

NRHM- The blue print for India's Goal of "Health for All "

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Introduction: In the 30th. World Health Assembly held in May 1977, it was decided that the main social goal of Governments and WHO in the coming years should be attainment by all people in the world by 2000AD a level of Health that would permit them to lead a socially and economically productive life. This came to be popularly known as "Health for All by 2000 AD." From the public health point it was appropriate as it set the direction for the development a health care service for the benefit of poor as well as rich nation by utilizing the resource most cost effectively. Health service based on the assumption that merely providing services for repairing of an impaired body of a diseased can never be the remedy to improve the health condition in any country. In later part of 20th Century it was becoming clear that poor living conditions in a degrading environment, illiteracy, poverty, inability to take decision regarding ones health are the major impediments to health. And the realization that without addressing the above if we go ahead with the "stand alone repair oriented health service model without simultaneous improvement in social, economic and environmental condition we cannot come out of the existing disease and socio economic cycle. This was basic logic for adopting a momentous decision. It was not aimed to make a disease free society but to make the people healthy enough to do their routine business. It has a positive connotation to achieve health. It suggested that the health service of each country should try to achieve by linking health with other social and economic development services with greater intersectoral coordination and effective community participation. One must also realize that all development services in any country aim to maximize the welfare of its citizen. India is a signatory of the above declaration.

Health services in Post Independent India: It is heartening to know that India's post independence health service development is based on a blue print i.e. "Bhore Committees Report" which emphasized on "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 and an intersectoral approach to health service development". The service model suggested was "three tier regionalized graded referral service with emphasis on providing a mix of preventive, promotive and curative services". As a follow up in 1952 India initiated its first community development program. Health service constituted one of the core components of the integrated package of service along with agriculture, Veterinary & Animal husbandry and other services. Since then through different plan period India's health services progressed to develop the country wide network along with tackling two great acute problem population explosion and different epidemic diseases. The progress may not be spectacular but over the years different National health programs reduced the communicable disease mortality substantially and one of the epidemic "Small Pox" was eradicated.

ICDS- A water shed in Health care Delivery Strategy: Second October 1975 is another momentous day in India's public Health history when Integrated Child Development Program was started by the Social Welfare department under HRD ministry. The active participation of health department was a glowing example of intersectoral approach. The program can be called as the forerunner of "Primary Health Care Strategy". This program was responsible for the paradigm shift of the health service planning. The life cycle approach in addressing the health status was utilized in conceptualizing a Health program. This program also brought forward the concept of Integrating packages of services which addressed primary health requirement (health education, immunization, Care of sick child) and health determinant issues (viz. nutrition, preschool training , sanitation and water supply) and delivered it at the door step of the community through "Anganwadi" , with active community participation and Intersectoral co ordination. It was also for the first time made it possible to bring the medical Academia participates in the process of actual health care delivery. This was also the period when Health system and community based research was institutionalized. The success of the program is well documented and the national as well as International peers applauded the success of the program. Taking cue of the success of ICDS several other programs addressing either imminent service or morbidity needs were launched. They are Universal Immunization

program, ARI control program, Diarrheal disease Control Program. Introduction of CSSM program was the initial step of integrating service packages on the basis of life cycle approach. Later the introduction of RCH program culminated the process of “Integrated life cycle approach” in service delivery. The full range of promotive, preventive and curative services including contraception to space births and limiting the size of the family, services addressing morbidities like RTI,/STI and HIV/AIDS and specific services for mother, child and also adolescent was integrated. In later period “Integrated Management of Neo Natal and Childhood Illness (IMNCI) 1 and 2 was also integrated to address the Neo natal and Child hood diseases was also added to make it complete. There was also a paradigm shift of service policy. For the first time the health department was relieved of the dreaded word “Target”. Target free approach was introduced in the planning. The planning process was reverted and a “bottom down Community need based” planning was introduced. The process of decentralization in planning and training and funding was initiated. For enhancing the community participation the institution of “Panchyati Raj” was given prime importance in planning, and implementation of health program. Continuous fund flow was one of the impediments of the program was addressed through formation of “State Committee on Voluntary Action” (SCOVA). This helped in quick release of fund for RCH activities. Funding was linked to performance. I.e. Perform an activity or achieve work completion and get the money or fund. RCH I was monitored and strengths and weakness of the program was reviewed and RCH II program was launched. RCH II was based formulated to address the goals of “Millennium Development (MDG)”, “Indian Xth National Development Plan” and” immediate and midterm goals of National Population policy (NPP) of 2000”.

