DEVELOPING STRATEGY FOR
DEPARTMENT OF HEALTH AND FAMILY WELFARE
MINISTRY’S VISION, MISSION, OBJECTIVE AND FUNCTIONS
Introduction:
India’s health system is at a crossroads. Since 1947, India’s health conditions have changed significantly. It has overcome many challenges with a reasonable degree of success, viz. managing to double the life expectancy at birth to close to present levels of around 65 years, reducing infant, child and maternal mortality significantly, eradicating a number of diseases and reducing the adverse impact of many others. At the same time, it faces greater demand for better services from health facilities, both public and private, and a transition from acute illness of relatively younger persons to the chronic diseases of adulthood. High levels of poverty lead to, and are exacerbated by, poor health conditions. India’s under-funded public health system and its extensively used but largely under-regulated private sector finds it difficult and challenging to meet country’s large, growing, and changing health needs. Although the Government of India has been seeking to promote a better health system for the country, one that can take advantage of the capacity of the government and private sectors and deliver better service and outcomes for all regions and socioeconomic groups, there have been inadequacies. Despite the fact that the IMR has declined significantly, it still is quite high and, India, of all the countries of the world, has the highest number of infants dying every year. The problem of child malnourishment remains largely unresolved. About three-fourths of children under the age of three years and about half the women of reproductive age suffer from anemia. Large scale inequities prevail in the health status across space, social classes, gender, income and education strata, etc. These problems along with communicable diseases viz. tuberculosis, malaria, etc. constitute the unfinished agenda of the post-Independence health system.

The developments mentioned in the preceding paragraph, regarding the situation in health sector prevailing in the country, is reflective of the “health transition” that encompasses three specific and interrelated shifts: (a) demographic transition that refers to a change in rates of mortality and fertility over time and aging of the population, (b) epidemiological transition that refers to changes in the dominant pattern of disease burden, from malnutrition and the communicable diseases of childhood to the chronic diseases of adulthood, and (c) social transition that encompasses a general increase in knowledge, awareness and expectations of the health system and a greater ability to take care of oneself.

1.2 Vision, Mission, Objectives and Functions:
While there can be several objectives of a health system, the following broad objectives encompass most such objectives.

- Improve the health status of the population by lowering mortality and morbidity rates
- Protect the population against the financial risks of health problems
- Respond to citizens’ demands and needs.
Considering these broad objective of the health system, the major objective of the Department of Health & Family Welfare has been enunciated in the National Health Policy (2002), which is to achieve acceptable standards of health care for the people of the country.

Accordingly the Vision and Mission along with the objective of the Department are listed in the following paragraphs.

Vision: To provide acceptable standards of Good Health care to amongst general population of the country by the end of 12th Five Year Plan.

Mission:

(1) Universal access to primary health care services by all sections heads of society with effective linkages to secondary and tertiary health care
(2) Improving Maternal and Child health.
(3) Focusing on population stabilization in the country.
(4) Developing human resources for health to achieve health goals.
(5) Reducing overall disease burden of the society.
(6) Strengthening Secondary and Tertiary health care.

Objectives:

1. To ensure availability of quality healthcare on equitable, accessible and affordable basis across regions and communities with special focus on under-served population and marginalized groups.
2. To establish comprehensive primary healthcare delivery system and well functioning linkages with secondary and tertiary care health delivery system.
3. To Reduce Infant Mortality rate to 28 per 1000 live births and Maternal Mortality Ratio to 1 per 1000 live births by 2012.
4. To reduce the incidence of communicable diseases and putting in place a strategy to reduce the burden of non-communicable diseases.
5. To ensure a reduction in the growth rate of population with a view to achieve population stabilization.
6. To develop the training capacity for providing human resources for health (medical, paramedical and managerial) with adequate skill mix at all levels.
7. To regulate health service delivery and promote rational use of pharmaceuticals in the country.
Functions:

1) Policy formulation on issues relating to health and family welfare sectors.
2) Management of hospitals and other health institutions under the control of Department of Health
   and Family Welfare.
3) Extending support to states for strengthening their health care system.
4) Reducing the burden of Communicable and Non-Communicable diseases.
5) Focus on development of human resources through appropriate medical and public health
   education.
   medical, nursing, paramedical education, pharmaceuticals, etc.

The other objectives include reducing mortality and overall disease burden through universal access to primary
health care services for all sections of society, strengthening secondary and tertiary health care by developing
human resources for health and at the same time bringing about population stabilization in the country.

1.3 Purpose:

Public health services comprise programmes and institutions organized by society that directly protect,
promote, and restore peoples' health through a collective action. Health services can be categorized as 'public
goods' since they have significant benefits beyond the individual, giving strong justification for government
involvement. Some of the main challenges facing public health are:

- How can critical gaps be removed in planning, implementation, monitoring and community
  leadership within the public health programmes.
- How to ensure better coordination and greater linkages between centre and States/UTs in
  respect of programme implementation so as to reform the health system, etc?
- How can existing programs of public health be strengthened and new effective programmes be
designed in order to meet the current as well as emerging challenges.

As mentioned earlier, the National Health Policy (2002) aimed at achieving an acceptable standard of health for
general population of the country. This was aimed to be achieved by increasing access to the decentralised
public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in
the existing institutions. Greater focus was given by ensuring a more equitable access to health services across
the social and geographical expanse of the country. The role of the private sector in providing health services
was to be enhanced, particularly for the segment of population which could afford to pay for services. Focus
was given to preventive and first-line curative initiatives at the primary health level through increased sectoral
share of allocation. Emphasis was also laid on rational use of drugs within the allopathic system and increased access to traditional medicine.

1.4 Aspiration:

The Department aspires to ensure availability of equitable, accessible and affordable quality healthcare across regions and communities with special focus on under-served population and marginalized groups. It aims at establishing comprehensive primary healthcare delivery system and well functioning linkages with secondary and tertiary care health delivery system as well as develop human resources for health (medical, paramedical and managerial) with adequate skill mix at all levels through appropriate medical and public health education and promote rational use of pharmaceuticals in the country.

The Tenth Five Year Plan (2002-2007) stressed the need to re-structure the public health system and envisaged devolving more responsibilities and funds to Panchayati Raj institutions, mainstreaming Indian systems of medicine and strengthening interventions for better management of communicable and non-communicable diseases. It also endorsed the need to institutionalize partnerships with diverse providers to enhance the availability of health services, expand coverage, improve technical quality of care at all levels and control costs for users. The National Rural Health Mission (NRHM) was launched in 2005 with a view to bringing in a dramatic improvement in health system and the health status of the people, particularly those who live in rural areas of the country.

Continuing with this broad objective, the Eleventh Five Year Plan (2007-2012), had set a goal of achieving good health for the people, especially the poor and the underprivileged. To achieve this objective, a comprehensive approach was advocated, which included improvements in individual health care, public health, sanitation, clean drinking water, access to food and knowledge of hygiene and feeding practices. Importance was accorded to reducing disparities in health across regions and communities by ensuring access to affordable health. Special attention was given to the health of marginal groups like adolescent girls, women, children, the older persons, disabled and tribal groups, with due recognition to gender issues as the cross-cutting theme across all schemes. The Eleventh Plan also specified certain monitorable targets relating to health sector.

Monitorable Targets Relating to Health Sector for the Eleventh Five-Year Plan

- Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births
- Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.
- Reducing Total Fertility Rate to 2.1.
- Providing clean drinking water for all by 2009 and ensuring no slip-backs.
• Reducing malnutrition among children of age group 0-3 to half its present level.
• Reducing anemia among women and girls by 50%.
• Raising the sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17

At the outset, it may be mentioned that although the above mentioned goals are “health related goals”, action on all these does not fall under the purview of Department of Health & Family Welfare. Issues relating to provision of clean drinking water, reducing malnutrition and anemia and raising sex ratio are not dealt with, while preparing the strategy paper.

