Post Graduate Certificate Course in Health System and Management

Module 2

Basics of Health System and Health Care Delivery

2015

Indian Association of Preventive and Social Medicine
Gujarat Chapter

Post Graduate Certificate Course in Health System & Management (PGCHSM)

Team –2014

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Preface

Understanding of Health system and acquiring skills of health management are assuming importance in protecting and promoting people's health. Sound epidemiological knowledge and skills are ineffective if it is not complemented with robust Health System and Effective management. Hence it is the high time for every health manager to acquire the managerial understanding and skills.

As a professional body in Public Health; it is our responsibility to act as a catalyst in increasing the quality of health services. This course; Post Graduate Certificate In Health System and Management is an attempt to bridge the gap between technical and managerial worlds for Community Physicians and Public Health experts.

This course is covering key topics on health system, planning, managing human resources, materials and machines. Also health fineness and health economics, monitoring and evaluation, quality in health care are covered. The strength of the course lies in its faculties. Faculties are mixed of experts from the medical colleges and public's health cadres. Also it is envisage that students who are opting the course develop critical and creative thinking, reasoning power and analytical skills in Community Health with vision of applicability.

We have successfully completed two PGCHSM courses during the years 2013 and 2014.

I am sure this is a small step, but it will go a long way in creating culture for learning about health system and health management in the medical expert involved with public health. We are looking forward to your suggestions and support to further enhance the quality of this course.

Dr. K. N. Sonaliya
President – IAPSM-GC (2015-16)
Dr. A. M. Kadri
Secretary – IAPSM-GC (2015-18)

Dr. Kaushik Lodhiya
Course Coordinator

Acknowledgement

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We are grateful to Dr. Pradeepkumar and Dr. P. B. Verma for their constant support and advice. We are also thankful to Dr. K.N.Patel, Dr. J.D. Gajjar and Dr. S.R. Patel from public health and Dr. Atul Trivedi, Dr. Udayshankar Singh, Dr. Niraj Pandit, Dr. Chandresh Pandya, Dr. Jay Sheth, Dr. Prakash Patel, Dr Urvish Joshi and Dr. Kapil Gandha from Community Medicine Department, Medical colleges for actively facilitating learning as faculties.

We deeply appreciate tireless efforts of Dr. Umed Patel and Dr. Kaushik Lodhiya for successfully steering the entire course and give a concrete shape.

Academia
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: About Module:

This is the second module in the series of Post Graduate Certificate Course in Health System & Management. The first module – Introduction to Public Health, introduced the participants to the concepts of primary health care, describes the evolution of public health, briefs to history of health planning in India along with description of Five year plans and its relevant topics.

Module 2 – introduces the participants to health system of India as well as health care delivery mechanisms. It begins with chapter describing public health system in India. As we know health care is provided by private sector, public sector as well as not for profit sector. Although private sector caters to over 70% of the patients, this sector is not much organized & so it has not been described. Public health system is organized from union level to the most periphery at sub-centre level. In this chapter an attempt has been made to describe the structure of health system at union, state & district levels. Much needed organograms are added at suitable places.

The second chapter in the sequence - 1. B deals with health system in urban areas. Rather than describing the current status the future recommendations under National Urban Health Mission are described here.

The third chapter – 1. C deals with community owner ship & community monitoring. It describes age old Panchayati Raj system in India. We have specially incorporated this chapter since the cities & towns are classified as nagarpalikas, mahanagarpalikas, etc. The PRI are involved in multiple matters concerning the delivery of health care from district levels to the village level.

Since not for profit sector is playing a pivotal role in managing many of the disease conditions like TB, HIV, NCD, etc. it has been described in chapter 1.D. We have compiled information from various international, national & local NGOs, so that we could present some of the most important contributions of that particular NGO. The next chapter deals with Health Policy. It describes the factors to be considered before forming any health policy, the challenges & difficulties towards effectively combating various disease conditions. Once again it was beyond the scope of this module to describe all factors in details. So only a few chosen & important factors are described. All attempts are made to ensure that participants are able to understand the nature of health policy for developed & developing countries. Chapter 3 deals with health indicators. It attempts to define indicators, describes their importance, describes the various ways by which indicators are expressed, and defines various types of indicators along with examples. Chapter 4 attempts to present various health legislations in a more classified manner.

All attempts are made to ensure that the contents of the module are accurate & up to date. However any fault in the module contents is sincerely regretted.

Team
PG Certificate Course in Health System and Management
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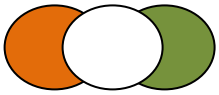
Post Graduate Certificate Course
In
Health System & Management



Module 2: Basics of Health System and Health Care Delivery

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M.D. (PSM)

Indian Association of Preventive and Social Medicine

Gujarat Chapter

2015

Chapter 1

INTRODUCTION TO HEALTH SYSTEM IN INDIA

Learning objectives: After studying this module participants will be able to

1. Understand organization, structure & composition of health system in India
2. Describe the functions of various levels of health organisations

For systematic understanding of structure, organisation & administration of health system in India, this chapter is presented as follows:

1. Health system set up from central to peripheral level

2. Health system set up in urban areas

3. Local self government in urban & rural areas

4. Voluntary health agencies in India

Chapter 1.A. HEALTH SYSTEM IN INDIA

In India Public and Private sector provides health care of primary to tertiary level to the patients/community through various kind of set up. Approximately **70%** patients are getting services from private sector while remaining **30%** patients are getting services from Govt. sector.

Private Sector: Doctors working in private sectors are providing services through:

- Single clinic
- Multi specialty clinic
- Single hospital
- Multi speciality hospital
- Super speciality hospital
- Multiple Super speciality Hospitals
- Trust hospital run though NGO
- Corporate hospital
- Medical Colleges

Public Sector: Department of Health and Family Welfare, Govt. of India has set-up from rural and remote area of the county to national capital level to cater the needs of citizens of India:

- Sub center
- Primary Health Centre
- Urban Health Center (for urban areas)
- Community Health Centre
- Sub district hospital
- District hospital
- Medical colleges

- Super specialty Hospital

Other set up are: ESIS Dispensaries and hospitals, Railway hospitals, Corporation hospitals and medical colleges etc.

NGOs & Associations: Central to local level NGOs like WHO, UNICEF, UNFPA, Red Cross, Rotary Club, Indian Medical Associations, Indian Dental Associations and many more organizations/associations are working for Health matters in India. They are involved as service provider, advocator, training, planning, monitoring, etc.

National Institutes: There are large numbers of national institutes' like:

1. National Institute of Occupational Health, Ahmedabad
2. National Institute of Nutrition, Hyderabad
3. National Institute of Mental Health, Bangalore
4. All India Institute of Public Health and Hygiene, Kolkata
5. National Institute of Health and Family Welfare, New Delhi
6. Malaria Research Centre (six centre's in India)

These institutes are working as **autonomous body** and as main technical institute in their field. They are involved advocacy, research, education, planning, monitoring, training, advisor etc.

