foundation of the system and the three-tier system was built on this is the Gram Panchayat (GP), the Taluk (Block) Panchayat (TP), and the Zilla Parishad (ZP). The GP, TP and the ZP, constitute the backbone of the Panchayat Raj Institutions (PRIs) in the country.

You must have also seen how the concept of the Panchayat Raj is historical reality and how the concept of the Panchayat Raj and Panchayat Raj Institution (PRIs) has been brought back into the administrative machinery and working through the 73rd and 74th Amendments. The 73rd Amendment brought in the formalized concept of the Panchayats as units of self-administration and the 74th Amendment brought in the concept of working of the District Planning Committee (DPC). These two processes really formalized the understanding and the application of the concept of regionalisation with the district as the nodal point for the region. Since the panchayats and DPCs had elected representatives of the people, the schemes were user friendly. The DPC and the various panchayats within the district were to monitor the progress of the various schemes and programmes within their area of responsibility and health care were one of them. This has the distinct advantage of promoting coordination between the different departments which are involved in overlapping and mutually beneficial schemes.

So, over a period of almost 50 years, we have come to realise that the district is a strong and viable unit of decentralisation of the administrative system and also

the health care. It is at this level that there is an integration of services and also the coordination. The TP and GP are viable for local administration but lack the funds and resources for implementation of programmes with a larger perspective.Regionalisation then is a viable and positive step taken to fulfil the objectives that we had in various programmes that authorities have conceived for the benefit of the villagers. Regionalisation also makes the plans more implementable from the point of view of the health worker too.

It was envisaged that adequate powers and responsibilities would be devolved upon these panchayats at the appropriate level to enable them to prepare and implement schemes for economic development and social justice.

The gram sabha or the village council has been envisaged as the foundation of the Panchayat raj system. There shall be three tiers of panchayats at the village, intermediate and district levels. All seats are to be filled by direct elections from territorial constituencies, with the ratio between the population and the number of seats being the same throughout the panchayat area. SC/ST reservation in proportion to their population in the panchayat- women 1/3rd of the seats for a term of 5 years.

A new schedule called the Eleventh schedule comprising 29 items has been added. To provide an effective role to the PHs (Panchayat Raj Institutions) in the planning and implementation of works of local significance ranging from drinking water, agriculture, land and water conservation to communications, poverty alleviation programmes, family welfare, education, libraries, cultural activities etc.

Check Your Progress 1

Fill in the blanks:

a) The concept of regionalisation of health care closely follows the regionalization of ………………………………

b) The concept of regionalisation of health care and administration are based on the .... System.

c) The Panchayat raj system is a .... tier system, with the .... as the foundation and the .... as the intermediate level and the .... as the top level.

22.3 ELEMENTS OF REGIONALISATION

In this section you will learn about various elements of regionalisation, namely, structure, demarcation of a region and hierarchy.

22.3.1 Structure

The structure of regionalisation consists of three basic components:

i) the demarcation of a region;

ii) presence of a graded hierarchy of services; and

iii) ensuring coordination of services through an integrated authority system.

The structure should also ensure that there are no hindrances to the process and that the flow of information and services up and down the system is smooth and continuous. The elements of regionalisation are the levels and as mentioned earlier there are three levels and these are the GP, TP and the ZP in the region of the District, based on the information that was given in the previous section you now know the history and the concept of regionalisation and you will now be able to correlate that with the structure of a region. This will help you to get an overall view of the concept and the elements as they would appear in a region. The district has been chosen as the region as it is so in actual practice and you can relate the information given to your district where you live and work and this will help you to understand the concept and the structure better. You will be able to conceptualise the principle of regionalisation of health care better if you relate it to the district that you know while going through the unit.

22.3.2 Demarcation of a Region

This is the first step and should be a very carefully thought out and weighted decision. Each area should be capable of a level of autonomy both in resources and personnel. There should also be a homogeneity in the region.