To achieve these objectives, the Eleventh Five Year Plan has given emphasis to a number of broad thrust areas viz. providing broad based healthcare in rural areas through National Rural Health Mission, setting up of Centres of Excellence patterned on the All India Institute of Medical Sciences (AIIMS), increasing focus on human resources for health, including strengthening of medical, para-medical education and nursing services, redevelopment of hospitals and greater focus on hitherto neglected areas, viz. care of older persons, providing humane solutions to problems of mental illness, reversing the trend of occurrence of major diseases viz. cancer, diabetes, cardio-vascular diseases, etc. The Rashtiya Swasthya Bima Yojana (RSBY) was expected to provide much needed insurance cover against illness to the population below poverty line. In order to achieve the goals, it was envisaged that public spending on health by the Centre and the States would have to increase significantly. The Eleventh Five Year Plan indeed provided for substantial increase in allocation for health programmes vis-à-vis the Tenth Five Year Plan.

As India invests so little in public health as a ratio of GDP, the most obvious action would involve allocating more financial resources and greater efforts on improving public health services. However, by itself, simply putting more money into public health will not be sufficient. The success of public health programs would depend on efficiency with which the resources are utilized/spent, adaptation of improvements in health related technology, more professional medical and public health education, etc. In the short term, intensive training and supervision in management, provision of supplies are some of the important steps in the direction of making these programs more effective.

The public sector has been organized largely to finance and deliver curative care, although it also implements a number of programs for family welfare and disease control. These programs are almost exclusively executed by an enormous array of under funded public institutions. Available data suggests that the number of medical personnel and hospital beds in India’s public sector is, in per capita terms, well below the comparable ratios prevailing even in low-income countries. Under the Indian Constitution, the responsibility for public health is
shared by the Central, State, and local levels of government. However, the public sector accounts for only a fourth of total expenditure on health. States vary widely in respect of their health spending as a ratio of GDP.

As documented in various studies, the delivery of health services by India’s public health system needs considerable improvement. The public sector health system also suffers from poor management, low service quality, and weak finances. Weak management and the low quality of services are related problems that include structural and institutional issues. There is also a very little coordination between public health programmes, programs related to family welfare, nutrition, water supply and sanitation, etc.
Section: 2

ASSESSMENT OF THE SITUATION
2.1 **Understand and assess external factors that will impact on Health System:**

As stated in the previous chapter, the health sector in India is characterised by a government sector that provides publicly financed and managed curative, preventive and promotive health services from primary to tertiary levels throughout the country at no or very low cost to the people, as well as fee-levying private sector that plays a significant role in the provisioning of mainly curative care.

The provision of health care by the public sector is a responsibility shared by the Central Government, State governments, and local governments. General health services are the primary responsibility of the states, with the Central Government focusing attention on medical education, drugs, population stabilization and disease control. The health programmes of the Central Government are mainly related to reproductive and child health and to the control of major communicable diseases like malaria and tuberculosis and these have contributed significantly to the programmes being implemented by the States.. More recently, under the National Health Rural Mission (NRHM) as well as Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), the Central Government has also emerged as an important contributor to the health systems development in the States.

Government health care services are organized at different levels and wide range of institutions offer different services. Primary health care is provided through a network of health sub-centres, primary health centres (PHCs) and community health centres (CHCs). These services are provided through 145,894 health sub-centres, 23,391 PHCs and 4,510 CHCs, functioning in 2009. At the district level on an average there is a 150-bedded civil/district hospital in the main district town and a few smaller hospitals and dispensaries spread over other towns and larger villages. The health care services are provided in these centres through a variety of human resources like multipurpose workers, Auxiliary Nurse Midwives (ANMs), Lady Health Visitors (LHVs), health assistants, general doctors / specialists, etc. Although large-scale health infrastructure and human resources exist, it is quite inadequate as compared to the requirements that have been worked out on the basis of certain norms that have been accepted. These are also inadequate as compared to those prevailing in a number of developing countries, leave above the developed countries. On the other hand, there are institutions like the All -India Institute of Medical Sciences (AIIMS) that are not only involved in providing health care of all varieties viz. preventive, promotive and curative, but also in teaching at undergraduate and post-graduate levels, research in medical and related, and in producing medical teachers in the country. As per the National Health Profile 2009, there are 11613 government hospitals in the country having 540328 beds with an average population per government hospital 97958 and average population per government hospital bed of 2105. In addition to this, 3378 hospitals and 22312 dispensaries exist under Ayurveda, Yoga, Unani, Siddha & Homeopathy (AYUSH) systems provide medical care facilities.
Despite a steady improvement in public health care infrastructure, utilization of public health facilities by population for outpatient and in-patient care has not improved. Studies conducted by National Sample Survey Organization (NSSO) clearly show a major decline in utilization of the public health facilities for inpatient care and a corresponding increase in utilization by the private health care providers, both in the rural as well as urban areas. Despite higher costs in the private sector, this shift shows people’s growing lack of reliance in the public health system. Critical shortage of health personnel, inadequate incentives, poor working conditions, absenteeism, long waiting times, inconvenient clinic hours, poor outreach, insensitivity to local needs, inadequate planning, management, and monitoring of service/facilities appear to be the main reasons for this trend.

The public health system in the country has various drawbacks. Although health is State subject and has been further decentralized to local bodies, the conceptualization and planning of a number of programmes is quite centralized, whereas it ought to have been decentralized, using locally relevant strategies. It may, however, be mentioned that implementation of the programmes is decentralized and in course of development of guidelines, State governments, NGOs and other experts are consulted. The approach towards disease control and prevention is mostly disease specific rather than comprehensive. This leads to vertical programmes for almost every disease. These vertical programmes are technology centric and work in isolation of each other. The provision of infrastructure is based on population norms rather than habitations leading to issues of accessibility, acceptability and utilization. Inadequate resources result in to lack of client conveniences and non-availability of essential consumables and non-consumables. The gap between requirement and availability of human resources at various levels of health care is wide and where they are available, the patient-provider interactions are beset with many problems, in addition to waiting time (opportunity cost) for consultation/treatment. Quality assurance at all levels is often not adhered to. There is lack of convergence with other key areas affecting viz. safe water, sanitation, hygiene and nutrition. Despite constraints of human resources, practitioners of Indian System of Medicine (ISM) and other locally available human resources have not been adequately mobilized and integrated in the system.

The country has a flourishing private sector partly on account of failure of the public sector to provide desired health care services. The growth of private hospitals and diagnostic centres was also encouraged by the Central and State governments by offering tax exemptions and land at concessional rates, in return for provision of free treatment for the poor as a certain proportion of outpatients and inpatients. Apart from subsidies, private corporate hospitals also receive large amounts of public funds in the form of reimbursements from the public sector undertakings, the Central and the State governments for treating their employees. Consequently, India has seen high growth of private health sector in both provision and financing. There is diversity in the composition of the private sector, which ranges from voluntary, not-for profit, for-profit,
corporate, trusts, stand-alone specialist services, diagnostic services to pharmacy shops and a range of highly qualified to unqualified providers, each addressing different market segments.

The cost of health care in the private sector is much higher than the public sector. Many small providers have poor knowledge base and tend to follow irrational, ineffective and sometimes even harmful practices for treating minor ailments. Bulk of the qualified medical practitioners and nurses are subject to regulation by their respective State Medical Councils under central legislation. In practice, however, regulation of these professionals is weak. The fee charged by the private hospitals differs substantially, as is the case with quality of services provided by them. There is strong case for regulation in these areas.

2.2 Identify key stakeholders, their core agenda and basis of working together with them

Health, being a State subject and Family Welfare being a concurrent one, the Central Government works in partnership with States/UTs. The performance in Health sector, therefore, depends on the success of this partnership. This is done under the aegis of Central Council of Health and Family Welfare, an apex body headed by Union Minister of Health and Family Welfare, comprising representatives from Union and State Governments as well as eminent individuals and experts. In addition, there is a Mission Steering Group of National Rural Health Mission (NRHM).

The determinants of health are very wide and this requires inter-sectoral convergence with Departments concerned with subjects to Drinking Water, Sanitation, Nutrition, Education, etc. The Anganwadi Centre under the Integrated Child Development Scheme (ICDS) at the village level is a major hub for health related activities. Likewise, wherever village committees have been effectively constituted for drinking water, sanitation, ICDS, etc., Panchayati Raj institutions also play a role in determining health outcomes. In addition, there are other Departments/Bodies that have an important bearing on the outcomes, viz. the Planning Commission and Department of Expenditure for provision of adequate funds.