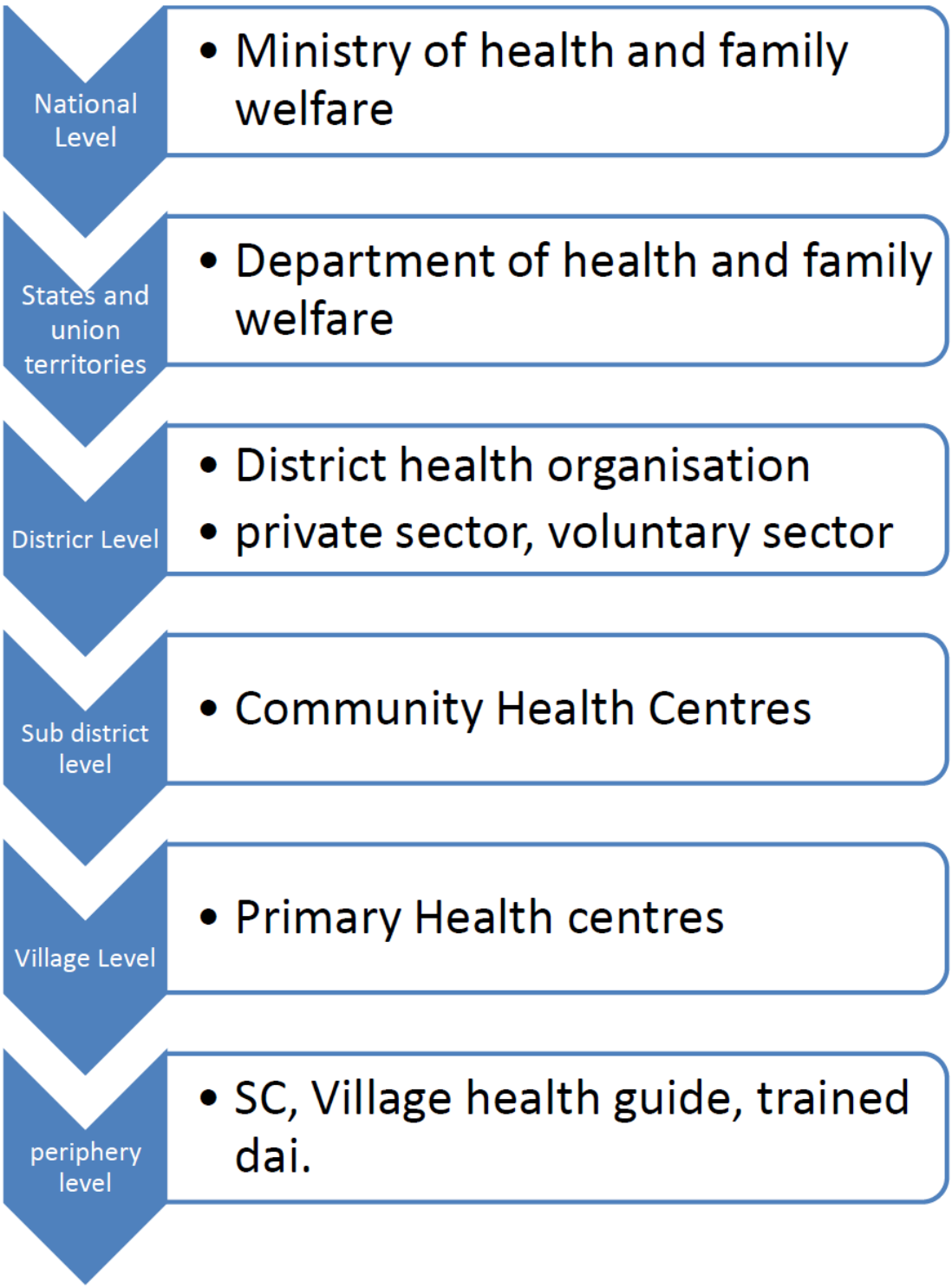
1. Health system set up from central to peripheral level

In the developing countries the organization of public health is determined to a greater extent by economic and developmental considerations. Governments in developing countries tend to provide health services, although not at the level of sophistication available in the developed countries. In most of the developing countries responsibility for public health is usually assumed by the central government through its Ministry of Health.
The poorest of the developing countries depend to a great extent upon support from non-governmental organizations and international agencies such as the WHO. These organizations do not always share the same vision of public health as the individual countries. Furthermore, they tend to provide assistance for specific diseases or subpopulations which often distort the priorities for health efforts. Health must compete with other governmental priorities for limited resources and often comes out second best. Because of the pressing need to address disease problems, particularly infectious disease problems, and the economic constraints under which they must operate, very few developing countries have developed plans for safeguarding the environment and assuring that it is healthy. Finally, there is often a shortage of health professionals trained in modern public health to design and implement effective public health programmes.

Organization of the health system

The healthcare services' organization in the country extends from the national level to village level. From the total organization structure, we can slice the structure of healthcare system at national, state, district, community, PHC and sub-centre levels.

Overview view of Public health system in India:



National level –
Health system at the national level consists of:
(1) The *Ministry* of Health and Family Welfare;
(2) The *Directorate* General of Health Services; and
(3) The *Central Council* of Health and Family Welfare.

1. Union Ministry of Health and Family Welfare

The Union Ministry of Health and Family Welfare is *headed by* a cabinet Minister (Union minister - Shri. Ghulam Nabi Azad), a Minister of State and Deputy Health Minister.

[What is the difference between Cabinet Minister & Minister Of State (MoS).?

Union Cabinet Minister - **Senior** minister in-charge of a ministry. A Cabinet minister may also **hold additional charges** of other Ministries, where no other Cabinet minister is appointed.

Minister of State (**Independent Charge**) - with no overseeing Union Cabinet Minister for that portfolio

Minister of State (MoS) - **junior minister** with an overseeing Cabinet Minister, usually tasked with a specific responsibility in that ministry. For instance, an MoS in the Finance Ministry may only handle Taxation
(source: Wikipedia)].

The Ministry has ***four departments***, viz. –

A. Departments of Health and Family Welfare
B. Department of AYUSH
C. Department of Health Research
D. Department of AIDS Control

These departments are headed by secretaries to the govt. of India.
The **department of Health & FW** is supported by a technical wing, the Directorate General of Health Services, headed by Director General of Health Services (DGHS).

According to India's Constitution, *services are divided into "lists*" which specify who is responsible for them and empowered to pass legislation on them: *the Union list for the Central (federal) government, the State list for the state Govt. and the Concurrent List for tasks deemed to be the shared responsibility of the Central and State governments.* Union laws override those made by the states for items in the concurrent list.

The health-related provisions in the **union list** relate to port quarantine, research, and scientific and technical education.

The **concurrent list** includes 'prevention of the extension from one State to another of infectious or contagious diseases or pests', and other issues with wider national ramifications such as food and drugs, family planning, medical education, and vital statistics.

Other than those mentioned above all other public health and environmental sanitation services are supposed to be the exclusive responsibility of **states**. However, the center exercises a great deal of power through financial control.

Using its financial and political influence, the central government can persuade the states to work towards specific health objectives and priorities, and provide the necessary technical support for this. An example of this is rural sanitation (in essence safe disposal of human excreta), which is listed as a 'state' subject but was largely neglected until the central government formulated a Central Rural Sanitation Program in 1984. This led the states to begin to implement rural sanitation schemes.

FUNCTIONS of Union MoHFW:

The functions of the union Health Ministry are under (a) the Union list and (b) the Concurrent list.

***(a) Union list*:**

(1) *International* health relations and administration of port quarantine

(2) Administration of *Central institutes* such as the All India Institute of Hygiene and Public Health, Kolkata;

(3) Promotion of *research* through research centers and other bodies

(4) Regulation and development of *medical Education*,

(5) Establishment and maintenance of *drug standards*

(6) Census, and collection and publication of other *statistical data*

(7) Immigration and *emigration*

(8) Regulation of *labour*

(9) *Coordination* with States and with other ministries for promotion of health.

(b) ***Concurrent list***: Functions listed under the concurrent list are responsibility of both the Union and State governments. The Centre and the States have simultaneous powers of legislation: The concurrent list includes:

(1) Prevention of extension of *communicable diseases* from one unit to another

(2) Prevention of *adulteration* of foodstuffs
(3) Control of *drugs and poisons*
(4) *Vital statistics*
(5) *Labour Welfare*
(6) *Ports* other than major
(7) *Economic and social planning*, and
(8) Population control and *Family Planning*.