Demarcation of the region could be done by time tested criteria of geography, economy, culture, ecology, and being a nodal centre. Since we are considering a district as a region for the purpose of delivery of health care and also for administrative purposes, most often the demarcation has already been done and generally the demarcation conforms to one or more of the principles enunciated above. However, in recent times there have been times when political considerations have been overriding in the formation of a district. These are generally the exceptions and are bound to create problems.

Most of the older and geographically determined districts have an inherent homogeneity and are culturally and economically uniform too. In these districts and regions it is easy to implement a new programme once the local population has been taken into confidence. The cultural and ecological homogeneity makes for easier implementation. Such regions are also capable of functioning in a self-contained way.

Some regions are nodal regions i.e. it is based on the headquarters being a communication centre and thereby the region around grows under its influence. This generally happens when the district is built around a large city or large commercial centre and all the surrounding area are dependent on and subsidiary to the centre. Such centres and regions often produce a lot of employment and facilitate establishment of high-tech centres for medical and health care too.

Where a region does not conform to the above-mentioned characteristics the region could be considered as a planning artifact which has been created to meet certain other needs. However, it has been found that even such dissimilar regions when brought under a uniform authority tend to become homogeneous over a period of time.

A region should be large enough to be self-sufficient in providing a broad range of services. Besides the size the population also is an important determining factor in provision of health facilities. Provision of highly specialised services

require a population base for establishment. For example, it is generally believed that for establishment of neurosurgery or open-heart surgery a population of one million is the minimum per unit. This could then be established only in the third tier of the system that is at the district headquarter hospital if such a requirement is visualised.

Transportation is another important determining factor in establishment of medical and health care services. Travel time has become a more accurate measure than distance in kilometers, as it takes into account of state of available transport and road conditions in addition to the distance itself. Then is the index to be used when expansion of health care facilities in a region are contemplated.

Demarcation of the region is fundamental to the success of the region as an administrative unit. Each region should have a degree of autonomy both in resources and in personnel. This happens automatically when the district or region is carefully planned. Most of the districts have also a certain homogeneity which is also essential for the smooth functioning of the machinery. A district headquarter is the hub of activity and hence there should be a smooth flow of information and resources out from it and of information and patients and patient related activity to it. Culturally and economically too there is this homogeneity in a district. However, in newly formed districts which have been created for political or economic reasons this homogeneity takes considerable time and efforts to develop. Most district headquarters are geographically homogenous too, this makes for ease of transportation and interaction between the functionaries at different levels. Some district headquarters are demarcated because they are nodal centres, this also makes sense as they have come up as commercial or communication centres and so they automatically assume the function of being in the hub or centre of the region. The broad principle of primary care at the village level and secondary care at the taluk or panchayat level and tertiary care at the district hospital level is a smooth and time tested system which works well.

Population and transport facilities within the region also need to be studied carefully before the demarcation of a new district is made.

Check Your Progress 2

1) List the criteria for demarcation of a region?

2) Name the factors which are essential for a region to be self-contained

22.3.3 Hierarchy of Services

Now, you will learn about the hierarchy of services. Once regionalization has been decided upon, it is essential that the region functions as a cohesive and coordinated unit. This implies that information and services and statistics should flow smoothlyup and down within the region. By up and down we mean that it should follow the natural flow of administrative channels. In any administrative set-up there is always a hierarchy. The dictionary defines the word hierarchy as 'A body classified in successively subordinate grades". In our application it means the step ladder type of levels that we have established in the system for optimal function.

You have already learnt about the three-tier system of structure in Health Care. This consists of the Primary Health Centre (PHC); Community Health Centre

(CHC) and the District Hospital. These three levels roughly coincide with the three administrative levels of control, the Gram Panchayat (GP), the Taluk Panchayat (TP) and the Zilla Parishad (ZP). The PHC being population based may not coincide with every village level, however the other levels would coincide. The level of care provided at these three levels are known as primary, secondary and tertiary.