The other stakeholders include the numerous health facilities being run by the government as well as private sector including hospitals, CHCs, PHCs, sub-centres, solo-private parishioners, etc. The stakeholders also include medical and para-medical personnel, NGOs, general public as well as employees of the Department.

An area that is crucial in the health sector is that of “human resources”. Hence, the quality of medical education is important. The regulatory bodies like Medical Council of India, Dental Council of India, Pharmacy Council of India and Indian Nursing Council have an important role in maintaining the uniform standards of medical education, promoting training and the research activities.
International Organizations including multilateral and bilateral organizations and donor agencies are also involved in specific schemes.

The Non-governmental Organizations are also critical for the improvement of health status of the society. Besides advocacy, NGOs are be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, working together with community organizations and Panchayati Raj institutions.

2.3 Assess Department’s Strengths and Weaknesses:

Strengths
(a) Large network of health institutions at all levels viz. primary, secondary and tertiary level.
(b) World Class Institutions like AIIMS.
(c) Well-established Disease Control Programmes.
(d) Community participation especially strengthened with the launching of National Rural Health Mission.

Weaknesses
(a) Shortage of requisite manpower, viz. doctors, nurses, paramedics, etc. as well as faculty to train these.
(b) Low level public expenditure on health.
(c) Large rural–urban disparities and inter-state in health related infrastructure and manpower.
(d) Variation in the performance of health indicators across states.
(e) Coordination with States can be difficult at times.
(f) Lack of proper regulatory mechanism in the area of drugs & medicines.
(g) Inadequate sharing of best practices.
(h) Weak mechanism for monitoring progress at Centre and State level.

2.4 Define the core learning agenda

Despite having large network of health institutions at all levels, well established health & family welfare programmes, shortage of human resources like doctors, nurses, paramedics exists in the country. The creation of human resources viz. good quality of doctors, nurses, etc. is a long drawn process and requires faculty of highest standards. In respect of providing good quality of medical education, the emphasis of the Ministry is to create a good system monitoring mechanism so as to implement the recommendations of the Medical Councils for providing the good quality of medical education.
The country has to deal with rising costs of health care by strengthening the public health care system that would help in reducing the costs of health care and providing accessible and affordable services in order to meet the growing expectations of the people. The challenge of providing quality health services in remote rural regions has to be met urgently. Given the magnitude of the problem, there is a need to transform public health care into an accountable, accessible and affordable system of quality services. This will also facilitate convergence and development of public health systems and services, which are responsive to health needs, as well as aspirations of people. Importance has to be given to reducing disparities in health across regions and communities by ensuring access to affordable health care.

Briefly, the core learning agenda is summarized and given below:

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<th>Sr. No.</th>
<th>Area</th>
<th>Learning agenda</th>
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| 1.      | Human Resources       | • Why health personnel are not available / stay in the areas where they are required most? What could be the remedial measures?  
• Large number of NRHM staff is contractual and many leave in between. How to retain them and keep them motivated?  
• How to reward initiative and innovations?  
• Why public health core competencies are lacking? |
| 2.      | Planning              | • Whether the planning being done is people centric? Are the activities undertaken are relevant to people's needs at various levels?  
• Why services do not reach to the poor / vulnerable groups?  
• Whether proper planning for preventive, promotive and curative services is being done? How to use the traditional / Local Knowledge?  
• Are we properly planning and developing tools before implementing any scheme on a large-scale basis? |
| 3.      | Governance            | • How to use the existing health systems effectively when additional funds provided fall short of resources required?  
• Why the system is not delivering the results in spite of all inputs being available?  
• How to make use of private sector through partnership or regulation?  
• Why inter and intra-state variation persist in health status? |
| 4.      | Monitoring & Evaluation | • Whether monitoring indicators are useful in taking crucial decisions for improving the quality and performance of the programmes.  
• How to have independent impact evaluations free from the bias of the implementers?  
• How to make the system transparent enough to deliberate the findings arising out of evaluation studies?  
• How to promote alternative sources of data on the same indicators? What are the questions we should put to research institutions for answering strategic options?  
• How to promote the use of data at various levels of governance? |

The tracking and management mechanism of any policy or programmes/schemes for good implementation and success, could be based on the following
• Strengthening the Health Management Information System (HMIS) focusing on data quality and use of information in decision-making. The HMIS should be able to meet most information needs of the system.

• Development of health Information Repository that would bring together at a single place, health and related information initiatives, data from surveys, etc.

• Development of qualitative and quantitative indicators to assess whether a programme has successfully achieved its set outcomes including baseline indicators. This needs to be coupled with strengthening of ongoing monitoring of the programmes / policies, enabling mid course corrections, if required. This may be in the form of meetings of concerned programme unit course corrections.

• Strengthening the process of community monitoring to make the system more accountable.

• Undertake Joint / Common Review Missions to see the implementation of the programmes involving members of academia, NGOs, research institutions, donors etc.

• Conduct household surveys through independent agencies to assess the reach of the programme and its impact on various indicators.
Section: 3

OUTLINE OF THE STRATEGY
3.1 Share the spectrum of potential strategies and chosen path

The strategy and chosen path, in order to achieve the targets set, is discussed in the following paragraphs.

A. National Rural Health Mission (NRHM):

The NRHM was launched in April 2005. The detailed framework for Implementation, which gives the mandate for large-scale health sector reforms in the country. The design of the National Rural Health Mission (NRHM) was an inclusive process, that involved a large number public health experts, civil society representatives among others to look at some of the key areas where interventions are required, viz., health financing, primary health structure, partnership with non-governmental organizations, medical and nursing education, role of rural practitioners, etc. The NRHM provides adequate flexibility to States to identify their key concerns and develop interventions that address their specific problems. Availability of human resources has been a priority as it was felt that a major issue in India is the non-availability of skilled health personnel in rural areas.

The NRHM Framework for Implementation has pushed for communitisation of facilities, adequate and flexible financing with community accountability, monitoring progress, innovations in human resources, building of capacity at all levels for effective and efficient decentralized management of the health system.

Based on evidence based assessment of progress as recorded by independent studies and review missions, it is clear that NRHM has led to increase in outpatient cases, inpatient cases, institutional deliveries, availability of ambulances, presence of community health worker in larger number of villages, better availability of drugs and diagnostics. NRHM also provided an opportunity at different levels viz. the Village to the Sub Centre, the PHC, the CHC, the Sub Divisional Hospital, and the District Hospital to create a community institution under the umbrella of the Panchyati Raj local government system, with provision of untied funds to meet institution and village specific needs for health care. However, in a number of States the utilization of untied funds at the local village, sub centre, PHC, CHC level remained slow in the initial phase. Though at the same time, a large number of institutions have made good use of these resources as per their felt need.

NRHM has pushed the quest for flexible financing with local level community accountability and this resulted into utilization of funds in the initial years. NRHM has successfully set up institutions for communitisation and is engaged the process of making them even more vibrant and effective government institutions. It has co-opted self help groups, women’s groups or any one with motivation in the Village Health and Sanitation Committees constituted under the umbrella of PRI. These community processes take time especially in a sector like health where decentralization has not been on the agenda at all, and PHCs, CHCs functioned without any control of local government in most States.
NRHM in the coming years will focus more on maternal and new born care, anaemia and severe acute malnourishment. It will also target the endemic areas of communicable diseases like Malaria, Dengue, Chickenguniya, Tuberculosis and Leprosy in a more focussed manner. NRHM will strive to strengthen the outreach services and expand the network of health care infrastructure and professionals in order to ensure better preventive and promotive health care. NRHM has remained underfunded and the achievement of the above said objectives will be contingent upon allocation of proper resources.

In the recent years, greater attention is being paid to integration of various systems of medicines with emphasis on developing synergies between modern and AYUSH system of medicine and offering greater choice to patients for undergoing treatment. The possibility of providing some basic allopathic training to AYUSH doctors as well as having courses on basic are in specific systems like Ayurveda and Homeopathy for desiring allopathic practitioners could be explored as a strategy.