NRHM the flagship program: The culmination of all the above integration of different health and health related package and the successive paradigm shifts in health policy, planning and approach to health care delivery was the launching of **National Rural Health Mission (NRHM) 2005-12**. NRHM is the first Health program in a “Mission Mode” to improve the health status of people of India. The programs aim is to address the health needs of the community according to the current public health knowledge and practices. It speaks of a comprehensive package of services viz. promotive, preventive, curative and rehabilitative service to be delivered to the community through a process of Intersectoral co ordination with other service departments and active community participation. It speaks of convergence of health and health related services addressing the needs of the Social determinants of health and delivery of the same package with the active participation of Panchyat Raj Institution for its sustainability. Health for the first time is seen as a component of development package. The program is going on well and the recent report by the expert committee is also encouraging. The Indian Academy of Public Health, has conducted a desk evaluation of the existing NRHM program with the objective to find out the strengths and weakness of the program..

Critical Analysis of the document:

A. Preamble:

- In its opening sentence the preamble of the mission document emphasizes the importance of health in the process of Social & economic development of the country and the mission aims to improve the quality of life. It is heartening to note that the mission envisages a goal which belongs to the core concept of public health. The goal of the mission is clearly defined and it is to improve the availability and accessibility of quality health services and the equity component is logically emphasized for the most vulnerable section i.e. for those residing in rural areas, the poor, women and children. The “**synergistic approach**” relating health to determinants of good health viz. segments of nutrition, sanitation, hygiene and safe drinking water is one of the major conceptual shifts in contemporary Health planning in India.
- **Comments:** The preamble speaks of improving the availability and accessibility of quality health service and about equity. The preamble do not mention one important element that is utilization. In a country like ours any public health person with some field experience would vouch that utilization of available health services is one of the major impediment in the successful implementation of any health program.

- But our apprehension of deliberate omission of “utilization” is correct as the determinants of good health in the preamble don’t include two other important determinants viz. (Education) literacy and economic status. In public health parlance some determinants have direct effect on health which is visible but there are some which have indirect effect but are the principle determinants affecting health. Literacy (not health education per se) and earning capacity of an individual are of this category. Utilization of health services mostly depends on these two important health determinants. Moreover to address these two determinants there are many effective programs under different ministry which could have been dovetailed with the program and this could have addressed the issue of utilization. The midterm evaluation should contain the output indicators to ascertain the utilization so that the point can be addressed scientifically through mid course correction if necessary. In the preamble the term “Good Health” seems to be out of place as it is not used in public health & it needs to be defined.