A. Department of Health & FW:

The Health Department is headed by *a secretary* to the Government of India as its executive head, assisted by joint secretaries, deputy secretaries and a large administrative staff.
Deals with medical & public health maters including drugs control & prevention of food adulteration.
The MoHFW's Department of Health is supported in its work by a vast network of autonomous research and training institutions which are spread all over the country but administratively under the central government. These include the National Institute of Communicable Diseases (Delhi), which was set up as a center for disease control; the Central Bureau of Health Intelligence (New Delhi), several apex and regional training institutes, and specialized institutions such as the Central Food Laboratory and Central Drugs Laboratory. It also includes the Indian Council of Medical Research which is headquartered in New Delhi and has 6 Regional Medical Research Centers, and over 20 specialized research institutions and laboratories across the country. The Department of Family Welfare is supported by another network of institutions, and 18 research centers across the country. Besides these, the work of the MoHFW is supported by institutions run by other bodies, such as the central government's Council of Scientific & Industrial Research which has institutions specialized in drug research and environmental engineering.
It has the following *technical divisions*:

1. Blindness Control
2. Bureau Of Planning
3. Cancer Control Programme
4. CCA
5. Central Design Bureau
6. CHS
7. Emergency Medical Relief
8. Food & Drugs
9. IC & IH
10. Immunization
11. Medical Education
12. Medical Tourism
13. Mental Health Division
14. National Programme For Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke(NPCDCS)
15. National Programme for Health Care of the Elderly NPHCE
16. National Programme for Prevention and Control of Deafness (NPPCD)
17. National Vector Borne Disease Control Programme
18. NGO Division

19. NHM Finance
20. NHM policy & Planning
21. NUHM
22. Infrastructure & HR Division
23. Telemedicine
24. ME-P II
25. Dental
26. Nursing
27. PMS
28. PMSSY
29. PNDT
30. Principal Accounts Office
31. Food Quality Control
32. Procurement
33. Revised National Tuberculosis Programme
34. Statistics Division
35. Training Division
36. Activities Of Health and Family Welfare
37. OP & Nirodh Marketing

B. Department of Indian System of Medicine & Health:

Established in March **95**.

The main areas of its functioning are:

1. Education
2. Standardisation of drugs
3. Enhancement of availability of raw materials
4. Research & development
5. IEC
6. Mainstreaming ISM & H in health care.

C. Department of Health Research

D. Department of AIDS Control

2. Directorate General of Health Services

(a) ORGANIZATION: The Director General of Health Services is the *principal adviser* to the Union Government in both medical and public health matters. He is assisted by an additional Director General of Health Services, a team of deputies and a large administrative staff. The Directorate comprises of *three main units*, e.g., medical care and hospitals, public health and general administration.

(b) FUNCTIONS: The GENERAL functions are surveys, planning, coordination, programming and appraisal of all health matters in the country.

The SPECIFIC functions are

(1) International health relations and quarantine

(2) Control of drug standards: The Drugs Control Organization is headed by the Drugs Controller.

(3) Medical store depots: These depots supply the civil medical requirements of the Central Government and of the various State Governments.

(4) Post graduate training: The Directorate General of Health Services is responsible for the administration of national institutes. Some of these institutes are:- the all India Institute of Hygiene and Public Health at Kolkata, All India Institute of Mental Health at Bangalore, College of Nursing at Delhi.

(5) Medical education: The Central Directorate is directly in charge of the following medical colleges at Pondicherry, and Goa.

(6) Medical Research: Medical Research in the country is organized largely through the Indian Council of Medical Research,

(7) Central Govt. Health Scheme:

(8) National Health Programmes:

(9) Central Health Education Bureau: An outstanding activity of this bureau is the preparation of education material for creating health awareness among the people.

(10) Health Intelligence: The Central Bureau of Health Intelligence was established in 1961 to centralise collection, compilation, analysis, evaluation and dissemination of all information on health statistics for the nation as a whole. The Bureau has an Epidemiological Unit, a Health Economics Unit, a National Morbidity Survey Unit and a Manpower Cell.

(11) National Medical Library: The aim is to help in the advancement of medical, health and related sciences by collection, dissemination and exchange of information.

3. Central Council of Health

*Union Health Minister is the **Chairman** and the State Health Ministers are the **members***.(in short – a council of all health ministers)

FUNCTIONS:

(1) To consider and recommend **broad outlines of policy** in regard to provision of remedial and preventive care, environmental hygiene, nutrition, health education and the promotion of facilities for training and research.

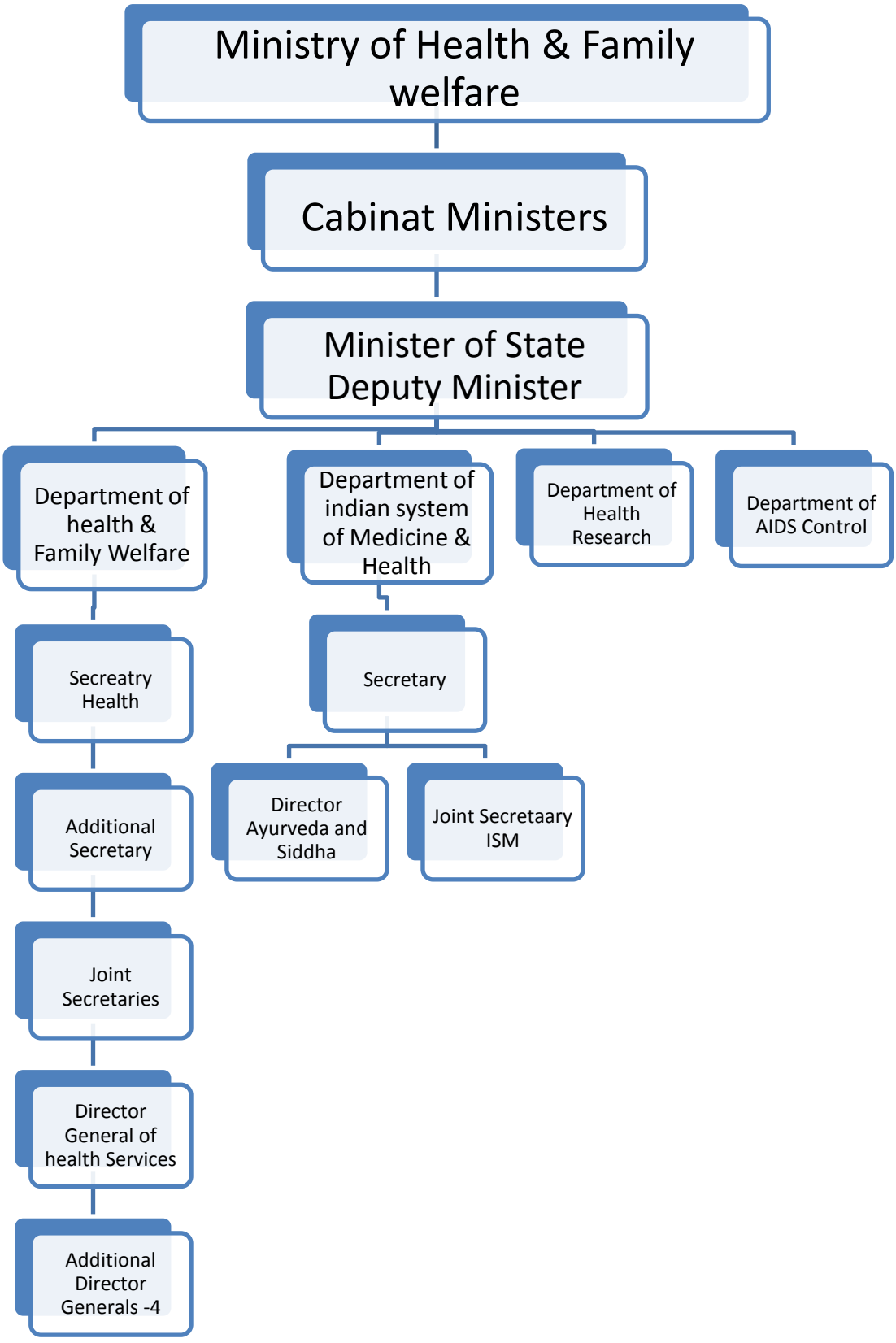
(2) To make proposals for **legislation** in medical and public health matters.

(3) To make recommendations to the Central Government regarding **distribution of available grants-in-aid** for health purpose to the States and to review periodically the work accomplished in different areas through the utilisation of these grants-in-aid.

(4) To establish any organization or organizations for promoting and maintaining **cooperation between the Central and State** Health administrations.