The key goal under National Rural Health Mission was to bring down Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR) and Total Fertility Rate (TFR) as well as subsequent decline in the incidence of communicable diseases. In the area of maternal and child health, the following interventions have been given strong focus:

- Improvement in the quality of healthcare at facilities to cater to the large number of institutional deliveries as a consequence of Janani Suraksha Yojana (JSY) and improvement in the referral transport. To give focused attention to facilities where institutional deliveries mostly takes place the concept of Maternal and Child Healthcare (MCH) centres have been introduced and specific facilities have been identified for institutional delivery at different levels. This include Level-1 facilities at sub-centres and some PHCs where normal delivery takes place, Level-2 facilities which include 24 X 7 PHCs and CHCs where complicated delivery can be attended, Level-3 facilities at District, Sub-Divisional hospitals and in some CHCs where complicated cases including caesarean section can be attended to. It is intended to equip these centres with human resource and equipments to guarantee services at these facilities. The setting up of sick new born care units, stabilization units and new born baby corners at these facilities to address the concern of the new born shall also be ensured.

To improve availability of skilled manpower in addition to availability of specialists, the multi skilling of doctors in specialized care like BEMoC, CEMoC and LSAS training, Skilled Birth Attendant skills are being taken up. This coupled with differential planning for health facilities and improvement of quality of services are expected to ensure attention to the pregnant mothers and new born.
• Special focus is being given to Home Base Newborn and post natal care to address the concern of the new born and the lactating mothers. For this purpose, special training modules have been developed for the ASHAs to equip them with skills on home based post natal and neo-natal care. The home visits by the ASHA are expected to ensure early detection of the dangerous signs and timely referral of cases to the health institutions.

• A system of name based tracking of pregnant mothers and children to ensure their ante-natal check-ups and immunization have been introduced. It will facilitate in identifying the drop out cases so that full ante-natal check-ups of the pregnant mothers and immunization of the children could be ensured.

• To ensure availability of doctors and para-medics in the remote and difficult areas, identification of facilities in such remote and difficult areas have been taken up. It is proposed to incentivise the personnel both financially as well as in non-financial and HR incentives terms to encourage health professionals to work in the remote facilities. The strategy include reservation in post-graduate diploma courses for Post-graduate doctors serving for specific facility in difficult and remote areas and weightage to rural postings for admission to PG courses etc.

• Increasing availability of Multi Purpose Male Health Workers at Sub-centre level - Considering the need for MPW Male workers to handle the communicable and non-communicable diseases, it is proposed to support States under NRHM for engagement of MPWs in identified backward districts and also strengthen the MPW training centres to facilitate training and availability of such Male workers.

• In the matter of population stabilization, the effort is to meet the unmet needs through increasing availability of the contraceptives at doorsteps, fixed day family planning services and post-partum centres at health centres. Involvement of people’s representatives, religious and social leaders and local bodies in promoting family planning will be given greater attention.

• Communicable Diseases continue to pose major public health problems in the country it terms of both morbidity and mortality. Major communicable diseases include Tuberculosis, Multi-Drug Resistant –TB, Malaria, Kala –Azar, Dengue, Chikungunya, Japanese Encephalitis and Leprosy. The Government has developed disease specific prevention and control strategies in consultation with the States/UTs, public health specialists and international experts. These diseases prevention and control programmes are implemented through States/UTs governments. After the advent of National Rural Health Mission (NRHM),
these disease control programmes have also been integrated into NRHM and are implemented under the overall umbrella of NRHM National, State and District levels.

B. **National Urban Health Mission (NUHM):**

On the lines of the National Rural Health Mission, it proposed to launch NUHM to meet the unmet needs of urban population living in urban slums of different towns and cities of the country. NUHM is likely to provide integrated health service delivery to the urban poor mainly in the urban slums. NUHM will be aligned with NRHM and other existing urban health schemes.

C. **Setting up of Centres of Excellence like All India Institute of Medical Sciences (AIIMS) in the underserved areas:**

The Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) has been launched with the objective of correcting regional imbalances in the availability of affordable/reliable tertiary healthcare services as well as to augment facilities for quality medical education in the country. PMSSY has two components in its first phase - (i) setting up of six AIIMS-like institutions and (ii) upgradation of 13 existing Government medical college institutions.

I. **Setting up of six AIIMS-like institutions:** Under the first phase of PMSSY, six AIIMS-like institutions are being set up, one each in the States of Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh (Bhopal), Orissa (Bhubaneshwar), Rajasthan (Jodhpur) and Uttarakhal (Rishikesh). These States were identified on the basis of their socio-economic vulnerabilities. Each institution will have a 960 bedded hospital (500 beds for the medical college hospital; 300 beds for Speciality/Super Speciality; 100 beds for ICU/Accident trauma; 30 beds for Physical Medicine & Rehabilitation and 30 beds for Ayush) intended to provide healthcare facilities in 42 Speciality / super-Speciality disciplines, Medical College with 100 UG intakes besides facilities for imparting PG/doctoral courses in various disciplines, and nursing college. The civil work for Hospitals and medical colleges complex is already under progress and is likely to be completed by the end of 2012.

II. **Upgradation of existing Govt. Medical College / Institutions:** Thirteen existing medical institutions in ten States are being upgraded. Upgradation of the medical college institutions broadly envisages strengthening the existing departments, through procurement of equipment. It is also proposed to build Super Speciality Blocks, Nursing College, OPD, etc. for many of the institutions. The upgradation work has started in all 13 sites. In most of colleges, bulk of the work is expected to be completed by the end of 2011.

In the second phase of PMSSY, it is proposed to set up two more AIIMS-like institutions to be located in Uttar Pradesh and West Bengal. It is also proposed to upgrade 6 medical college institutions.

One of the challenges that these institutes are likely to face once they are built/upgraded relates to availability of trained faculty to impart knowledge to the students in the medical colleges being set up at these sites. For
this, development of human resources of health is perhaps the most crucial component. This issue is discussed in the following section.

D. Increasing focus on human resources for health:

(i) National Commission on Human Resources for Health: Considering the importance and shortage of human resources in the health sector, the Government intends to set up a National Commission for Human Resources in Health (NCHRH) as an overarching regulatory body for health sector to reform the current framework and enhance supply of skilled personnel. The proposed Commission will have responsibility for the determination and maintenance of standards of medical education throughout the country, for identifying the range of trained personnel required and to ensure that the facilities required to train the required number of persons is available.

The National Commission, which will coordinate all aspects of medical, dental, nursing and pharmacy education, will consist of senior professionals and experts selected/nominated on the most stringent standards. To facilitate the work of the NCHRH, the proposed Bill also provides for setting up several subsidiary bodies each of which will independently perform one of the many essential tasks in governing medical education of which are currently performed by the MCI. It is also proposed to have a National Committee for Accreditation and a National Medical Education and Training Board. These bodies, though under the general supervision of the NCHRH, will be entirely independent in their structure and functioning and will consist of senior professionals, selected/nominated through a rigorous process.

The existing councils (MCI, DCI, INC, Pharmacy Council, Central Council of Indian Medicine, Central Council of Homoeopathy) are proposed to be re-established with specific responsibility for registering professionally qualified persons in their respective disciplines, maintaining State and National Registers of professionals as well as for maintaining the highest standards of professional conduct and ethics amongst registered professionals.

(ii) Bachelor of Rural Health Care (BRHC): Presently, there are around 300 medical colleges in India. However, imbalance of availability of medical professionals in rural and urban India has been a serious concern. The rural areas continue to be underserved, both in terms of manpower and infrastructure. In consultation with the Medical Council of India (MCI), norms have been fixed to encourage posting of doctors in rural areas by way of incentives or reservation in PG Medical Diploma courses and additional weightage to posting in rural areas for admission to post-graduate courses. The availability of the qualified personnel will help to overcome the shortage of medical professionals in the rural areas. In addition, in order to address the
issue of imbalance in terms of availability of medical professionals in the rural the urban areas, commencement of a three years degree course, “Bachelor of Rural Health Care” is being planned.

The salient features of the proposed course are as under:

- The course is proposed to be conducted by a medical school attached to the district hospital and will be affiliated to a university for conferring the degree. The medical practitioners will be registered with the concerned State Medical Councils.
- The duration of the course will be three years with six months of rotational internship,
- The candidates eligible for the course will be those who have completed their entire schooling and passed their qualifying examinations (10 +2) from notified rural area in the concerned district
- Admission will be district based as far as possible,
- After acquiring this degree, the graduates will be employed only in sub-centres.
- The quality of education will not be compromised,
- The doctors acquiring this degree will handle common ailments compared to MBBS doctors who are competent to handle difficult ailments.
- Person with MBBS degree and/or PG degree with certain stipulated experience will be permitted to teach in the medical schools,
- Medical college teachers who have superannuated from the medical college can also be re-employed till the age of 70 years.