B. State of Public Health, Vision/ Mission, and Goals & Strategy:

- **State of Public Health:** It contains all the relevant information sans the status of the determinants of health and the current programs being implemented by various departments which are referred to in the preamble. The description of the state of public health in the mission document reflects the poor resource allocation both by the central and state agencies. And the mission document articulates the commitment of the government to rise the public spending on Health from 0-9% of GDP to 2-3% GDP. It is one of the most coveted policy decisions.
- **Comments:** The National health Policy 2002 in order to achieve equity sets out an allocation pattern of 55% of total public health investment for primary, 35% for secondary and 10% for tertiary health sector (1) The commitment does not specify the proportion to be allocated to the primary, secondary and tertiary sector of health services. As such it would be difficult to analyze the effect on equity later. The figures would have helped us in comparing our achievements at the end of the mission period against the amount allocated. Till date the emphasis of the service delivery was on program mode which hampered the growth of comprehensive health services in the country even in well performing states. The mission statement also rightly addresses the striking regional inequalities and the demographic challenge of population stabilization by seeking to provide effective health care to rural population throughout the country with special focus to 18 states which have weak public health indicators and/or weak infrastructure. This is according to the public health dictum something for all but more for those who are in need.
- As per the state of public health statement of the document an average Indian spends a substantial amount (58%) of his total annual income for his hospital treatment. 40% of hospitalized Indians borrow or sell assets to cover hospital expenses. But the most important figure which needs immediate attention is that **“25% of hospitalized Indians fall below poverty line because of hospital expenses”**.
- **Comments:** As we are all aware of Government of India’s most publicized Poverty alleviation programs which are implemented in all the states. Why these programs cannot be suitably converged to break the poverty and disease cycle? At present the poverty alleviation program is covering those who have already reached the status of below poverty line. It is always better to have a preventive program for a situation like poverty, or else the condition may increase the need for costly health service by increasing the disease burden. Health Insurance scheme may be linked with the poverty alleviation/ income generating programs under different ministry. The mechanism of convergence at the district level may be the beginning. But a positive impact can only be achieved if the required service packages reach the needy family at the right time. Introducing health insurance for the rural population is a revolutionary step in health care financing in a country like India. But to introduce such

system one should be very careful as in the present condition it would be difficult to monitor the misuse of such insurance scheme when the proposed provider also includes private institutions. Two fundamental requirements for effective implementation of such scheme are standardization of treatment protocol for common morbidity and its cost and the other component is establishment of a strong regulatory body to control the exploitation both by the client and the provider like TRAI. Probably the authority is developing such packages.

- **The Vision/ Mission:** The key element in the “vision” chapter is the “architectural correction of health system”. The key components defined are the induction of a Female Health Activist “ASHA”, and involvement of Health & sanitation committee for the preparation of a village health plan under the supervision of the Panchyat Raj system, integration of all vertical health programs and also strengthening rural hospitals as per IPHS. It is also envisaged that the above will lead to optimal utilization of funds and infrastructure and strengthen the delivery of primary health care. It is also to be noted that emphasis is also given on effective integration of health concerns with determinants like sanitation & hygiene, nutrition and safe drinking water through a District Plan for health. It clearly indicates that the NRHM seeks to improve “access of rural people, especially poor women and children to equitable, affordable, accountable and effective primary health care.” The mission also includes “**integration of organizational structures, optimization of health manpower, decentralization and district management of health programs, community participation and ownership of assets**”.
- **Comments:** These are the core health service reforms issue but the million dollar question is how to make these statements a reality. We shall examine the same in the Strategy and plan of action section.
- **The Goals:** The “Goals” defined are of two categories one belongs to the outcome / impact they are IMR, MMR, Mortality & morbidity of communicable & non communicable disease, (prevention & control of communicable & non communicable ...), population stabilization with a gender and demographic balance. The other categories relate to service delivery goals. It includes both quantitative & qualitative component. The quantitative service components are “universal access to public health services” & “access to **integrated comprehensive primary health care**”. The qualitative components are “promotion of healthy life style,” & revitalization of “local health traditions and mainstream Ayush”.
- **Strategy:** The strategy adopted to achieve the integration of the existing vertical health program and convergence of standalone programs addressing the different social health determinants as stated in its strategy is “ **to train and enhance capacity of Panchyat Taj Institution (PRI) & to enhance the capacity of PRI to own control and manage public health services, promote access to health care by introducing a Accredited Social Health activist(ASHA), to prepare and implement an intersectoral health plan prepared by the District Health Mission, including Drinking water, sanitation & hygiene and nutrition and to integrate vertical health and family welfare program at National, State, District and Block level.**” For a program of this magnitude one anticipates on the strategy of effective convergence of services under different departments and its delivery strategy to deliver the right package to the right beneficiaries, in the right time. Besides the decentralized planning, improving management skill for better program management and an assurance of technical support we don’t observe any conceptual change of strategy formulation. The strategy seems to be too simplistic and traditional, based on the principles of good governance/ management of program.
- **Comments:** “In formulating a strategy the steps to be carried are review of the relevant epidemiology and potentially effective intervention is usually required, with reference to the current position.” (Charles Guest pn. 556 Oxford text book). From the epidemiological point of view the current health problems affecting the community in general are already existing

