PMO VERSION

National Mission for Rural Health Care

Preamble

This Mission seeks to improve rural health care delivery in states where it is weakest at present by ensuring a provider in each village, effective hospital care to the rural population and converged local level action on health and the determinants of health for maximum impact. The Mission will be the instrument to integrate multiple vertical programmes at the District level along with their funds. The Mission will ensure the right of every child in India to basic health services

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Current Situation

- Health status of the people is extremely poor in the rural areas. Health delivery is weakest in the 10 states of Bihar, Jharkhand, Madhya Pradesh, Chattisgarh, Orissa, Rajasthan, Uttar Pradesh, Uttaranchal, Assam, Jammu and Kashmir. 7 states in the North-East also need special focus
- Poverty and ill-health are mutually reinforcing
- These states also contain the 150 population-focus districts: Population stabilisation needs effective basic health care and not coercive population control measures

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Current Situation

- IMR decline has slowed down in the nineties
- MMR has increased from 424 maternal deaths(out of 100,000) to 540 in the last decade
- Resurgence in communicable diseases: 2 million malaria cases annually, 5 lakh die annually of tuberculosis, 6 lakh children die each year of diarrhoea all of which preventable
- Public investment in health is only 0.9% of GDP and India one of the 5 lowest spenders on health
- Only 17% of health care needs are met by the public sector
- It is against this background that NCMP conceives revamping health care delivery and proposes 2-3% of GDP to be invested in health to improve the state of basic health care.

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Current Situation

- Health sector internally fragmented through multiple schemes objectives. Its own resources are therefore fragmented
- It is a sector that needs " extra" sector action to be effective (for example determinant services like safe water, nutrition, sanitation etc impact health outcomes)
- Panchayats provide such opportunity for intersectoral action: but not utilisised
- Opportunity to redesign ineffective national programmes mandate in NCMP/PM's directive to revamp delivery

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Challenge 1. Strengthening Village level care

- **There is no public health provider at the village level in many villages in the country.**
- **The nearest provider- a Multi-Purpose Worker or ANM has been provided on the wrong norm of population and not habitation and thereby having one person for a cluster of villages.**
- **The health agenda of the MPW/ANM is given from "above" and therefore unable to respond effectively to real health concerns of the people.**
- **Local bodies not effectively empowered in health to be able create intersectoral action to combat disease**
- **Private providers are not accredited and therefore do an entrepreneurial function, not a public health one**
- **Government has " programmes for individual diseases" and not a plan for comprehensive health care**
- **Health care delivery is completely top-down with priorities set above and flowing down**

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Challenge1. Strengthening Village Health Care

- First Unit of MPW (ANM) fails because not a resident of the village
- Therefore every village must have a health provider. Population-based provisioning of health workers has been a mistake
- The provider could be could be a trained barefoot doctor
- To be seen as a community health activist or a social entrepreneur and not as the lowest link of a government chain.

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Challenge 1: Strengthening Village Health Care : Task 1. **Creating a barefoot doctor in every village**

- Should be a local resident, preferably a woman
- Educational qualifications of High School
- To be selected by a team consisting of the local panchayat representative, MPW and Anganwadi worker
- Trained by the government at block or district level for 6 months ending in certification/accreditation
- Training module to be an integrated package of modern and ISM
- Provision for recurring training each year
- Allowed to practice non scheduled drugs
- The person to be " incentivised" for delivery of services to be paid against performance
- Link with banks for setting up service unit

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Challenge 1. Strengthening Village Health Care. Task 2: **Creating the Village Health Team**

- There should be constituted in each village, a Village Health Team as a frontline team headed by the elected panchayat representative and consisting of the MPW, anganwadi worker and local teacher who will enable the community health activist
- This team should in turn be enabled to develop a Village Health Plan mapping morbidity profile and and a Village Health Register.
- These Village Health Registers should aggregate into the sub Centre level Health Plan which in turn will feed into the district plan
- The Village Health Team will have as its tasks:
  - Action on determinants of Health
  - Community level health surveillance
  - Promotion of health seeking behaviour

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Challenge 1: Strengthening Village Health Care:
Task 3: **Strengthening the Sub Health entre**

- If resources permit, increase the number of MPW (any addition be women)
- MPW be empowered to represent health concerns under her charge through fortnightly reports to PHC
- MPW at sub centre level will develop an action plan based on Village Health Plans
- Sub Centre be given autonomy in matters of providing incentive amounts to community health activists against services rendered
- **Untied fund of Rs 10,000/ each year to the sub centre for triggering community health action**
- Important to give autonomy to the sub centre to be as much a planner for health

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Challenge 2: Strengthening the Sector PHC (the " nearest" hospital)