Ministry of Health & Family Welfare has also set up a Task Force to frame course curriculum for the Course. Under this Task Force, four sub groups consisting of eminent medical educationists & specialists have been formed. Consultations are being carried out with the States for introduction of the course.

In the recent years, greater attention is being paid to integration of various systems of medicines with emphasis on developing synergies between modern and AYUSH system of medicine and offering greater choice to patients for undergoing treatment. The possibility of providing some basic allopathic training to AYUSH doctors as well as having courses on basic care in specific systems like Ayurveda and Homeopathy for desiring allopathic practitioners could be explored as a strategy.

(iii) Development of Nursing Services:

Considering the shortage of nurses in the country, it is proposed to strengthen Schools/Colleges of Nursing. Strengthening of these Schools/Colleges would include procurement of Audio Visual System, improvement of
library, furniture, additions and alterations of school/college/hostel building. In addition, several schools of Nursing attached to the Medical Colleges are proposed to be upgraded into Colleges of Nursing. The upgradation is meant for increasing the availability of graduate nurses.

Considering the need of nursing personnel in the country, **Auxiliary Nurse Midwives (ANM) and General Nursing and Midwifery (GNM) training schools keeping are being established, giving due consideration to regional imbalances.** These training institutions will be established in those districts, which are not having ANM and GNM training Schools. The guidelines for opening of ANM and GNM training schools have been circulated to the States to make preparation of identifying the location, allotment of land, locating the clinical facilities and identifying the faculty.

(iv) **Strengthening / Upgradation of Paramedical Institutions:**

In order to augment the supply of skilled paramedical manpower and to promote quality of paramedical training through standardization of such education/courses across the country, a National Institute of Paramedical Sciences (NIPS) and eight Regional Institutes of Paramedical Sciences (RIPS) are proposed to be established. The proposal also entails developing the existing Regional Institute of Para Medical and Nursing Sciences (RIPANS), at Aizawal and supporting State Govt. Medical Colleges for conducting paramedical courses through one time grant.

The proposal has following components:-

(a) **Manpower Development Scheme through support to State Government Medical Colleges:** This consists of two components:

(i) Commencement of Under-Graduate Paramedical Courses and increasing intake capacity of students in existing Under-Graduate courses in various State Government Medical Colleges.

(ii) Commencement and increasing intake capacity of students in Post-Graduate Paramedical Courses.

(b) **Establishment of National Institute of Paramedical Sciences (NIPS) & eight Regional Institute of Paramedical Sciences (RIPS).** It is proposed to establish one National Institute of Paramedical Sciences and 8 Regional Institutes of Paramedical Sciences (RIPS) as well as developing RIPANS at Aizawal, as the 9th RIPS.
E. Re-development of Hospitals and Institutions:

To provide the better health services to the people, it is felt that the existing hospitals / institutions need to expand in such a manner so that the health services can be provided in a better way and also reducing the waiting time. For this, 9 hospitals/institutions have been selected for upgradation, which has already started in most of the hospitals and is expected to likely complete by the end of the 11th Plan.

It is important to keep in mind that development of human resources in health of all kinds is a long term process. A perspective plan (say 20-30 years) needs to be prepared, (along with a medium term plan), in order to meet the shortages of different categories of health personnel, particularly in the rural areas. Ensuring that health personnel serve in the rural areas could involve providing monetary and/or non-monetary incentives e.g. higher salary, reservation in Post-Graduate seats for those serving in the rural areas, housing, etc. An important development of human resources relates to availability of well-trained faculty to impart knowledge. Relaxation in the norms of teacher-pupil ratio for P.G. courses in the medical colleges is one such step that could help in raising the number of trained faculty. More such steps will have to be taken in order to ensure that there is no shortage of faculty to meet the requirement of large number of health personnel.

F. Control and Prevention of Non Communicable Diseases

Considering the fact that non-Communicable Diseases (NCDs) are now surpassing the burden of communicable diseases in India and that the existing health system is mainly focused on communicable diseases, it is important that greater attention is paid to the non-communicable diseases. There is a strong case for an NCD Mission to be set up which will address the entire range of illness including mental illness, problems of old age, blindness, deafness and the control of tobacco use. An integrated National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) is under implementation. The Programme aims at prevention and control of (NCDs), using health promotion and health education advocacy, early detection of persons with high level of risk of developing the disease, through opportunistic screening, capacity building of health system at all levels to tackle NCDs and improvement of quality of care and developing trained manpower at various health care facilities in Districts/States.

The National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) has the following objectives:

- Prevent and control common NCDs through behaviour and life style changes,
- Provide early diagnosis and management of common NCDs,
- Build capacity at various levels of health care for prevention, diagnosis and treatment of common NCDs,
• Train human resource within the public health setup viz doctors, paramedics and nursing staff to cope with the increasing burden of NCDs, and
• Establish and develop capacity for palliative & rehabilitative care.

The operational guidelines for implementation of the programme have been issued.

**Health Care for Elderly**

The country has been witnessing a large increase in the elderly population and the proportion of elderly in the total population is steadily rising. Keeping this in view, it is important that specific programmes for health of elderly are devised. The National Programme for the Health Care of the Elderly (NPHCE) is being launched with the following objectives:

• To provide an easy access to promotional, preventive, curative and rehabilitative services to the elderly through community based primary health care approach.
• To identify health problems in the elderly and provide appropriate health interventions in the community with a strong referral backup support.
• To build capacity of the medical and paramedical professionals as well as the care-takers within the family for providing health care to the elderly.
• To provide referral services to the elderly patients through district hospitals, regional medical institutions.

Expected Outcomes of NPHCE are to set up 8 Regional Geriatric Centres with a dedicated Geriatric OPD and 30-bedded Geriatric ward District Geriatric Units with dedicated Geriatric OPD and 10-bedded Geriatric ward in 100 District Hospitals and Geriatric Clinics/Rehabilitation units set up for domiciliary visits in Community/Primary Health Centres in the selected districts. Operational Guidelines have been prepared and disseminated to States for implementation.

In respect of mental health programme, it is estimated that 6-7 % of population suffers from mental disorders. Together these disorders account for 12% of the global burden of disease (GBD) and an analysis of trends indicates this will increase to 15% by 2020 (World Health Report, 2001). One in four families are likely to have at least one member with a behavioral or mental disorder (WHO 2001). These families have to not only provide physical and emotional support to the persons suffering from such disorders, but also bear the negative impact of stigma and discrimination. Most of them remain untreated. Poor awareness about symptoms of mental illness, myths & stigma related to it, lack of knowledge on the treatment availability & potential benefits of seeking treatment, are some of the causes for the high treatment gap. With a large population on one hand,
and very few psychiatrists being available on the other (less than one psychiatrist is available for every 4 lakhs population), the availability of mental health resources is woefully inadequate.

To address the burden of mental disorders, National Mental Health Programme (NMHP) was started. It has the following components:

- **District Mental Health Programme (DMHP):** DMHP is community based mental health initiative that presently focuses essentially on; (i) Early detection and treatment, (ii) Training of general physicians and health workers, (iii) IEC activities. The following new activities are proposed to be implemented under the programme:
  - Life skills education and counseling in schools,
  - College Counseling services,
  - Work place stress management, and
  - Suicide prevention services.

- **Manpower Development:** This is a crucial area under the programme and involves upgrading of a number of centres to Centres of Excellence. This will help in increasing the training capacity in mental health specialties and providing high quality tertiary care mental health services. In order to address the shortage of mental health professionals in the country, 30 PG departments each in the mental health specialties of Psychiatry, Clinical Psychology, Psychiatric Social Work, Psychiatric Nursing are proposed to be supported in the Eleventh Plan by establishment/improvement in infrastructure and engagement of faculty for these courses. 19 PG departments have been supported so far.

- **Modernization of state run Mental Hospitals:** Some state run mental hospitals that still remain to be modernized would be modernized so as to improve their service.