[How many times it meets in a year – annually]

Organisation of Health System at Union Level



Selected List of Central Health Institutions under the MOHFWs Department of Health
(Note: this list may not be complete, it was taken from the websites of the MoHFW, the ICMR, and WHO-India, and from Misra and others 2001: Appendix 1)

- National Institute of Communicable Diseases, New Delhi
- All India Institute of Hygiene and Public Health, Calcutta
- Central Health Education Bureau
- Central Bureau of Health Intelligence
- Central Research Institute, Kasauli
- Central Drugs Laboratory
- Central Food and Standardisation Laboratory
- Pasteur Institute of India, Coonoor
- National Tuberculosis Institute (NTI), Bangalore
- Indian Council of Medical Research (ICMR), headquartered in Delhi, and under it:

I. • 6 Regional Medical Research Centres
II. • 5 Centres for Advanced Research
III. • and a slew of permanent research institutes/ centres:

- ✓ Malaria Research Centre (MRC) , Delhi
- ✓ Institute of Pathology (IOP) , Delhi
- ✓ Institute of Cytology and Preventive Oncology (ICPO) , Delhi
- ✓ Institute of Research in Medical Statistics (IRMS) , Delhi
- ✓ Centre JALMA Institute of Leprosy (CJIL), Agra
- ✓ Rajendra Memorial Research Institute of Medical Sciences (RMRIMS), Patna
- ✓ National Institute of Cholera and Enteric Diseases (NICED), Kolkata
- ✓ National Institute of Occupational Health (NIOH), Ahmedabad
- ✓ National Institute for Research in Reproductive Health (NIRRH), Mumbai
- ✓ Institute of Immunohaemotology (IIH), Mumbai
- ✓ Enterovirus Research Centre (ERC) , Mumbai
- ✓ Genetic Research Centre , Mumbai
- ✓ National Institute of Virology (NIV). Pune
- ✓ National AIDS Research Centre (NARI), Pune
- ✓ National Institute of Nutrition (NIN), Hyderabad
- ✓ National Centre for Laboratory Animal Science (NCLAS), Hyderabad
- ✓ Food and Drug Toxicology Research Centre (FDTRC), Hyderabad
- ✓ Tuberculosis Research Centre (TRC), Chennai
- ✓ National Institute of Epidemiology (NIE), Chennai
- ✓ Vector Control Research Centre (VCRC), Pondicherry
- ✓ Centre for Research in Medical Entomology (CRME) , Madurai

And under the MoHFWs **Directorate-General of Health Services**: apex hospitals, including medical colleges, nursing schools, pharmacy and dental colleges, public health training institutes, Central Health Service, hospitals and dispensaries, port offices, and Drug Controller's Organization.

- Central Drug Research Institute, Lucknow
- National Environmental Engineering Research Institute, Nagpur
- 6 zonal laboratories of the National Environmental Engineering Research Institute
- Industrial Toxicology Research Centre, Lucknow

STATE LEVEL

The organization at State level is under the State Department of Health and Family Welfare in each State **headed by Minister** and with **a Secretariat under the charge of Secretary/Commissioner** (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS).

By and large, the organizational Structure adopted by the State is in conformity with the pattern of the Central Government. The **State Directorate of Health Services**, as the technical wing, is an attached office of the State Department of Health and Family Welfare and is headed by a Director of Health Services. However, the organizational structure of the State Directorate of Health Services is not uniform throughout the country. For example, in some states, the **Programme Officers** below the rank of Director of Health Services are called **Additional Director** of Health Services; while in other states they are called **Joint/Deputy Director,** Health Services. But regardless of the job title, each programme officer below the Director of Health Services deals with one or more subject(s). Every State Directorate has supportive categories comprising of both technical and administrative staff. The area of medical education which was integrated with the Directorate of Health Services at the State has once again shown a tendency of maintaining a separate identity as Directorate of Medical Education and Research. This Directorate is under the charge of Director of Medical Education, who is answerable directly to the Health Secretary/Commissioner of the State.

Some states have created the posts of Director (Ayurveda) and Director (Homeopathy). These officers enjoy a larger autonomy in day-to- day work, although sometimes they still fall under the Directorate of Health Services of the State.

Health as per constitution of India is a **state subject**. The state health department is assisted by Corporations, muncipalties, Panchayati Raj, ad hoc statutory bodies like mines board of health, ESI corporations, etc where ever they exist.

Political head: a minister of a cabinet rank is the political head of the health department.
- Formulates policies, Monitoring & implementation of these policies.

Administrative head: state secretariat

Secretariat means a complex of departments.

Headed by an IAS officer of the rank of commissioner who functions as secretary to the Government in the department of health & FW.

He is assisted by joint secretaries along with other administrative staff.

Technical head: Executive department function below secretariat.

Headed by specialists & are concerned with supervision, coordination & control of policy framed by state govt.

Headed by Director of Health services who has under him Joint directors (-Medical, Food & Drug, ESI, Administration, etc) & deputy directors responsible for inspection & supervision of all National Health programs along with program specialist of the rank of Assistant Directors to deal with individual & specific programs.

In Gujarat-

Cabinet Minister - Nitinbhai Patel *: Finance, Health, Medical education, Family welfare, transportation*

Ministers of State - *Parbat Patel****: Health, Family welfare, Child welfare***

Mr. P.K.Taneja - Principal Secretary(PH) and ***Commissionerate of Health, FW, MS, ME & Research.***

5 Add. Directors for - Health, FW, MS, ME, Statistics viz. *Dr. P.V.Dave, Dr. N B Dholakia, Dr. Sunil R. Avashia, Dr. P.D. Vithalani, Mr. K.K.Panchal, respectively.*

To summarise & further clarify the state level organization of health: State health administration

At present there are 28 States (& 7 UT) in India, with each state having its own health administration. In all the States, the management sector comprises the State Ministry of Health and a Directorate of Health.

1. State Ministry of Health

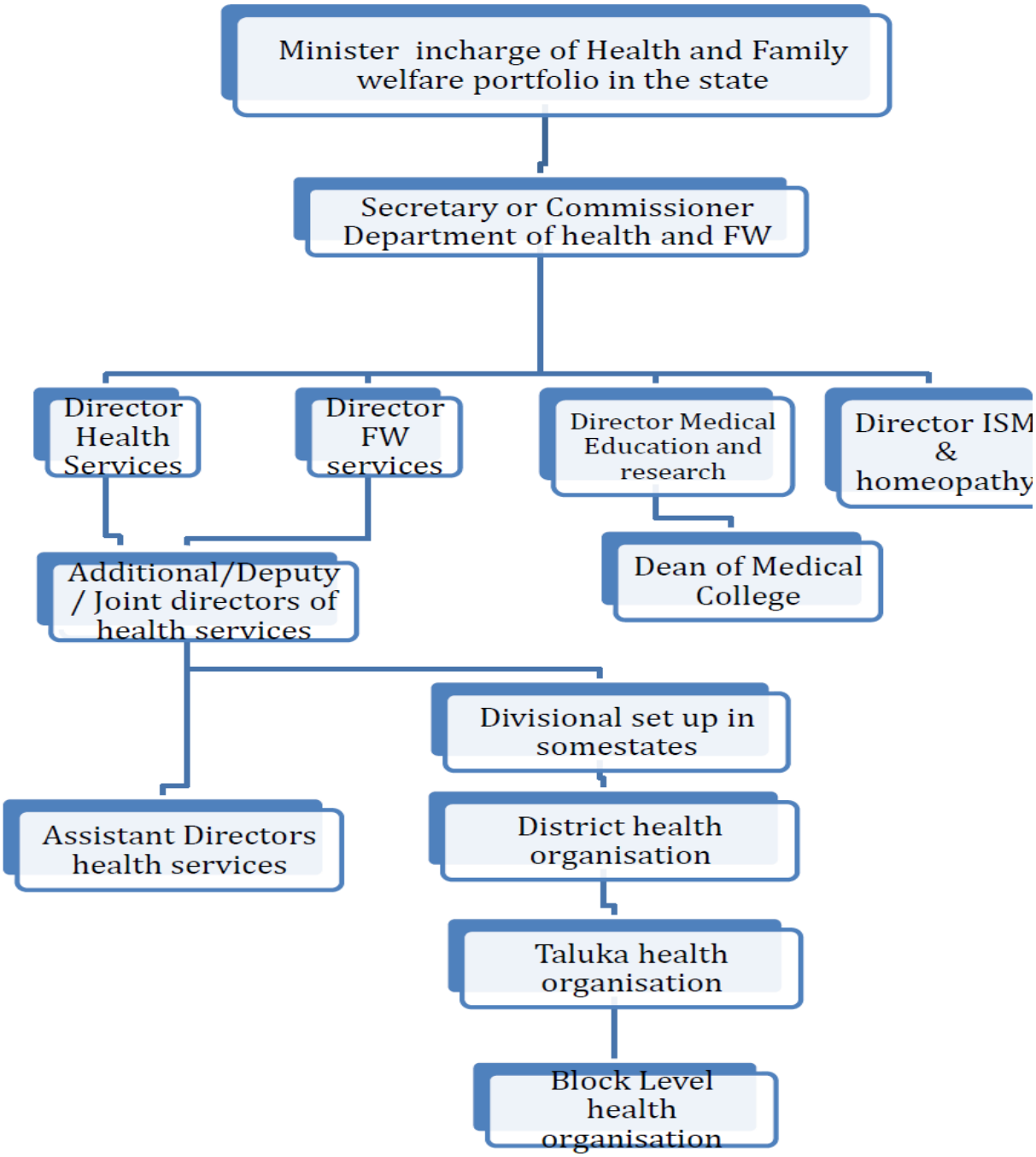
The State Ministry of Health is headed by a Minister of Health and Family Welfare and a Deputy Minister of Health and Family Welfare. The Health Secretariat is the official organ of the State Ministry of Health and is headed by a Secretary who is assisted by Deputy Secretaries, Under Secretaries and a large administrative staff. The Secretary is a senior officer of the Indian Administrative Service.