health problems like communicable disease, poor nutrition along with specific health problems of physiologically vulnerable group like Mother & Child, emerging and re emerging infectious & chronic diseases emergency health problem, like accidents natural disasters. The determinants of the current health condition are prevailing demographic status, environmental condition, social, educational and economic condition, evolving life style and behavioural changes and the availability & utilization of effective health services. The interventions available for the above are of two types one is the personalized care services and the other is the public services. The personalized care services are provided to an individual. It may be promotive, preventive, curative and rehabilitative. This may be a patient or a beneficiary under any program. Besides medical care for acute and chronic diseases, the types of service provided through most of our health & welfare program are of this nature. The other service group is the public health services that address the different social determinants of health, which are being delivered under different ministries with different service delivery strategy. The public health services are water sanitation, education, income generation poverty elevation programs for a better access to nutrition, and treatment, housing etc. These services are public services and are generally delivered at the “family/community level and not individual level”. The service delivery strategy in the two types of services is different. Effective delivery of personalized services can only be achieved if we can reach all individual who are in need i.e. diseased or beneficiaries assess their health needs by examination and provide them the package and ensure compliance. It includes three “C”s case finding, case holding & compliance. The approaches vary according to the status of health consciousness of the community and the capability of service provider both first contact and support providers. Though it is termed as personalized service aimed at individual level but success depends on the family and communities perception. For effective delivery of public services the strategy is convergence of required services and to deliver it to the family or community at need at the appropriate time.

- It can be better appreciated with the following example. A family of four husband wife and two children under six. The head of the family is an illiterate daily wage earner and is land less in BPL category. His wife is pregnant and one of the child is severely malnourished, the elder one is suffering from chronic respiratory infection and the father is diagnosed as a case of Pul TB. This is not a hypothetical case these are the type we encounter in slums, peri-urban and peri industrial area. There are existing government programs for addressing all the condition present in the above family but unfortunately our strategy of service delivery is so inadequate that it does not reach this vulnerable section. The worst thing is that the children are enlisted in the nearby AWC and are receiving the supplementary nutrition. So it is not the question of case finding. If the synergy was there between the AWW and FHW it would have been definitely possible to enrol the mother and even the father suffering from TB. In some parts of the country it might have happened if health and welfare services are working at tandem. But to bring out the family of the so called “disease and poverty cycle” as described in the document the above steps are not sufficient. Here the strategy of convergence of other programs addressing the social determinants is of prime importance. As he is a BPL he is entitled to get the benefit of other existing services of income generating, poverty alleviation, food subsidy and rural housing. But unfortunately our services delivery system is so much fragmented with their individual delivery strategy that effective convergence is a pipe dream. If the said person is directed to avail the existing services which are available at different centres probably he will waste two to three months travelling through the intricacies of procedure laid down by each department which may also be sometimes contradictory for different program and ultimately without any result.
- If one realizes the situation he will be pragmatic enough that such services if are to be effectively and efficiently delivered must have a common objective and have the common objective criteria for selection of beneficiaries and should be provided through a “Single Window”. The beneficiary finding procedure should be event related like specific disease, nutritional status, pregnancy, and victims of natural and manmade disaster, condition, socially and economically deprived person. Even in those cases if we prioritize the families

with disease malnutrition and other health condition the effect will be dramatic and the utilization of services will improve as the credibility of the services will be felt by the people. The other requirement for such delivery strategy will be a single community level registration system of all the families for any services to be provided. At present there are as many family registers are available for as many service program and each has its own deficiency and inadequacy. With the universalization of AWC for each 1000 population let us make the AW registers as the base registers for all services after verification of the local registration authority. This will reduce duplication as well as inadequacy of our primary data source.