- **Support for Central and State Mental Health Authorities:** As per Mental Health Act 1987, State Mental Health Authorities (SMHA) are the statutory bodies entrusted with the task of development, regulation, coordination of mental health services in States/UTs. However, in most of the States, there is no allocation for these bodies and as such they function in an ad-hoc manner and are unable to do justice to their statutory role of implementation of Mental Health Act 1987 and development of mental health services. The future strategy has to ensure that States/UTs duly constitute SMHAs with adequate financial and administrative support.

- **Training and Research:** To deal with shortage of skilled mental health professionals in short term, skill based training has to be provided to DMHP teams at identified institutes. Standard Treatment
Guidelines, Training modules, CMEs, distance learning courses in mental health, etc. will also be supported.

The National Tobacco Control Programme aims to facilitate the implementation of tobacco control laws and to bring about greater awareness about tobacco’s harmful effects of tobacco.

COTPA, 2003 (Cigarettes and Other Tobacco Products Act- 2003): Parliament has enacted anti tobacco law titled “Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act, 2003”. The Act is applicable to all tobacco products and extends to whole of India. The specific provisions of this law include:

- Ban on smoking in public places.
- Ban on direct/indirect advertisement of tobacco products.
- Ban on sale of tobacco products to children below 18 years.
- Ban on sale of tobacco products within 100 yards of the educational institutions.
- Mandatory depiction of specified health warnings on tobacco products.
- Testing of tobacco products for tar and nicotine.

Strategy has to ensure that the provisions of the Act are implemented effectively.

3.2 Develop a plan to engage the stakeholders

The government can play an effective role for development of an effective health system, regulation and setting standards for measuring performance of public/private sector in health, issuing guidelines to help the states, development of partnership with non governmental stakeholders, developing framework for effective interventions through capacity development and decentralization including transfer of schemes and financing in the states.

Health is a State subject and implementation of any national mission/programmes is also the responsibility of the States Governments, without which it is not feasible to achieve the goals “Health for all”. State Governments also have necessary flexibility to take care of the local needs and socio-cultural variations. The States could be urged to take up innovative schemes to deal with local issues. Keeping in view the decentralization, the States would be required to devolve sufficient administrative / financial powers to the Panchayti Raj institutions (PRIs). The Panchayti Raj institutions, right from the village to district level would have greater say in the public health delivery system in their respective jurisdiction. To institutionalize community led action for health, the necessary amendments to acts and statutes in States to fully empower local bodies in effective management of the health system. Concerted efforts with the involvement of NGOs and other resource institutions will be made to build capacities of elected representatives and user group members for improved and effective management of the health system.
The success of improvement of health status depends as such on drinking water, female literacy, nutrition, early childhood development, sanitation, women’s empowerment, etc. as they do on hospitals and functional health systems. Realising the importance of wider determinants of health, NRHM seeks to adopt a convergent approach for intervention under the umbrella of the district plan. Likewise, wherever village committees have been effectively constituted for drinking water, sanitation, ICDS, etc. NRHM will attempt to move towards one common village health committee covering all these activities. Panchayti Raj institutions will be fully involved in this convergent approach so that the gains of integrated action can be reflected in district plans. While substantial spending in each of these sectors will be by the concerned Department, the village health plan/district plan will provide an opportunity for some catalytic resources for convergent action. NRHM’s household services through ASHA and AWW will target availability of drinking water, firewood, livelihood, sanitation and other issues, in order to allow a framework for effective convergent action in the village health plans. The Ministry has constituted an inter Departmental Committee on convergence with the Mission Director as Chairman. Convergence is also envisaged at the level of the Mission Steering Group (MSG) which has representation of the concerned Ministries. Similar mechanisms are available at the State level. Convergence with the Department of Women and Child Development and with AYUSH has been clearly outlined and shared with States.

The non-governmental organizations also play the critical role for the success of mission/programmes. The Mission would like partnerships with NGOs by evolving for establishing the rights of households to health care. Efforts will be made to co-opt NGOs at all levels of the health delivery system. Besides advocacy, NGOs would be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, working together with community organizations and Panchayti Raj institutions.

Health and Family Welfare is a sector where a large number of external agencies participate within the overall framework of government programmes. The Ministry/programmes has to be empowered to negotiate and take decisions regarding externally aided proposals within the framework approved by the Cabinet. The intention of the programmes structure is to ensure that no time delays take place in achieving the time bound objectives and outcomes of the Mission/Ministry goals.

3.3 Plan to build knowledge and capabilities

Decentralized planning, community ownership of the health delivery system and inter-sectoral convergence are the pillars on which the NRHM is being implemented. The implementation teams particularly at district and state levels would require development of specific skills. Even at the Central level, the program management unit within the MOHFW would need technical and management support from established professionals in the field.
Considering the mandate given under the Mission, the National Health System Resource Centre (NHSRC) was upgraded to serve as an apex body for technical assistance, dissemination and for functioning as a Centre of Excellence for facilitating the Centre and the State in the programme. The NHSRC is providing necessary technical assistance to the Mission directorate. The NHSRC would respond to the requests of the Centre / States / Districts for providing technical assistance for capacity building not only for NRHM but for improving service delivery in the health sector in general.

A comprehensive plan for training has been designed at all levels. This would call for strengthening of the NIHFW. In addition, the States would need to closely examine the training infrastructure available within the state including State Health & Family Welfare institutes, ANM Training Centres, Medical Colleges, Nursing Colleges, etc. and identify the investment required in them to successfully carry out the training/sensitization programmes. Comprehensive training policy is being developed to provide support for capacity building at all levels including PRIs/Community.

Considering the large scale requirement for technical support, there is a need to enable many other national institutions to respond to request from states and districts for technical support in planning and implementation of the programme. This would not only help programme implementation but it would also improve the quality and relevance of work done in these institutions.

The requirement of the health system need public health specialists at all level. Support is being provided for medical officers from state governments for a one year PG Diploma in Health Management. It has to be ensured that state governments start making use of such public health oriented medical officers in key administrative responsibilities at district and state levels. There is a need to universalize basic protocols of care at all levels with wide publicity at facilities to ensure that all facilities across the country have the basic protocols in place. There is a need to keep a thrust of basic protocols and design of training and skill development programmes in such a manner that medical officers, nurses, paramedics and community health workers are able to operationalize basic protocols after training.

3.4 Lay out key priorities

Considering the broad objectives of the National Health Policy - 2002 and Eleventh Five Year Plan (2007-2012), the Ministry of Health & Family Welfare had set a goal of achieving good health for the people, especially the poor and the underprivileged. To achieve the goal, key priorities areas have been identified to reduce disparities in health outcomes across regions and communities by ensuring access to affordable health. Special attention has been given to the health of marginal groups like adolescent girls, women, children, the
older persons, disabled and tribal groups, with due recognition to gender issues as the cross-cutting theme across all schemes.

**Key priorities areas:** Some of the key areas that are being addressed over time in the health sector in the country, inter-alia, include -

1. Providing broad based healthcare in rural areas through National Rural Health Mission by increasing the scope of convergence with the other Departments and stakeholders.
2. Launching of National Urban Health Mission to improve the health status in the urban areas.
3. Setting up of Centres of Excellence like All India Institute of Medical Sciences (AIIMS) in the under served areas to reduce the regional imbalances,
4. Increasing focus on human resources for health, including strengthening of medical, para-medical education and nursing services,
5. Redevelopment of hospitals and other related Institutions
6. Greater focus on hitherto neglected areas viz. taking care of older persons, providing humane mental healthcare, reversing the increasing trend of occurrence of major diseases viz. cancer, diabetes, cardiac vascular diseases, etc.

In addition to the above, the Eleventh Five Year Plan (by the year 2012) aims at -

- Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births.
- Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births.
- Reducing Total Fertility Rate to 2.1, i.e. achieving replacement level of fertility.
Section 4

IMPLEMENTATION PLAN
4.1 Strategic Initiatives:

Some of the major strategic initiatives in the coming years will have to be in the areas of reducing inequities prevailing both in terms of health outcomes as well as access to health-care, bridging the gap between requirement of human resources for health and their availability, ensuring greater accessibility of health-care services in the unserved and underserved areas to as to reduce the both communicable and non-communicable diseases (and incidence of morbidity and mortality), ensuring availability of quality drugs at affordable prices, reducing the rate of growth population that would ultimately lead towards the goal of population stabilization, reduction in the burden of out of pocket expenses, particularly for the poorer section of society by raising the public expenditure on health sector and ensuring that money is spent efficiently.