2. State Health Directorate

The Director of Health Services is the chief technical adviser to the State Government on all matters relating to medicine and public health. He is also responsible for the organization and direction of all health activities. With the advent of family planning as an important programme, the designation of Director of Health Services has been changed in some States and is known as Director of Health and Family Welfare. A recent development in some States is the appointment of a Director of Medical Education in view of the increasing number of medical colleges.

The Director of Health and Family Welfare is assisted by a suitable number of deputies and assistants. The deputy and Assistant Directors of Health may be of two types-regional. ***Regional Directors*** inspect all the branches of public health within their jurisdiction, irrespective of their speciality. ***The Functional Directors*** are usually specialists in a particular branch of public health such as mother and child health, family planning, nutrition, tuberculosis.

Organisational Structure of Health services at State Level



Regional level – In the state of Bihar, Madhya Pradesh, Uttar Pradesh, Andhra Pradesh, Karnataka and others, zonal or regional or divisional set-ups have been created between the State Directorate of Health Services and District Health Administration. Each regional/zonal set-up covers three to five districts and acts under authority delegated by the State Directorate of Health Services. The status of officers/in-charge of such regional/zonal organizations differs, but they are known as Additional/Joint/Deputy

Directors of Health Services in different States.

District level - In the recent past, states have reorganized their health services structures in order to bring all healthcare programmes in a district under unified control. The district level structure of health services is a middle level management organisation and it is a link between the State as well as regional structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side. It receives information from the State level and transmits the same to the periphery by suitable modifications to meet the local needs. In doing so, it adopts the functions of a manager and brings out various issues of general, organizational and administrative types in relation to the management of health services.

The district officer with the overall control is designated as the Chief Medical and Health Officer (CM & HO) or as the District Medical and Health Officer (DM & HO). These officers are popularly known as DMOs or CMOs, and are overall in-charge of the health and family welfare programmes in the district. They are responsible for implementing the programmes according to policies laid down and finalized at higher levels, i.e. State and Centre. These DMOs/CMOs are assisted by Dy. CMOs/AHDO and programme officers. The number of such officers, their specialization, and status in the cadre of State Civil Medical Services differ from the State to State. Due to this, the span of control and hierarchy of reporting of these programme officers vary from state to state.

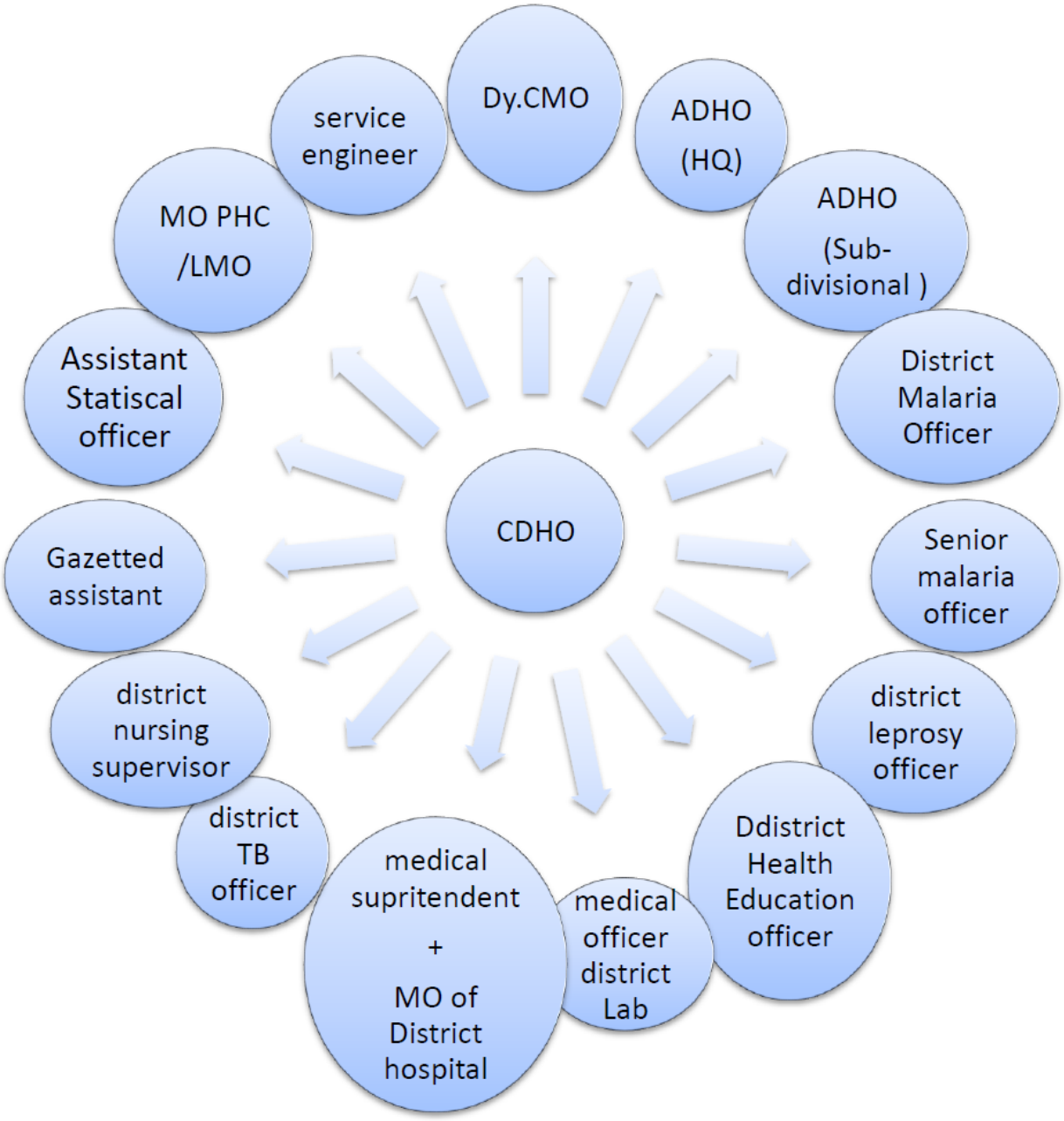
To summarise health organisation at the district level

The District

The principal unit of administration in India is the district under a Collector. There are 640 (year 2011) districts in India.