Location Level	**Administrative Level**	**Health Care Level**	**Type of Health Care**
District Headquarters	Zilla Parishad	District Hospital	Tertiary
Taluk/Block Headquarters	Taluka Panchayat or Panchayat Samiti	Community Health centre	Secondary
Village	Gram Panchayat	Primary Health Centre/Subcentre	Primary

The above table explains the hierarchical system in health care. It may however be subject to minor modifications depending upon geographical, topographical andcommunication line locations. The administrative levels are based on the Karnataka model which has shown a good degree of success The hierarchical system whether in health care or in administration are generally based on population figures. Population is the overriding deciding factor as it determines the resources available and the type of services that could and need to be provided. Complex, costly and infrequently used facilities should be made available at a place where the catchment area is large and where the facilities would be adequately utilised. For example, complex surgeries and investigative facilities would be better utilised at the tertiary level hospital in the District Headquarters. Quite often this may be associated with a medical college too which would enhance the provision and utilization of these facilities.

In any large organisation it is necessary to lay down a hierarchy of services. You have learnt about the hierarchy of services as it exists in health care at district level, panchayat level and at the level of the village. You have also learnt of the three tiered system of the District Hospital, the Community Health Centre and the Primary Health Centre, and how these three levels are complimentary to each other. Cooperation and coordination between these three levels is essential and integral to the success of the entire process and will also ensure smooth and uninterrupted flowof information up and down the three levels. This will help to coordinate flow of patients for referral from the PHC to CHC and then on to the District Hospital if necessary and then back to his village with the necessary follow up notes. You have also learnt how the structuring of authority and responsibility takes place between these levels. You have also touched upon the type of differences that could arise insuch a system if total cooperation and coordination is not present between the different levels and if the person at the helm of affairs does not have the necessary authority, or if this has been delegated to persons who are unable to implement them.

You will agree to that health care administrative set up closely follows that of thedistrict hierarchy itself. The District Medical Officer or the District Health

Officer is located in the headquarters where the District Collector or Commissioner is also located. This hierarchical ladder goes right down to the village level where the functionaries are at the same level too. The care afforded to the patient is also in thesame hierarchical pattern depending on the facilities available. Tertiary care being available at higher levels, secondary care is provided at the CHC and primary care at the village level in the PHC.

22.3.4 Primary Level

These services generally constitute the first contact of a patient with the health care facility and organisation. The PHC and the Sub Centres (SCs) cater to the needs ofthe villagers and need to be given due attention. They should be adequately staffed and also properly equipped to carry out the necessary function. It is planned to give the three tiers greater autonomy in order that their functioning is not interfered with in any way.

You would be visiting a Primary Health Centre **as** a part of practical activities. You should take this as an opportunity to see for yourself the working of the PHC and make an assessment of level of regionalisation.

Health programme management at a micro level is done by the Gram Panchayat. Are the members of the GP capable of this? Health programmes have to be managed judiciously and with care. At times GPs are staffed by illiterates, neo literates or even first-time-ever-office bearers and this often causes a bit of stagnation in the process and lack of progress. You should be able to assess this andif you think that this requires to be rectified then you should suggest corrective steps. Do you think that the members of the GPs should go through some sort of training? Should they be introduced to the health programmes and the functioning of the PRI (Panchayat Raj Institutions)? These questions need to be answered by you in your assessment of the programme.

22.3.5 Secondary Level

Here we are dealing with the Taluk Panchayat as it is called in Karnataka and in many other states, it is also referred to as the Panchayat Samiti in some states. This is the middle level and generally the medical facility available here is the Community Health Centre of the Community Hospital. The effect of the concept of Regionalisation of health could be felt here. There should be enough staff and equipment here for the patient to receive secondary level of treatment. If this centre or hospita is well equipped and staffed it would take the load off the district hospital. At present due to poor staffing and equipment often it is seen that the patient goes from the PHC directly to the District Hospital and thereby puts a strain on the system of tertiary care which that centre is meant to provide.