- The PHC is today a dysfunctional unit in many parts of the country. One for every 30,000+ population
- An instance of planning failure: Conceived as **both** a "hospital"for in patient care and a territorial " supervisory" unit for health needs below (of 30 odd villages)
- Equipped not to deliver either. Fails as hospital because it has only one doctor, one nursing assistant, one dresser, one compounder for in patient care. Remaining staff are supervisors of MPWs.
- Has 6 beds. Mostly underutilised (utilisation % is zero to 2%)

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Challenge 2: Strengthening Sector PHC: Task: 1: States to Review and restructure Sector PHC

- Restructuring options:
- (a) Have more doctors and make it functional as first referral unit. This will depend not merely on finances but willingness of people to serve in these locations
- (b) examine if ISM doctors can be added to make it functional
- (c) Consider making it a fixed-day/fixed hour OPD service and doctor being provided transport to provide same services at Sub Centre level
- (d) Pull out the medical staff and attach them to CHC above and allot territorial jurisdiction as a mobile team (supported with transport) with fixed days in sub Health Centres. Tasked to activate Sub Health Centres and nodalise health concerns of the Sector PHC area
- **States free to consider these or more options: GOI to support locally relevant transition**

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Challenge 3: Improving Referral (Hospital)Care: Task: Strengthening Community Health Centres

- Clear set of norms in terms of personnel, to equipment and practices established as standards to make it an effective referral unit
- These norms to be in public domain
- Time-bound action to fill gaps in terms of standards
- Create for each CHC a Management Committee of Users (like Rogi Kalyan Samiti) which will oversee the hospital
- Financial autonomy for CHC for purchase of drugs etc(laid out as set of norms under "practices")

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Challenge 4: Effective Management of Public Health at District level: Task 1: Creating a District Health Mission as unified authority

- Integration of multiple units under the Department of Health and Family Welfare along with funds under a common District Health Mission
- Mission to be chaired by ZP President/ Collector with District Health Head as Covenor
- All related departments (water supply, sanitation, nutrition, education etc) represented in the Mission
- Giving managerial support to this unit
- Making the Mission accountable to Zilla Panchayat in case it is led by officials

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Challenge 4: Task 2: Creation and Implementation of a District Plan

Plan to be an aggregation of Village Health Plans first aggregated at Sub Centre and then Sector PHC levels

1. Provision of Community Health Activists in each village, identification, training, accreditation, creating performance-related incentives
2. Training of all Traditional birth attendants
3. 3. Creation of Frontline Village Health Teams in all villages and their training
4. Creation of a Villlage Health Document through panchayat leadership and the Village Health Team.

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Challenge 4: Task 2: Creation and Implementation of of a District Plan

5. Mapping of providers including private providers and accrediting them for public health outcomes
6. Revamping of Sector PHCs
7. Making CHCs effective hospitals under community management
8. Inter-sectoral Action for nutrition, safe water, sanitation, school health education all to be part of the plan
9. Developing and implementing a training plan in the district covering community health activists, TBAs, Village Health Teams, local body representatives, private providers etc.

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Challenge 4: Task 2: Creation and Implementation of a District Plan

10. Allocation of resources under the District Health Fund of the Mission
11. Ensuring constitution and effective functioning of hospitals under User Management
12. Ensuring provision of untied funds to Sub Health Centres
13. Creating an effective quality circle for public health management involving representatives from public and private sector, NGOs and citizen representatives
14. Creating a system of Public Reports on the State of Public Health in the District reported annually as a public document on the state of health provisioning in the district

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Challenge 4: Task 2: Creation and Implementation of a District Plan

15. Operationalising a Technical Resource Support Group to assist the District Mission in planning and implementing the district health plan
16. Inbuilding in the plan a clear role for the private sector (non profit and for-profit) at the district level to complement government action for public health provisioning

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Challenge 5: Restructuring State Health Delivery: Task 1: Creation of State Rural Health Mission and defining its role

1. Setting up a State Rural Health Mission under the Chairmanship of Chief Minister, Ministers of related departments, experts from outside the government, representatives of ZPS, NGOs, Chief Secretary, Secretaries of related departments, Vice Chairman Planning Board, Chief Secretary etc as members and state Secretary for Health as Convenor
2. Ensure resource allocations for District Missions
3. Review Implementation of District Health Mission Plans and all Mission related activities

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Challenge 5: Restructuring State Health Delivery: Task 1: Creation of State Rural Health Mission and defining its role

4. Developing protocols for involvement of the private sector in public health outcomes in the state (This should not be sought to be done at the Central Level to avoid charges of privatising the health sector. The argument has to be seen located in a larger neglect of the public health system)
5. Promotion of Community Health Insurance (This is best done at state and not central level as state situations are highly uneven in their ability to respond to a nation-wide insurance scheme)
6. Promotion of Community Health Insurance for the Urban Poor (urban poor given locational advantage could perhaps have effective insurance cover)