Most districts in India are divided into two or more sub-divisions, each in charge of an Assistant Collector. Each division is again divided into tehsils (talukas), in charge of a Tahsildar. A tahsil usually comprises between 200 to 600 villages. The rural areas of the district have been organized into Blocks, known as Community development blocks, the area of which may or may not coincide with tahsil. The block is a unit of rural planning and development, and comprises approximately 100 villages and about 80,000 to 1,20,000 population, in charge of a Block Development Officer. Finally there are the village panchayats, which are institutions of rural local self-government.

Organisational structure of Health department at district level



Sub-divisional/Taluka level – At the Taluka level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer (ADHO). Some specialties are made available at the taluka hospital. The ADHO is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital. These hospitals are being gradually converted into Community Health Centres (CHCs).

Community level – For a successful primary healthcare programme, effective referral support is to be provided. For this purpose one Community Health Centre (CHC) has been established for every 80,000 to 1, 20,000 population, and this centre provides the basic specialty services in general medicine, paediatrics, surgery, obstetrics and gynaecology. The CHCs are established by upgrading the sub-district/taluka hospitals or
some of the block level Primary Health Centres (PHCs) or by creating a new centre wherever absolutely needed.

It is manned by four medical specialists i.e. Surgeon, Physician, Gynaecologist and Paediatrician supported by 21 paramedical and other staff. It has 30 in-door beds with one OT, X-ray, Labour Room and Laboratory facilities. It serves as a referral centre for 4 PHCs and also provides facilities for obstetric care and specialist consultations. As on March, 2007, there are 4, 045 CHCs functioning in the country.

PHC level – At present there is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Many rural dispensaries have been upgraded to create these PHCs.

A PHC is manned by a Medical Officer supported by 14 paramedical and other staff. It acts as a referral unit for 6 sub-centres and refer out cases to Community Health Centres (CHCs-30 bedded hospital)/sub-district / district hospitals. It has 4-6 indoor beds for patients. There are 22, 370 PHCs functioning as on March 2007 in the country.

Each PHC has one medical officer, two health assistants – one male and one female, and the health workers and supporting staff. PHCs are established and maintained by State Governments under the Minimum Needs Programme (MNP)/Basic Minimum Services Programme (BMS).

For strengthening preventive and promotive aspects of healthcare, a post of Community Health Officer (CHO) was proposed to be provided at each new PHC, but most states did not take it up.

Sub-centre level – The most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker. At present, in most places there is one sub-centre for about 5,000 populations (3,000 in hilly and desert areas and in difficult terrain).

Sub-Centres are assigned tasks relating to interpersonal communication in order to bring about behavioral change and provide services in relation to maternal and child health, family welfare, nutrition, immunization, diarrhoea control and control of communicable diseases programmes. The Sub-Centres are provided with basic drugs for minor ailments needed for taking care of essential health needs of men, women and children.

There are 1,45,272 Sub Centres functioning in the country as on March 2007. Currently a Sub-centre is staffed by one Female Health Worker commonly known as Auxiliary Nurse Midwife (ANM) and one Male Health Worker commonly known as Multi Purpose Worker (Male). One Health Assistant (Female) commonly known as Lady Health Visitor (LHV) and one Health Assistant (Male) located at the PHC level are entrusted with the task of supervision of all the Sub-centres (generally six subcentres) under a PHC. The Ministry of Health & FW, GOI provides assistance to all the Sub-centres in the country since April 2002 in the form of salary of ANMs and LHVs, rent (if located in a rented building) and contingency, in addition to

drugs and equipment kits. The salary of Male Health Worker is borne by the State Governments.

The 73rd and 74th constitutional amendments have given the powers to the local bodies in some states of India. In the process, different states have adopted different stakeholders for the benefit of health services, with the help of community participation, which gives stress on safe drinking water and sanitation at village level. The Panchayats are given the power to look after the welfare of the people.

In some of the Indian states District Health System has been entrusted to the control of Panchayati Raj System while in others it is still under the total control of state Government.

TO SUMMARISE THE HEALTH SET UP IN INDIA:

Health care setup at Central level: There is Ministry of Health and Family Welfare

CENTRAL LEVEL

MINISTRY OF HEALTH AND FAMILY WELFARE

Nirman bhavan,New Delhi

CABINET MINISTER

And STATE MINISTERS (one or two)

ADMINISTRATORS

(IAS OFFICERS CADER)

1.Principal secretary Health & Family Welfare

HEALTH	FAMILY WELFARE
Secretary	Secretary
Joint Secretary	Joint Secretary
Deputy Secretary	Deputy Secretary
Under Secretary	Under Secretary

TECHNICAL EXPERTS

1.DIRECTOR GENERAL

Health Services

HEALTH	FAMILY WELFARE
Director	Director
Deputy Director	Deputy Director
Joint director	Joint director

STATE LEVEL

MINISTER OF HEALTH AND FAMILY WELFARE And **DEPUTY MINISTER HEALTH AND FAMILY WELFARE**
ADMINISTRATORS (IAS CADRE) 1.Principal Secretary of health 2.Comissioner of health and
TECHNICAL EXPERTS (Example of Gujarat) 1.Director (Post abolished) 2.Additional Directors • Health (PHCs/CHC) • Family welfare • Medical education and research • Medical services (Sub district/District Hosp) 3.four Deputy Directors 4.two Joint Directors

REGIONAL LEVEL (Example of Gujarat)

SIX REGIONS IN GUJARAT 1. RAJKOT(Rajkot, Jamnagar, Kutch, Porbandar) 2. BHAVNAGAR 3. AHMEDABAD 4. GANDHINAGAR 5. VADODARA 6. SURAT
REGIONAL DEPUTY DIRECTOR

District Level

DISTRICT MEGISTRATE(Collector)IAS And **DISTRICT DEVLOPEMENT OFFICER (IAS or GAS)** Also influence of **LOCAL MEMBERS OF PARLIAMENT** **AND ASSEMBLY**
CHIEF DISTRICT HEALTH OFFICER (DPH)
• ADDITIONAL DISTRICT HEALTH OFFICER (DPH) • DISTRICT TUBERCULOSIS OFFICER(DPH) • DISTRICT MALARIA OFFICER (Lab Tech) • EPIDEMIC MEDICAL OFFICER (MBBS) • QUALITY MEDICAL OFFICER(MBBS) • REPRODUCTIVE AND CHILD OFFICER(DPH)

BLOCK LEVEL

BLOCK/TALUKA HEALTH OFFICER (MBBS)

PHC LEVEL

Population norms PHC: 30,000 rural 20,000 in hilly, tribal &difficult areas

SUB CENTER LEVEL

Population coverage under sub center:5,000. And 3,000 in hilly, tribal & difficult Areas :ONE FHW & MPW

VILLAGE LEVEL

-ACCRIDATED SOCIAL HEALTH ACTIVIST(ASHA)

Source: MOHFW site, Gujhealth site, AFMC pune, K. Park

Chapter 1.B

INTRODUCTION TO HEALTH SYSTEM IN INDIA

URBAN HEALTH SYSTEM

National Urban Health Mission:

The Government of India has launched the National Urban Health Mission (NUHM) as a sub-mission under the National Health Mission (NHM), the National Rural Health Mission (NRHM) being the other sub-mission.

NUHM seeks to improve the health status of the urban population particularly slum dwellers and other vulnerable sections by facilitating their access to quality health care. NUHM would cover all state capitals, district headquarters and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with population below 50,000 will be covered under NRHM.

Key features of NUHM are enumerated below:

Creation of service delivery infrastructure:

Urban- Primary Health Centre (U-PHC):

Functional for *approximately 50,000 population*, the U-PHC would be located within or near a slum. The working hours of the U-PHC would be from 12.00 noon to 8.00 pm. The services provided by U-PHC would include OPD (consultation), basic lab diagnosis, drug /contraceptive dispensing and delivery of Reproductive & Child Health (RCH) services, as well as preventive and promotive aspects of all communicable and non-communicable diseases.

Urban-Community Health Centre (U-CHC) and Referral Hospitals:

30-50 bedded U-CHC providing inpatient care in cities with population of *above five lakhs*, wherever required and 75-100 bedded U-CHC facilities in metros. Existing maternity homes, hospitals managed by the state government/ULB could be developed.