B. Comments on Plan of Action:

The mission document is really to be appreciated as it translates into action all that was mentioned in the National Health Policy as well as the commitment to the WHO to shape the Health care Delivery with the Primary Health care approach. The National Health policy 2002 under its head Inter-sect oral Coordination states that “The state should also try to bring in effective linkages with other social sectors like education, water supply, sanitation and Nutrition which are also contributory factors to improving general Health status of the community. Convergence of socially relevant programs of these sectors with the health sector would bring in greater effectiveness in implementation”

- But it is really intriguing to observe that an ongoing effective health related program “Integrated Child Development Scheme (ICDS)” under the Social welfare department of HRD ministry is not included for linkage or convergence. ICDS is referred in one place in the whole document viz. in Section A of plan of action in reference to training of ASHA in Anganwadi training schools. After going through above statements full of public health wisdom one wonders why ICDS was not included. As the document justifies inclusion of other health related program on the basis of some important criteria viz. “Synergistic Approach”, “National Priority” and “Core unit of Health Plan.”. Let us examine the case of ICDS accordingly.
- Whether Child development does not qualify to be included in the “**Synergistic approach**”?
- Is it not a **National priority**? Should it not be included as a core unit in a Health Plan?
- Whether ICDS a centrally sponsored scheme cannot be **rationalized/ modified** in consultation with states?
- Can the concept of “**funneling**” funds to district for effective integration of program not be used for linking ICDS with NRHM?
- Child development not only fulfills all the above criteria but it is one of the “**Central issues of any Health Plan**”. The only alibi for its exclusion may be that the nodal department of ICDS is not Health & FW but Social Welfare under HRD ministry. But this also cannot explain as per the statement in the section of Action Plan (F). The TCS is also a program where the nodal department is not health but it has been included and modalities are also defined. It is also baffling to understand that the modalities defined for including TCS refers to the process of rationalization / modification in consultation with the states and also the concept of “funneling funds” to district for effective integration. Whether the same cannot be applied to include ICDS. The aim of NRHM is to improve the quality of life. 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, the women and children. Integration of an ongoing program like ICDS with its universal coverage in the nooks and corners of the country would have been the most cost effective way reaching the mission goals. However there must be some valid reasons which are beyond our comprehension for its non inclusion as a core unit of District Health plan. IPHA strongly feels that the implementation of ICDS program should be directly linked with the NRHM. From the public health point of view it is a procrustean crime to have minimal functional linkage of the two programs having a common aim & goal of improving the quality of human life and achieving a favorable level of development indicator like IMR, MMR etc, providing an interlinked and interdependent service package. ICDS without the health component cannot be effective. Health services without utilizing the vast infrastructure of ICDS and input of supplementary nutrition and other welfare packages will

not be able to improve the child health condition. In the National Coordination and state coordination committee the minister of HRD is one of the members. So though it is not mentioned specifically in the document we can presume that there is convergence between the two important programs from two different ministries. The convergence in real term should be perceptible in midterm reviews. But it is always advisable to lay down the detailed process of convergence from the grass root level to the district level in the plan of action. This is necessary so that the job description for each category of worker becomes clear and the other supporting services like training, supervision, monitoring can be planned. Integration of two such important and prestigious programs from two different ministries will have a tremendous impact on attaining the goal of both the program.