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Challenge 5: Restructuring State Health Delivery: Task 1: Creation of State Rural Health Mission and defining its role

7. Developing norms for public health outlets like sub centres, PHCS, CHCs etc and ensuring compliance
8. Decetralise financial arrangements for making local units effective in terms of services like provision of drugs
9. Develop a Human Resources Plan for Health Sector in the state covering medical and non -medical staff (nursing etc) and implement it
8. Develop and implement a performance-linked incentive scheme for Community Health Activists (who should not be paid honarariums but instead compensated for services delivered)
9. Integrate ISM into mainstream ghealth delivery

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Challenge 6: Reform at National Level Task 1: Integration of Funds at under an omnibus head of the National Rural Health Mission

- Option 1: A new plan scheme created (akin to the Macro-Management for the Agricultutre Sector where such an omnius scheme pools all other schemes into it) called National Rural Health Mission
- Option 2: Adopt a "funnel" approach and ensure all funds flow to the District Health Mission
- Now that MTR of Planning Commission is under way, an opportunity to combine
- From fiscal 05-06, either Option 1 or 2 in place

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Challenge 6: Reform at National Level
Task 1: Schemes with funds under an omnibus head of the National Rural Health Mission

- Schemes to be integrated
  - Strengthening of Rural Health Care Infrastructure
  - Population Control
  - Reproductive and Child Health
  - National Malaria Eradication Programme
  - National Leprosy Eradication Programme
  - National Kala Azar Programme
  - National Programme of Control of Blindness
  - National Iodine Deficiency Disorders programme
  - National Filaria Programme
  - Revised National Tuberculosis Programme
  - (National Aids Programme and National Cancer Programme not being integrated)

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Challenge 6: Reform at National Level;
Task 1: A National Mission with Integration of Funds at under an omnibus head of the National Rural Health Mission

- These schemes if budgeted separately(as in option 2) must flow into the District Health Mission through states
- A comprehensive MIS system called People Health Watch will be developed for monitoring.
- This MIS will from the second year be in the public domain
- Centre will develop a Community Health Insurance Scheme for the Urban Poor to ensure that urban poor concerns are on board (as this is seen as Rural Health Care Mission)

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Mission Outcomes 2004-2009

- At the village level, every village gets a provider--either MPW or Community Health Activist
- At the village level, a trained dai in each village
- At the village level, a sensitised frontline team of panch,MPW,Anganwadi worker etc
- At village level, action on determinants of health
- At the Village level. A Village Health Plan
- At village (cluster) level, a better functioning sub Health Centre with untied funds for community health action

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Mission Outcomes: 2004-2009

- **A better functioning CHC for hospital care**
- **Each CHC working under community control, with local resource mobilisation**
- **At District level, a coordinated plan that links with private providers**
- **At District level, a coordinated plan with action on determinants**
- **At District level, integration of resources internal to health sector and combining with outside sector funds**
- **At District level, effective support staff**
- **At District level, effective programme review and public accountability**
- **Impact on IMR, MMR, Universal Immunisation, Reduction in Communicable Diseases in 4 years, mainstreaming Aids prevention, leading to population stabilisation**

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Mission Implementation Structure

- For all Missions : Mission Coordinating Group Chaired by Prime Minister with Ministers of Mission Areas, Deputy Chairman Planning Commission, Cabinet Secretary and Principal Secretary to PM
- For National Rural Health Mission: Mission Steering group chaired by the Minister f Health with Experts, Secretaries of three wings of Health, Secretaries of related departments and experts/NGOs from outside (who constitute 50% of the group)
- Mission director at the level of Joint secretary with support staff

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Mission Timelines (October 04-March 05)

- Cabinet Note for circulation: 20 October
- Cabinet Clearance: 1st week of November
- Launch of Mission : 14 November (as Orientation of State Governments and Communication to Districts)
- Integration of Schemes by Planning Commission into a common Mission: 31 November
- Approval in NDC January
- Mission budgeted in fiscal 2005
- Preparatory action : December 04- March 2005

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Finances currently available

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Issues for Decision

- Approval of the Strategy of the mission
- Approval of Mission Implementation Structure
- Consideration if Mission should be a National Mission covering all states (issue raised in consultation)
- Consideration if Mission should include urban areas (raised in consultation)

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Everybody wins

- Citizens get improved health services
- Local bodies/ District gets leadership roles in planning for their area
- State governments/ state managers get freedom from vertical programmes that dissipate energies
- Government of India is able to target its resources better and ensure better outcomes
- Private Sector, NGOs get space to collaborate
- Development Partners get a common platform to support

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