22.3.6 Tertiary Level

The tertiary level services are provided at the tertiary level hospital, that is the District Hospital. Here there is a concentration of the more specialised services like sophisticated laboratory and investigative facilities, here there are better facilities for treatment too. More complicated and high-tech operations and treatment of a higherorder is offered. This is the apex of the pyramid of regional

care as has been earlier started. Cases are referred from the Primary Health Centre at the village level to the Community Health Centre at the block of Taluk level and then from there, the more complicated cases are referred to the District Hospital.

Manning of these centres by technical personnel is also dependent on the level of technical expertise expected of them. In the concept of regionalisation it will be seen that the more highly trained manpower is required at the tertiary level and medium trained persons at the middle level and basic training are imparted to the personnel at the primary level. This is true of all technical manpower. Doctors also follow the same pattern, an MBBS doctor in the PHC and possibly a new post graduate at the CHC and an experienced post graduate with higher specialisation at the District Hospital. This fits in with the overall concept of regionalization as you have understood it too.

Check Your Progress 3

1) What do you understand by the term hierarchy?.

2) What are three levels of Health care facilities within a District?

3) Where would you expect the highest level of care, and where would you expect, the most modest type of care within district?

22.4 STRUCTURING OF AUTHORITY AND RESPONSIBILITY

In the previous sections of this unit, you have learnt of the three-tier system of health care division and how this works. It works well because it is structured in lines with the administrative set-up. If these PRIs (Panchayat Raj Institutions) are to work, then there should be a smooth structure in their authority and responsibility.Empowerment of the PRIs will hasten the decentralisation or the regionalisation process. You must have heard of decentralisation which is basically another term for regionalisation.

The concept of decentralisation or regionalisation implies delegating authority and responsibility from the central (National level) to the regional level. Within a region there is again delegation of responsibility and authority to the local level to the extent possible. The region is seen as the logical and desirable level for the planning and administration of health services.

“Midway between the local level-where highly technical problems cannot be solved, and the national level-where sometimes a theoretical equilibrium is sought-the region is the platform on which the public health plan can be fashioned, far enough from local contingencies to regard them with detachment, but near enough to appreciate their importance; far enough from the central authorities for objectivity, but near enough to influence them.”

You will realise from the above that while control of the region is exercised from the centre of the region, in our case the District Headquarter, there has to be a sense of participation from the local level. The largest user of the services is the

man at the local level and therefore it is imperative that he or his representative take part inthe decision-making process in so far as it deals with the local level of the region. This is where the gram panchayat as elected representatives come into play and have a say in the type of care that is provided. This of course would depend on the finances that are available. All this has to be planned at the district level. It is in this process of empowerment of the PRIs that the 74th Constitutional Amendment was passed.

Constitution for the District Planning Committee (DPC)

In accordance with the provisions of the 74th Constitutional Amendment, a District Planning Committee is envisaged in each District to prepare and consolidate the plans prepared by the Panchayats and the municipalities in the district and to generate a draft development plan for the district as a whole. While preparing the district plan, the DPC is expected to note the locational aspect of project, care for integrated development of infrastructure and environmental conservation and evolve criteria for sharing of the natural and financial resources. However, the composition of the DPC has been left to the discretion of the state, but it has been stipulated that 80% of the members shall be those elected to panchayats and municipalities.

22.5 DISTURBING VARIABLES

Regionalisation has not always been easy to implement. There have been instanceswhere a "well planned" system has gone away because the so *called* "well planned" system was not actually well planned. There have been instances where for lack of involvement of the right persons the scheme has failed. When you try to study the working in your PHC, TP and ZP, you should also see how the scheme is working and whether there are hindrances.

A few bureaucratic hurdles that were encountered in one district where one NW had decided to try and implement the scheme of regionalisation on a small scale. These are only examples and there could tie many more such bottlenecks.