- The plan of action in the NRHM document describes elaborately about the new link worker “ASHA”. The only apprehension is that “ASHA” should not be politicized like “Anganwadi.” The concept of performance based incentive and social recognition either by providing some other non monetary privileges or career progression for suitable workers can be tried. Introduction of any remuneration would politicize the system and would be counterproductive. It is apprehended that during election any of the state would take the step and later all the other will have to follow. Component B, C & D calls for strengthening peripheral health institution like Sub-Centers, Primary Health Centre and Community Health Centers for **providing quality preventive, promotive, curative, and supervisory and outreach services**. The Sub Centre manned by the FHW would be the most peripheral health institution which would be the key element in the successful functioning of ASHA. The success of ASHA depends on the support and guidance she receives from the FHW. And justifiably in the mission document there is provision for an **“untied fund of Rs. 10000 per annum , essential drugs and also additional outlays for Multipurpose worker Male & Female wherever needed and sanction of newer sub centers as per 2001 census norms and for upgrading existing sub centers including buildings for sub centers functioning in rented premises. From”** But unfortunately what is lacking is the functional linkage between “AWW and ASHA” working in the same area covering the same population with services which are complimentary. How these two vital workers should work in tandem to cover the total population, register the households identify the beneficiaries and sensitize their captive population to utilize the services is not in the document but probably it is taken care of during the training. But this should not remain a topic of training but rather it should be the agenda to work together under the supervision of the Health workers, Health assistants, M&HO and Mukhya sevikas and CDPO respectively. The two packs of service personnel are to be totally interlinked in providing the service and let it be the model of the intersectoral coordination and convergence. We are of the opinion that the family register maintained by the AWW and verified by the concern local registration authority be the basic document for all service planning and delivery purpose. Multiple registry creates confusion and will interfere in convergence and service delivery.
- Component C & D of the Plan of Action details **“the provision of 24 hour service in 50% of PHC by addressing shortage of doctors, especially in high focus States, through mainstreaming AYUSH manpower”**. Emphasises is given on **“Observance of Standard treatment guidelines & protocols”**. **“Additional Outlays”** ear marked for **“intensification of ongoing communicable disease control programmes, new programmes for control of non-communicable diseases, up-gradation of 100% PHCs for 24 hours referral service, and provision of 2nd doctor at PHC level (1 male, 1 female) would be undertaken on the basis of felt need**. One of the key elements of strengthening of CHC for first referral care is **“operationalizing existing Community Health Centres (30-50 beds) as 24 Hour First Referral Units, including posting of anaesthetists.”** To improve the quality of services in the CHC **“Codification of new Indian Public Health Standards, setting norms for infrastructure, staff, equipment, management etc”** is done.

For making the health services accountable to the community they serve; the following actions are suggested:

- **Promotion of Stakeholder Committees (Rogi Kalyan Samitis) for hospital management.**
- **Developing standards of services and costs in hospital care.**
- **Develop, display and ensure compliance to Citizen's Charter at CHC/PHC level.**
- **In case of additional Outlays, creation of new Community Health Centres (30-50 beds) to meet the population norm as per Census 2001, and bearing their recurring costs for the Mission period could be considered.**

If the above plan of action can be implemented there would be a revolutionary change in the of health care service delivery scenario of the country and we shall definitely achieve the NRHM goal of providing quality health services to the rural community etc as envisioned in the preamble. The chain of institution linking villages to sub centres, PHC, CHC, District Hospital and Regional tertiary hospital constitute the Health care delivery system. Effective functioning of any system depends on some key elements. The key element is mostly conceptual and is to be translated to functional plan. The key elements for effective functioning of any health care system are the concept of **“Regionalization of the health Care Delivery”** and **“Graded referral system including reverse referral”**. The mission also has adequate provision of expert and management support and one envisages that they should take care of the same or any other strategy they think to make the Health care Delivery System effectively functional by optimizing the use of the three tier health institutions comensurating to the actual need. The other component in the Plan of Action related to service delivery is component (G) on strengthening Disease Control programs. It calls for integration of ***“National Disease Control Programmes like Malaria, TB, Kalazar, Filariasis, Blindness & Iodine Deficiency disorder and Integrated Disease Surveillance Programme, for improved programme delivery.”*** It also emphasises of ***“New Initiatives would be launched for control of Non Communicable Diseases”***. The other high lights in the service deliver section are:

- **Disease surveillance system at village level would be strengthened.**
- **Supply of generic drugs (both AYUSH & Allopathic) for common ailments**
- **at village, SC, PHC/CHC level.**
- **Provision of a mobile medical unit at District level for improved Outreach services.**

The program is in the mission mode and nation is committed to achieve the goal. On critical analysis of the strategy it is observed that with the better decentralized bottom down health planning and adequate resource mobilization it would be possible for developing the infrastructure. The strong managerial input through the strengthening of management system and support will definitely help in achieve improving the quality of service. But the convergence of the different health and health related infrastructure is doubtful without a clear cut strategy. This is discussed in the strategy section.