A Five Year Plan provides the overall direction and basic framework for policies, programmes and schemes as well as broad outline for the preparation Annual Plans. The formulation of the Five Year Plan is a lengthy and intensive process. It has also to be ensured that these plans are consistent with National health and population policies. Five Year Plan of any Ministry or Department is a multi-stage consultative process. The following paragraphs describe different stages of the process.

As a first step the Planning Commission requests all Ministries and Departments to set up Working Groups on various subjects concerning socio-economic development. These Working Groups include representatives from related Ministries and Departments, non-governmental organizations (NGOs) and experts. Each Ministry and Department can also create Sub-Groups, made up of experts, to undertake in-depth analysis of existing policies, the plan of action, programmes, schemes, and their implementation. This analysis also includes an assessment of the policy, plans, programmes to address the concerns of vulnerable sections of society viz. poor, women, children, elderly, backwards sections of society, etc. Based on such analysis and discussions, the Sub-Groups come up with a set of recommendations, which are forwarded to the Working Group. The Working Group(s) consolidate all the recommendations, including proposed financial outlays, and submits these to the Planning Commission.

Meanwhile, the Planning Commission sets up high level Steering Committees (usually one for each department), which analyse and hold a series of in-depth discussions on the Working Group Reports received from Ministries and Departments. Based on these discussions, the Steering Committee comes up with a set of recommendations, that becomes the basis for the formulation of the Five Year Plan and Annual Plans along with the targets for achieving the indicators during the Plan. A series of discussions with the Planning Commission follow. The physical targets as well as financial outlays are determined by the Planning Commission, based on the indications regarding gross budgetary support (GBS) for the Plan. In doing this
exercise, the Commission keeps in mind both the available resources and the inter-sectoral priorities. Representatives of the Ministry of Finance are also there in the consultations. Based on the available resources, the concerned Departments allocate funds for the programmes, schemes, keeping in view the priorities decided in the consultative process.

4.2 Stakeholders Engagement and Learning Agenda:

The achievement of better health outcomes, as envisioned in various Plan documents, National Health Policy –2002, National Rural Health Mission (NRHM), Millennium Development Goals, require coherent policies and a comprehensive approach that not only addresses issues that are directly related to health but also take account of social, economic and environmental determinants of health. These outcomes, interventions, programmes and institutional mechanism have to be constituents of health policies, strategies and plans.

The preparation of strategic plan, for say next five years, involves a number of steps like consultation with various stakeholders, analyzing the recommendations of various Working Groups & Steering Groups on health & family welfare sector set up by Planning Commission, apart from consultations held by the Ministry with various groups, international experience, etc. Since the process for the preparation of the Twelfth Five Year Plan has not yet picked up momentum, the Strategic Plan and in particular the implementation framework associated with it, could undergo substantial modifications, in case priorities, targets undergo changes in the Twelfth Five Year Plan, that is going to commence in little more than a year.

The implementation framework of Plan has to ensure that the gap between the aspirations and performance/achievements is minimized. Keeping this in mind, it has to be ensured that role of health policies, strategies and plans does not have to confine itself to the narrow boundaries of health systems alone but it has to include other social determinants of health and ensure greater interaction between health sector as well as other sectors of the economy/society.

Formulation of policies, strategies and plans cover wide spectrum of dimensions that could encompass

- Vision & Policy directions, strategy to detailed operational planning.
- Comprehensive (detailed) health planning to disease specific or programme planning.
- Time horizons long term, medium term, short term
- National & Sub-National Plans
As stated in an earlier chapter, to be more effective, formulation of National health policies and strategies has to be a consultative process and as much a political process as a technical process and should take into account the prevailing socio-economic situation as well as the institutional framework. The plan and policies should be comprehensive, broad-based, balanced and consistent. Medium term plan should be consistent with long-term goals and short-term operational plan and programmes should be in line with the medium term goals. Often, the operational plans and programmes are at variance with the medium term and long term goals. The gap can be bridged by better managing a more inclusive dialogue between the different stakeholders. There is a scope for improving the process of planning and policy dialogue, combining the following steps, so as to achieve desired goals.

- Investing in institutional and individual capacities, including strengthening policy and planning units within Department of Health and ensuring better dialogue between them.
- Broadening of policy dialogue beyond public sector to include private sector and individuals & experts.
- Broadening the policy dialogue beyond health sector, aligning health strategies with national development plans as well as other sectors of the economy.
- Greater cooperation among donor agencies as well as more meaningful interaction with them.
- Greater focus on monitoring and evaluation of the national health policies, strategies and plans.

4.3 Resource Requirement for the Chosen path:

Based on the goals set for the next five years, the need for requirement of resources can be projected. As the programmes/projects for the next five years are not yet final, it is premature to project the financial and human resources for the years to come at this stage. However, considering the priorities laid down in the previous sections, an attempt has been made to estimate the financial resources required in the years to come i.e. upto 2016-17 so as to strengthen institutions and improve the operations in the health sector. It may be mentioned that these estimates are highly indicative and could undergo revision as and when the detailed Plan for the Twelfth Five Year Plan is finalized.

For working out the future requirement, two alternate scenarios have been attempted. These are briefly described in the following paragraphs.

Scenario I:
The per-capita expenditure/allocation by the Government (Centre & States) increased by an average of nearly 15 per-cent per annum in nominal terms in the last few years. The per-capita allocation for the year 2010-11
works out to around Rs.689, which is close to about Rs.57 per month. Keeping in view the requirements of health & family welfare as projected in Eleventh Five Year Plan and relatively much lower allocations, as well as keeping in view the overall budgetary constraints, it is assumed that an overall increase of 30% (nearly double the trend) would not be too unrealistic for the I year 2011-12. This implies that the per-capita allocation of Rs.896 per annum or approximately Rs.75 per month. Multiplying this by the projected population of the country, it is estimated that around Rs.107 thousand crore would be required in the terminal year of the Eleventh Five Year Plan i.e. 2011-12, as against allocation of Rs.75540 crore in 2010-11 (Centre and States put together). Keeping in view the backlog of infrastructure facilities and manpower requirements, greater amount of funds could be required.

For the five year period from 2012-13 to 2016-17, the following assumptions are made to estimate the requirement of funds.

- It is assumed that the economy will grow at 9% per annum, as in the absence of firm projection of growth rate for Twelfth Five Year Plan, it is assumed that targeted growth rate for Eleventh Plan would continue to remain the same in the five years 2012-13 to 2016-17.
- With an assumption of inflation of 6 per-cent per annum, and
- Elasticity of 1.3 of health expenditure with respect to income.

Given these assumptions, per-capita allocation in nominal terms would need to increase by around 20 per-cent per annum in the Twelfth Five Year Plan. This would imply that the per-capita allocation on health & FW will have to increase from Rs.896 in 2011-12 to around Rs.2230 in 2016-17. Given this, and the projected population of around 127 crore, the fund requirement for the health sector would have to increase from around 107 thousand crore in 2011-12 to 283 thousand crore in 2016-17. The total requirement of funds for health sectors for the five year period 2012-13 to 2016-17 in nominal terms is estimated to be around Rs.1,000 thousand crore.

**Scenario II:**

The Eleventh Five Year Plan had aimed at raising the public expenditure on health to 2 per-cent of GDP. The national Common Minimum Programme (2004) of the UPA-I Government had indicated that the public expenditure of health should be raised to 2-3 percent of GDP. However, going to by the available trends, this is unlikely to be realised. However, it is possible to aim for target of achieving the 2% public expenditure as a percentage of GDP by the end of Twelfth Five-Year plan. In order to achieve 2% public expenditure on health of GDP by 2016-17, the requirement of funds will have to increase to approximately Rs. 362 thousand crore in
the year 2016-17. This has been calculated on the basis of the assumption that the rate of growth of GDP in the year will be 15% (9% growth rate and 6 % inflation) at current prices in the year 2011-12. It may be mentioned that the total requirement of funds for the years 2012-13 to 2016-17 works out to around Rs.1178 thousand crore. For achieving 3 percent of GDP, the requirement of funds for health sector would have to increase to 543 thousand crore by 2016-17 and 1573 thousand crore for the Plan as a whole. It needs to be reiterated that these resource requirements are necessarily indicative

4.4 Tracking Measurement Mechanism:
The success of any programme, apart from other things, depends on a well-established monitoring and evaluation system for monitoring of activities of programmes / schemes / institutions / hospitals at various levels including National, State and lower levels. Besides independent reports, the data on programme performance under NRHM is monitored through the online Health Management Information System (HMIS).