There could be many more such factors and they could differ place to place. It would not be possible to list them all. They have to be looked for and tackled on a day-today basis. You must look for these in your PHC, TP, ZP. It has quite often been seen that projects fail, not due to lack of funds as is commonly thought, but due to bad planning and poor implementation and also lack of involvement of the grass-root level workers and beneficiaries.

Well documented schemes which failed listed some of the reasons as below:

a) The State authorities did not feel it necessary to be involved in a district scheme which was being planned by an NGO.

b) District Health officers who were to oversee the working of the scheme were transferred frequently.

c) Panchayat members were not involved and the state authorities had expressed a degree of caution by noting that "Elected members vary in caliber and attitudes, Consult the District Health Officer before involving them". This

sort of negative suggestion with a frequently transferred District Health officer, left the whole programme without an impetus.

d) Dynamic leadership was lacking as *seen* by the fact that *even* when workshops were held and suggestions made they were not implemented for very trivialbureaucratic reasons. Repairs to vehicles were not carried out though funds were available, but the procedure for releasing funds was long. Contingency funds were not give to the PHC. Drugs available in the stores did not reach the sub-centre.

e) Passing of bills related to travel expenditure was delegated to the Taluk officersbut most of these posts were vacant and hence these bills remained unpassed.

Implementation of any programme or concept always needs careful planning and motivated and dedicated personnel. It is necessary that time should be spent onfamiliarising worker at all the three levels on the benefit of regionalization and to explain how this system works to the benefit of all levels.

Problems crop up in the system when functionaries at different levels are not sure of their duties or assume duties of other levels.

Problems can occur in the smooth flow of patients from the PHC to the CHC and then on to the District Hospital. This should be looked into and any obstacles cleared, like transport, staffing (drivers) and so on. For this purpose, you need to check what happens to the patient when he is discharged from the District Hospital,Does he come back in an organized manner? Does he have notes for the PHC doctor on the follow up of his clinical condition? All these are to be built into the system or regionalisation if it to succeed.

Assigning of responsibilities in implementation of the National programme at the grass root level also causes problems. All these need to be looked into. A common sense approach with an open mind generally yields simple and practical solutions to most of these problems of implementation. It is also best to involve thefunctionaries affected in the decision-making process or at least to consult him/her before a final decision is taken, otherwise some simple hurdles are missed out when these are discussed in higher levels. Taking decision making to the periphery and to the concerned person, pays great dividends. In fact, this itself is the basis for regionalisation.

22.6 THE REGIONALISATION PROCESS

The process of regionalisation has been introduced to effect better efficiency in the system and if this has to work as planned, then there should be a free flow of information and of patients within the region. This includes referral of patients fromthe periphery to the centre that is from the PHC to the CHC and then on to the District Hospital. After the necessary treatment these patients should be able to go back to their villages with the necessary feedback and follow up of the treatment.

22.6.1 Coordination within the Region

For the regionalisation or decentralisation process to be successful, it is necessary that there should be cooperation between all the levels of the three-tiered system

and its agencies. The district level is the most crucial in the chain of command of the various departments of the district. This is so for the Public Health Department and also, for the affiliated departments which are concerned with the general welfare of the people of the district and the taluks and the villages. Coordination does not take place spontaneously. It will also not take place if the process of coordination is left to one of the agencies involved. "There has to be a carefully designed administrative structure which will oversee the function of coordinating the variousdepartments and particularly the large areas where there is an overlap of the functions of these departments, so that the common man may benefit the maximum through optimal utilisation of resources. The coordination mechanisms itself will entail costs. However, these will be offset by improved functioning and eliminating duplication of effort and resources."

22.6.2 Monitoring

Any system which involves the participation and the cooperation of three different levels of functionaries and also keeping open channels of communication between all these levels should also be carefully monitored so that mid-stream correctionscan be applied so that the scheme has the right impact on the people who are to be the beneficiaries, that is the last villager should feel the impact of the scheme. Monitoring is better done by an agent independent of the functioning of the scheme itself as otherwise there is a tendency for bias in the interpretation of the results, distribution of resources, funds etc.