In towns/ cities, where some sort of public health institutions like Urban Family Welfare Centres, Maternity Homes etc., exist effort will be made to strengthen them on the lines of U-PHC and U-CHC.

Outreach:

Creation of Sub Centres has not been envisaged under NUHM. Outreach services will be provided through Female Health Workers (FHWs)/ Auxiliary Nursing Midwives (ANMs) headquartered at the UPHCs.

ANMs would provide preventive and promotive health care services to households through routine outreach sessions.

Expansion of services through outreach to children by covering at least all government schools and Anganwadi Centres. Other schools located in the slums would also be covered. During such sessions, screening for birth defects, diseases, disability and deficiency (4 Ds) would be carried out and follow-up actions would be initiated.

Targeted interventions for slum population and the urban poor:

Mahila Arogya Samiti (MAS) – will act as community based peer education group in slums, involved in community mobilization, monitoring and referral with focus on preventive and promotive care, facilitating access to identified facilities and management of grants received. Existing community based institutions could be utilized for this purpose.

Capacity building of community – NUHM would provide capacity building support to MAS / Community Based Organisations for orientation, training, exposure visits, participation in workshops and seminars etc., apart from annual grant of Rs.5000 per MAS for mobilization, sanitation and hygiene, and emergency healthcare needs.

Link Worker / ASHA - One frontline community worker (ASHA) would serve as an effective and demand–generating link between the health facility and the urban slum population. Each link worker/ASHA would have a well-defined service area of about 1000-2,500 beneficiaries/ between 200-500 households based on spatial consideration. However, the states would have the flexibility to either engage ASHA or entrust her responsibilities to MAS. In that case, the incentives accruing to ASHA would accrue to the MAS.

Outreach services – Weekly medical camp would be organised in slum areas.

Public Private Partnerships:

In view of presence of larger number of private (for profit and not for profit) health service providers in urban areas, public – private partnerships particularly with not for profit service providers will be encouraged. NUHM will also support innovations in public health to address city and population specific needs. However, clear and monitorable Service Level Agreements (SLAs) need to be developed for engagement with Private Sector.

Role of Urban Local Bodies

The NUHM would promote active participation of the ULBs in the planning and management of the urban health programmes. In the seven mega cities, namely Delhi, Mumbai, Kolkata, Chennai, Bengaluru, Hyderabad and Ahmedabad, the NUHM would be implemented through the City Urban Health Mission/Society. In other cities/ towns, NUHM will be implemented through the District Health Society except the large cities where in the view of the State Government, implementation of NUHM can be handed over to the City Urban Health Mission.

Funding/budget mechanism

Funds will flow to the City Urban Health Society/ District Health Society, through the State Government / State Health Society. The SHS/DHS will have to maintain separate accounts for NUHM.

Convergence:

Intra-sectoral convergence is envisaged to be established through integrated planning for implementation of various health programmes like RCH,RNTCP, NVBDCP, NPCB, National Mental Health Programme, National Programme for Health Care of the Elderly, etc. at the city level.

Inter-sectoral convergence with Departments of Urban Development, Housing and Urban Poverty Alleviation, Women & Child Development, School Education, Minority Affairs, Labour will be established through city level Urban Health Committees headed by the Municipal Commissioner/Deputy Commissioner/District Collector.

States are also encouraged to explore possibility of engaging the Railways, ESIC and corporate sector (through CSR).

Other aspects:

Extensive use of Information Technology would be made for hospital management, reporting and monitoring as well as service delivery.

Public Health laboratories would also be strengthened for early detection and management of disease outbreaks.

Source: guidelines for preparing NUHM programme implementation plan (PIP) for 2013-14, department of health & family welfare, government of India

Chapter 1.C

INTRODUCTION TO HEALTH SYSTEM IN INDIA

DECENTRALISED HEALTH ADMINISTRATION BY LOCAL SELF GOVERNMENT

Local Self Government for Rural & Urban areas

Since PRI are involved in management of health services we here provide a short introduction about PRI.

RURAL AREAS:

The "*panchayat raj*" is a South Asian political system mainly in India, Pakistan, Bangladesh and Nepal . It is the oldest system of local government in the Indian subcontinent. The word "panchayat" literally means "assembly" (ayat) of five (panch) wise and respected elders chosen and accepted by the local community. However, there are different forms of assemblies. Traditionally, these assemblies settled disputes between individuals and villages. Modern Indian government has decentralized several administrative functions to the local level, empowering elected gram panchayats. Gram panchayats are not to be confused with the unelected khap panchayats (or caste panchayats) found in some parts of India.

Recommendations of Balwant Rai Mehta Committee

The Balwant Rai Mehta Committee was a committee appointed by the Government of India in January 1957 to examine the working of the Community Development Programme (1952) and the National Extension Service (1953) and to suggest measures for their better working. The recommendations of the committee were approved by NDC in January 1958 and this set the stage for the launching of Panchayati Raj Institutions throughout the country. The committee recommended the establishment of the scheme of 'democratic decentralisation' which finally came to be known as Panchayati Raj.

Establishment of a 3-tier Panchayati Raj system - Gram Panchayat at the village level, Panchayat Samiti at the block level, and Zila Parishad at the district level. This system was adopted by state governments during the 1950s and 60s, as laws were passed to establish panchayats in various states. It also found backing in the Indian Constitution, with the 73rd amendment in 1992 to accommodate the idea. The Amendment Act of 1992 contains provision for devolution of powers and responsibilities to the panchayats both for the preparation of economic development plans and social justice, as well as for implementation in relation to 29 subjects listed in the eleventh schedule of the constitution.

The panchayats receive funds from three sources:

1. Local body grants, as recommended by the Central Finance Commission

2. Funds for implementation of centrally sponsored schemes

3. Funds released by the state governments on the recommendations of the State Finance Commissions

In the history of Panchayati Raj in India, on 24 April 1993, the Constitutional (73rd Amendment) Act 1992 came into force to provide constitutional status to the Panchayati Raj institutions. This act was extended to Panchayats in the tribal areas of eight states, namely Andhra Pradesh, Gujarat, Himachal Pradesh, Maharashtra, Madhya Pradesh, Odisha and Rajasthan starting 24 December 1996. Currently, the Panchayati Raj system exists in all the states except Nagaland, Meghalaya and Mizoram, and in all Union Territories except Delhi.

The Balwant Rai Mehta Committee was a committee appointed by the Government of India in January 1957 to examine the working of the Community Development Programme (1952) The Act aims to provide a 3-tier system of Panchayati Raj for all States having a population of over 2 million, to hold Panchayat elections regularly every 5 years, to provide seats reservations for scheduled castes, scheduled tribes and women; to appoint a State Finance Commission to make recommendations as regards to the financial powers of the Panchayats and to constitute a District Planning Committee to prepare a development plan draft for the district.

The 3-tier system of Panchayati Raj consists:

1. Village-level Panchayats

2. Block-level Panchayats

3. District-level Panchayats.

Powers and responsibilities are delegated to panchayats at the appropriate level:

- Preparation of the economic development plan and social justice plan.
- Implementation of schemes for economic development and social justice in relation to 29 subjects given in the Eleventh Schedule of the Constitution.
- To levy and collect appropriate taxes, duties, tolls and fees.

Gram Sabha:

In most of the states, each constituency of the members of the Gram Panchayat is called the Gram Sabha and all the voters of the same constituency are members of this body. However, in some states this is called Ward Sabha/Palli Sabha etc. In West Bengal it is called *Gram Sansad (village parliament).* Gram Sabha in West Bengal has a different meaning. Here all the voters of the Gram Panchayat as a whole constitute the Gram Sabha.

Under the Constitution there can be only three tiers of the Panchayat. *The Gram Sabha is not a tier of the PR system*. It does not have any executive function and operates as a recommending body only.

Gram Sabhas hold meetings normally 2 to 4 times a year, but can meet as and when necessary. In some states dates of these meetings are fixed (Madhya Pradesh, Gujarat etc.) while in others dates are fixed by the Gram Panchayats. Issues to be discussed in the meetings can be wide ranging but the essential agenda should include: Annual Action Plan and Budget, Annual Accounts and Annual report of the GP, selection of beneficiaries for different social service programmes (Indira Awas Yojana (IAY), Pension Schemes etc), identification of schemes for preparation of Annual Plan for development programmes (e.g. MGNREGS) of GP, consideration of the Audit reports, analyses of GP's performance etc.