Independent evaluation studies are also carried out through the Household Surveys like National Family Health surveys, District Level Household Surveys, Annual Health surveys, Concurrent Evaluation, etc. These survey provide important information as the programme indicator and their impact. Further, the Regional Evaluation Teams located in the offices of the Regional Directors of Health and Family Welfare, Government of India also make visits to the districts, facilities and households every month for verification about the facilities and the services provided. Teams comprising government officers, health experts, representatives of NGOs, development partners, etc also visit the States / districts as part of the Joint Review Missions and Common Review Mission under the RCH programme and the NRHM.

The National Rural Health Mission (NRHM) has time-bound quantifiable goals to be achieved through specific road maps with appropriate linkages and financial allocations for strengthening the health infrastructure. A continuous flow of good quality information on inputs, outputs and outcome indicators, is essential for monitoring the progress of NRHM at closer intervals. Integral to this process is using information for decentralized planning where the States prepare Integrated District Health Action Plans (IDHAP) culminating to the State Health Action Plans or Programme Implementation Plans (PIP) through which resource mobilization takes place.

At the national level constant efforts are being made in order to improve the Monitoring & Evaluation system in pursuance to the recommendations of the Task Force on HMIS, according to which, inadequate attention is being paid towards strengthening support systems for an effective MIS system in terms of dedicated manpower, their training, IT interventions and dedicated funds.
Surveys

Under NRHM, one of the strong pillars is to involve the community and NGOs in partnership for evaluation of the NRHM. Thus, the Advisory Group on Community Action (AGCA) is working towards developing a system for Community Monitoring of the health facilities and the services provided.

E-Governance Initiatives

The E-Governance activities undertaken in the past by the Ministry were in selected areas. With a view to integrating the E-governance and IT initiatives in the Ministry, an E-Governance Road Map has been prepared.
Section 5

LINKAGE BETWEEN STRATEGIC PLAN AND RFD
5.1 Linkage between Strategic Plan and RFD

The Strategic Plan has been prepared keeping in view the overall vision mission and objectives of the Department and they reflect the aspiration of the Department. This has been discussed in Section 1. The Results Framework Document for the year 2010-11 was prepared in line with the vision mission and objectives of the Department. The strategies for achieving goals/objectives of the Department would also have an impact on achievement of the success indicators visualized in the Results Framework Document of the Department. It may be mentioned that the success indicators mentioned in the RFD 2010-11 would broadly continue to be the same in the 2011-12 and changes would be made in these indicators should the need arise in future, keeping in view the changes in priorities.
Section 6

CROSS DEPARTMENTAL AND CROSS FUNCTIONAL ISSUES
6.1 Linkage with potential challenges likely to be addressed in the Twelfth Five Year Plan

At the outset, it may be mentioned that formulation of Twelfth Five Year Plan is a multi-stage consultative process and priorities of Plan can be approved only by the National Development Council. Yet some of the key areas that should receive attention during the Twelfth Five Year Plan are discussed here. These include, (i) augmentation of human resources for health sector and hence bridging the gap between requirement and availability of personnel viz., doctors, para-medicals, nursing and other staff at the grass-root level, (ii) improvement in health related infrastructure at various levels viz. primary, secondary and tertiary so as to improve access to these facilities including by having facilities in remote, difficult areas including hilly and tribal areas and reduce regional imbalances in the availability of health infrastructure, (iii) greater emphasis on reproductive and child health (including institution deliveries) in order to ensure that the reduction in child and maternal mortality is achieved at the earliest, (iv) prevention and control of communicable and non-communicable diseases, (v) population stabilization, (vi) health-care for elderly, (vii) improvement in nutrition status of population in general and women and children in particular, (viii) ensuring availability of quality drugs at affordable prices, etc.

These issues have been addressed in the strategic paper in some detail.

6.2 Identification and Management of cross departmental issues including resource allocation and capacity building issues

Health, being a State subject and Family Welfare being a concurrent one, the Central Government works in partnership with States/UTs. The performance in Health sector, therefore, depends on the success of this partnership. The determinants of health are very wide and this requires inter-sectoral convergence with Departments concerned with subjects to Drinking Water, Sanitation, Nutrition, Education, etc. In addition, there are other Departments/Bodies that have an important bearing on the outcomes, viz. the Planning Commission and Department of Expenditure. The role of various agencies that is critical for delivering the agreed results is given in the following paragraphs.

The indicators of health depend crucially on availability of drinking water, female literacy, nutrition, early childhood development, sanitation, women’s empowerment, etc., in addition to institutions such as hospitals and well functioning health system. The Anganwadi Centre under the ICDS at the village level is a major hub for health related activities. Likewise, wherever village committees have been effectively constituted for drinking water, sanitation, ICDS, etc., Panchayati Raj institutions also play a role in determining health outcomes.
Convergence with all the Departments that influence health related outcomes is necessary for improved health indicators. These Departments include Women & Child, Education, Panchayati Raj, Water & Sanitation Department besides the Departments within the Ministry viz. Department of AIDS Control, AYUSH and Department of Health Research.

Apart from the actions of various Central Government Departments, the achievements of results would critically hinge on the implementation being done at the State Government level for various programmes, apart from providing adequate resources from their own funds and improve the absorptive capacity for utilization of funds.

An area that is crucial in the health sector is that of “human resources”. Hence, the quality of medical education is important. The regulatory bodies like Medical Council of India, Dental Council of India, Pharmacy Council of India and Indian Nursing Council have an important role in maintaining the uniform standards of medical education, promoting training and the research activities.

The Non-governmental Organizations are also critical for the improvement of health status of the society. Besides advocacy, NGOs are be involved in building capacity at all levels, monitoring and evaluation of the health sector, delivery of health services, working together with community organizations and Panchayti Raj institutions. The successful operations of NGOs could have an impact on the outcomes.

6.3 Cross functional linkages within departments / offices

The various Departments within the Ministry of Health and Family Welfare viz. the Department of Health & Family Welfare, Department of AYUSH, Department of AIDS Control and Department of Health Research along with the various responsibility centres, subordinate offices, etc. have distinct roles but common goal of ensuring health for all, an objective that has been enunciated in the National Health Policy. There are various mechanism /forums where the cross functional issues are addressed viz. Central Council for Health & Family Welfare, where all the four Departments are represented, among others. Similarly, there is regular interaction with the responsibility centres to address common issues in addition to the issues that pertain to individual institution.

6.4 Organizational review and role of agencies and wider public services

The department has already accepted and implemented the recommendations of the Administrative Reforms Commission regarding formulation of Citizen’s/ Client’s Charter and Public Grievance Redress Mechanism as part of the strategy initiatives. The Department has already formulated and implemented the Citizen’s/ Client’s Charter and Public Grievance Redressal Mechanism. Necessary directions have been issued to all responsibility centres for preparation and implementation of Citizen’s/ Client’s Charter and Public Grievance Redress Mechanism.
Section 7

MONITORING AND REVIEWING ARRANGEMENTS
7.1 Monitoring and Reviewing Arrangements

In consonance with the National Health Policy and National Rural Health Mission, the Health and Family Welfare programmes aim at achieving good health for the people, especially the poor. These programmes are constantly monitored and assessed through multiple monitoring mechanisms including analysis of structured monthly and quarterly reports, periodical review meetings/Joint Monitoring Missions, External Surveys, Health Management Information System (HMIS), Performance Audit by CAG, Mid-Term Appraisal by Planning Commission etc. The expenditure incurred by the States is being monitored through a quarterly Financial Monitoring Report (FMR) received from the States/UTs. In addition, the programme performance reviews are also undertaken by Common Review Missions, Joint Review Missions and also through monthly concurrent audit and annual audit of the State/District Health Societies for proper implementation of health and family welfare schemes.

The details of monitoring and reviewing arrangement of the schemes/programmes under the Department of Health & Family Welfare has already been covered under section 4 dealing with “Tracking Measurement Mechanism”