Health Manpower: The key inputs to deliver a quality personnel care service to the individual beneficiary and public health services to the community universally available through the net work of different health institution is trained & committed man power. A detailed analysis of the Mission document reveals the directives to answer the manpower issues. They are as under.

- In the preamble the key directive is ***“Optimization of health manpower.”*** In the strategy section emphasis is given on the areas of competence to be developed among the health manpower. They are
 - ***“Strengthening capacities for data collection, assessment and review for evidence based planning, monitoring and supervision.”***
 - ***“Developing capacities for preventive health care at all levels for promoting healthy life styles, reduction in consumption of tobacco and alcohol etc.”*** It also states intent to ***“Formulation of transparent policies***

for deployment and career development of Human Resources for health.”

- In the Plan of action section of the document it states that for strengthening sub centre additional manpower like ANM & MPW (M) would be provided **“as per 2001 population norm”**. Additional manpower requirement for institutions like PHC and CHC would be through” mainstreaming Ayush manpower” and providing an extra doctor (one male and one female) and the manpower for CHC would be as per “Indian **Public Health Standards norms”** The intention of improving the health manpower is reflected in component (J) of the plan of action **“Medical and para-medical education facilities need to be created in states, based on need assessment.”**
- The other relevant section on manpower is seen in the Program Management Support centre under the Technical support section of the document. It states that **“for Developing Manpower Systems – recruitment (induction of MBAs/CAs /MCAs), training & curriculum development (revitalization of existing institutions & partnerships with NGO & private sector. Sector institutions), motivation & performance appraisal etc”**

Comments: An effective delivery of health & family welfare services requires efficient functioning of the various personnel in adequate number. In the existing set up various categories and type of health personnel working to achieve the goals of health includes male and female multipurpose health workers, health assistants male & female, technicians, health educators, computers (statistical workers), block extension educators, Nursing personnel, pharmacist, Medical officers, District Program officers and State program officers. In the present document a specific direction is given to develop a new category of management manpower viz. MBAs/CAs/MCAs. For effective improvement of health planning and management we need to have such type of people. But putting such people only at the district or block level without revamping the existing manpower would not serve the purpose. The key elements for delivering the services are the field level worker and their supervisors. After introduction of the NRHM program the workload of both the male and female worker would increase tremendously specially for male worker. The female worker traditionally looks after the RCH component. But the male workers who were mostly workers under some vertical programs would be transformed to look after a varied type of work which would now include besides communicable diseases non communicable diseases control. The immediate need is to change the training curriculum and training them accordingly. Basic training for male worker needs immediate attention. At present we have 30 % shortage of MPWs and as per 2001 population norm the requirement would be much more. The minimum training period is 1 ½ year for basic course. We can reduce it by 1 year if we have a good supervisory system. But unfortunately the weakest link in the chain of peripheral manpower is the Supervisors (LHV & Health Assistant (M)). In most of the states the post are filled up by promoting the male and female health worker. Ideally they are supposed to get a promotional training. If the state government wants to introduce the same whether there are sufficient institutions to train them. If at all it is their sufficient trained trainers for training? Well trained motivated supervisors at this level are the key persons to improve the quality of health service coverage and improve the monitoring etc. There is another worker in PHC's in many of the states they are known as Block Extension Educators. As a matter of fact any public health person would agree that if in a PHC you have a motivated and efficient BEE and the Medical officer has delegated the job, the performance of such PHC is better than the other.