22.6.3 Basis of Regionalisation

You also learnt that the district serves very well as the nodal centre for the regionalisation process. It occupies a central place in the three-tiered system from both sides. It is at the bottom of the three-tiered system when you consider the three tiers of the Centre, State and District. It is at the top of the regionalisation three tiers, that is the District, the Taluk and the Village. This unique feature gives theconcept of regionalisation and has various advantages. Principal among these is the fact that the ntire governmental administrative machinery too is district based. It is ideal, therefore, that the health care machinery too follow the same system. This makes coordination between the various departments which are closely associated with health care, like food, water supply, environment, poverty removal and so on smooth and easy.

22.6.4 Panchayat Raj

We have also seen how the concept of the Panchayat Raj is historical reality and how the concept of the Panchayat Raj and Panchayat Raj Institutions (PRIs) has been brought back into the administrative machinery and working through the 73rd Iand74th Amendments. The 73rd Amendment brought in the formalised concept ofthe Panchayats as units of self-administration and the 74th Amendment brought in the concept of the working of the District Planning Committee. These two processes really formalised the understanding and the application of the concept of regionalization with the district as the nodal point for the region. Since the panchayats and DPCs had elected representatives of the people, the schemes were user friendly. The DPC and the various panchayats within the district were to monitor the progress of the various schemes and programmes within their area of responsibility and health care were one of them. This has the

distinct advantage of promoting coordination between the different departments which are involved in overlapping and mutually beneficial schemes.

It has been amply demonstrated that a well organised and coordinated three tiered hierarchy of the Zilla Parishad and the Panchayat Samiti and the Village Panchayat and their corresponding Panchayat Raj Institutions of District Hospitals, CommunityHealth Centres and the Primary Health Centres, are currently the best institutions for providing health care at the various levels. This concept and practice of regionalisation has been seen to work well and smoothly where there is good coordination at all levels and between the functionaries of the different levels. Since elected bodies are involved in their implementation, it ensures involvement of the beneficiaries through their elected representatives too. The process of regionalisation of Health Care which closely follows the regionalisation of administrative machinery is therefore a successful step towards the provision of health care.

22.7 LET US SUM UP

In this unit you have learnt about the concept and process of regionalisation. The concept came up when it was realised that concentrating all the administrative, financial and such other powers in the centre and taking all the decisions there, didnot take into account the needs and felt needs of the last beneficiaries that is the villagers for whom the health care activities were meant.

You have also learnt about the basis of evolving of a region, the level of services provided within the region and also about the hierarchy of services within the region. Further you learnt that district serves a nodal point for the regionalisationprocess and it occupies a central place in the three-tiered system from both sides. Subsequently you learnt how the concept of panchayat raj and panchayati raj institutions (PRTs) have brought back into administrative machinery and working through 73d and 74th amendments.

Towards the end you learnt about the problems/disturbing variables in implementation of the regionalisation process as well as the monitoring and coordination within the region.

22.8 ANSWERS TO CHECK YOUR PROGRESS

Check Your Progress 1

a) general administration.

b) Panchayati Raj

c) three, *Gram* Panchayat, Taluka Panchayat, Zila Parishad

Check Your Progress 2

1. Geography,
   - economy,
   - ecology,

- culture, and
- nodal centre

2. cultural homogeneity

- ecological homogeneity

Check Your Progress 3

1) The dictionary defines this world hierarchy as "a body classified in successively subordinate grades." In our application it means the step ladder type of levels that we have established in the system for optimal function.

2) Primary level-PHCs and Sub-centres

   Secondary level-CHCs

   Tertiary level-District Hospital

3) Highest level of care is available at district hospital.

   Most modest type of care is available at PHCs and Sub-centres.

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