- Manpower development needs urgent consideration. Following may be considered for addressing the same. We need three types of personnel one is vocationally trained in institutions private and public for carrying out the work of male and female worker, lab technician etc. The curriculum and the training are to be standardized.
- Induction of a full time well trained public health personnel in the PHC would be the most cost effective way of delivering the health packages under any health program. Their role is to supervise the implementation of health program under the leadership of the PHC MO and assist the PHC MO in planning, monitoring health program and attend to public health emergencies. The graduate course can be started under different universities with a

standardized curriculum and training with the help of public health professional bodies. This should not be confused with the existing MPH program. For putting in to action the “**Career development Strategy**” a distance learning modular program under IGNOU or other open university program may be started so that eligible health workers get some scope to enhance their status. At present there is no such scope for peripheral health workers. This would rather boost the ongoing Masters in public Health program (MPH). A master degree holder in Public Health would not like to be a supervisor at the PHC level. He would be placed at the district for planning etc as per the NRHM paper. For effective planning, monitoring and implementation you need field level personnel who can provide valuable inputs for efficient functioning of the management cell in the district level. The graduate public health personnel if undergoes Post graduate course should be allowed to have further promotion up to the state level and a percentage of the post should be reserved at district and state level for eligible promotes. Graduate public health personnel is also priority requirement in many Organized public and private sector undertaking, which at present is being managed by appointing doctors or the now extinct Sanitary Inspectors.

- The other important area is continuing education. Here one can think of public private partnership. Existing online training facilities like “MEDVARSITY” under Apollo Health Education and Research Foundation (AHERF) which have a pan India presence and are conducting many online courses on their own and in collaboration with IGNOU. It can be utilized as a PPP model. The online training is cost effective and the participants can get the training while discharging their duties. There are many private health institutions where the training load is not being properly utilized. If private institutions are involved than a mechanism for accreditation and quality control has to be developed.
- The other area which really needs serious consideration is private and public partnership in health care delivery and training. In training private sector has a tremendous scope. One can observe it in states like Andhra, Karnataka, Maharashtra and other southern states the number of Government and privately owned medical and paramedical training institute. The only precaution should be standardization of training and evaluation and financial exploitation by the private institution. For Medical and Nursing education there are statutory bodies but for others there is no single authority. A regulatory body for public health and paramedical body may be introduced for standardization it may be at the regional level rather than at the central level. A central appellate authority would be necessary.
- For regulating the quality of services we should take the model used by Tele communication. A central and five regional level regulatory authorities may be created. This would be constituted by Representative of Health Department, Health experts members representing judiciary, corporate sector, Accounts, Renowned social worker, retired bureaucrat etc. They should have autonomy to function. To stop the exploitation of the patients in their moment of crisis we need to standardized basic protocol for different morbidity with the help of different professional bodies and as well as formulate standard guidelines for health service delivery institution. The guideline should include essential requirement for providing different types of health services by a institution which should include infrastructure trained manpower adequate manpower and organization to provide services. The regulatory authority should also define the cost of each service as per the service providing capability of the institution. A regulatory authority is a must as NRHM wants to include the Rural Medical Practitioner in it service delivery ambit.
- **Health Insurance:** One third of our population is urban based and two thirds rural based. If all the populations are covered the twin objective of resource mobilization and cross subsidization would be achieved. The private sector would have enough resources generated through insurance premiums so as to cross subsidize the poor. However if the government does not regulate the private health care sector, than the system might end up in achieving the resource mobilization and the poor would not be cross subsidized. The type of beneficiaries like different employees may be covered by the employers even there should be a provision that for even wage earners an amount should go as the premium of

insurance. The employer based scheme should increase its base especially for those workers in unorganized sector. If the coverage is good it would be possible to provide only accident and acute short time illness benefit. The community based may be voluntary or government sponsored. Those who are target group for poverty alleviation and or income generation they are to be included and the benefits are to be given for accidents, hospitalization for some specific condition which has standardized treatment protocol and the outcome is predictable. Maternity, child and special group benefit people may be included in the Insurance program.

- **Health Service Regulatory Authority:** A good regulatory body with independent medical audit team may provide us good input in stream lining community based Insurance program. The regulatory body should strictly devise a pricing mechanism. It should have two components one is service component and the other is hospitality component. This is necessary as the technical component should consist of package which are allowed practices in the country and also standardized. The services may be categorized as insurance and general with a minimum and maximum limit. The other component is hospitality which should be according to the consumer preference and not regulated. The charges are to be fixed and reviewed periodically. The patient's right are to be defined and informed by any of the service providers.