Gram Panchayat:

A Gram as defined under the Act (meaning a village or a cluster of villages) is divided into a minimum of five constituencies (again depending on the number of voters the Gram is having). From each of these constituencies one member is elected. Body of these elected members is called the Gram Panchayat. Size of the GPs varies widely from state to state. In states like West Bengal, Kerala etc. a GP has about 20000 people on an average, while in many other states it is around 3000 only.

Block panchayat:

A block panchayat (panchayat samiti) is a local government body at the tehsil or taluka level in India. This body works for the villages of the tehsil or taluka that together are called a Development Block. The panchayat samiti is the link between the gram panchayat and the district administration. There are a number of variations of this institution in different states. It is known as Mandal Praja Parishad in Andhra Pradesh, Taluka panchayat in Gujarat, Mandal Panchayat in Karnataka, Panchayat Samiti in Maharashtra etc. In general, the block panchayat is a form of the Panchayati raj but at a higher level.

Constitution

The constitution is composed of ex-official members (all sarpanchas of the panchayat samiti area, the MPs and MLAs of the area and the SDO of the subdivision), co-opt members (representatives of SC/ST and women), associate members (a farmer of the area, a representative of the cooperative societies and one of the marketing services), and some elected members.

The samiti is elected for 5 years and is headed by the Chairman and the Deputy Chairman.

Departments

The common departments in the Samiti are as follows:

1. General administration
2. Finance
3. Public work
4. Agriculture
5. **Health**
6. Education
7. Social welfare
8. Information technology and others

There is an officer for every department. A government appointed Block Development Officer (BDO) is the executive officer to the Samiti and the chief of its administration.

Functions

1. Implementation schemes for the development of agriculture.

2. Establishment of primary health centres and primary schools.

3. Supply of drinking water, drainage, and construction/repair of roads.

4. Development of cottage and small-scale industries, and the opening of cooperative societies.

5. Establishment of youth organisations.

Sources of income

The main source of income of the panchayat samiti are grants-in-aid and loans from the State Government.

District level panchayat

The governing system at district level in Panchayat Raj is also popularly known as "Zila Parishad". Chief of administration is an officer from IAS cadre - collector.

Functions:

1. Provide essential services and facilities to the rural population

2. Supply improved seeds to farmers. Inform them of new farming techniques

3. Set up and run schools and libraries in the rural areas

4. Start Primary Health Centers and hospitals in villages. Start vaccination drives against epidemics

5. Execute plans for the development of the scheduled castes and tribes. Run ashramshalas for adivasi children. Set up free hostels for them

6. Encourage entrepreneurs to start small-scale industries and implement rural employment schemes

7. Construct bridges, roads & other public facilities and their maintenance

8. Provide employment

Sources of Income:

1. Taxes on water, pilgrimage, markets, etc.

2. Fixed grant from the State Government in proportion with the land revenue and money for works and schemes assigned to the Parishad.

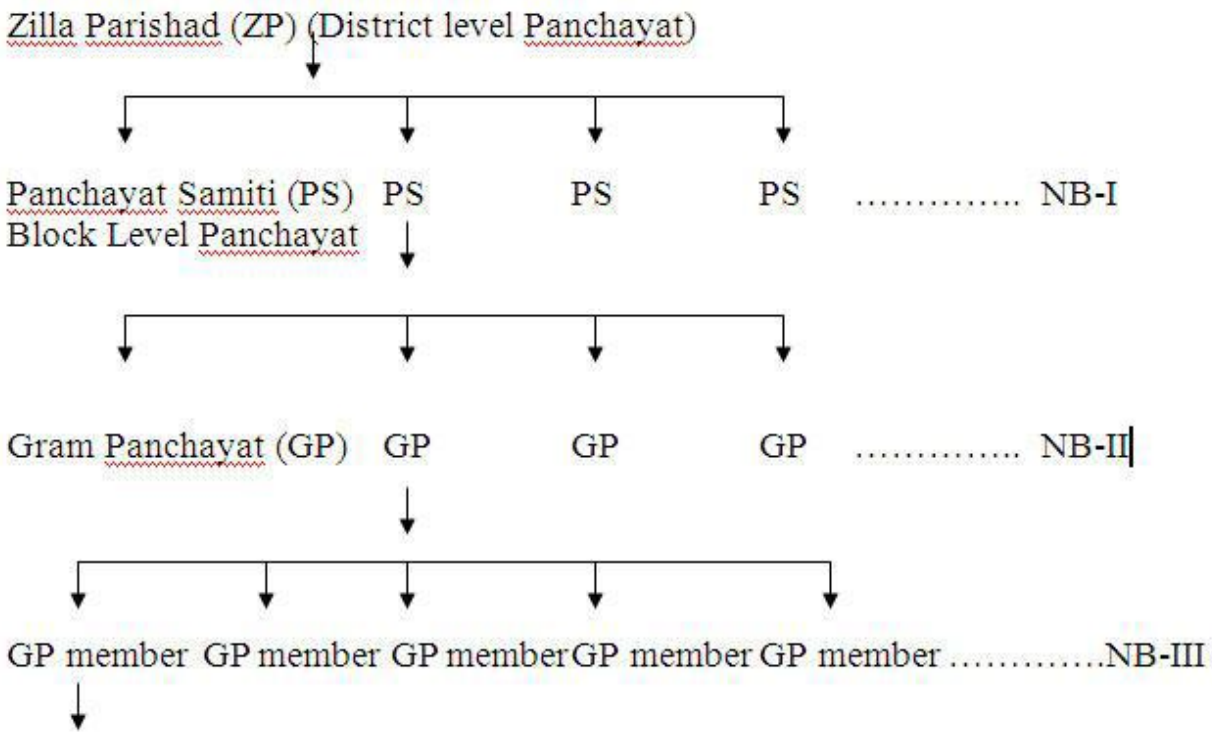
The functions of Panchayats are divided among different Committees (as ministries are formed in state and union governments), which are called Standing Committees/Sthayee Samitis/Upa Samitis etc. One of the members remains in charge of each of such committees while the over-all charge rests with the chairperson of the Panchayat. Panchayats are supported by a host of other of officials, the number of which varies from state to state.

Reservation for women in PRIs in India

The Union Cabinet of the Government of India, on 27 August 2009, approved 50% reservation for women in PRIs (Panchayati Raj NIJO Institutions). The Indian states which have already implemented 50% reservation for women in PRIs are Madhya Pradesh, Bihar, Uttarakhand and Himachal Pradesh. As of 25 November 2011, the states of Andhra

Pradesh, Chhatisgarh, Jharkhand, Kerala, Maharastra, Orissa, Rajasthan and Tripura also reserve 50% of their posts for women

The diagram at the end of the note demonstrates the typical structure of the rural local governance system in India.



Urban areas

According to Census of India, 1991, there are 3255 Urban Local Bodies (ULB) in the country; classified into four major categories of

1. Municipal corporations

2. Municipalities (municipal council, municipal board, municipal committee)

3. Town area committees

4. Notified area committees

The municipal corporations and municipalities are fully representative bodies, while the notified area committees and town area committees are either fully or partially nominated bodies.

As per the Indian Constitution, 74th Amendment Act of 1992, the latter two categories of towns are to be designated as municipalities or nagar panchayats with elected bodies. Until the amendments in state municipal legislations, which were mostly made in 1994, municipal authorities were organised on an Latin: ultra vires (beyond the authority) basis and the state governments were free to extend or control the functional sphere through executive decisions without an amendment to the legislative provisions.

After the 74th Amendment was enacted there are only three categories of urban local bodies:

- Nagar nigam (municipal corporation)
- Nagar palika (municipality)
- Nagar panchayat (city council)

This article provides that there be a Nagar panchayat for transitional areas i.e. an area in transition from rural to urban, a municipality for a smaller urban area and a municipal corporation for a larger urban area. Article 243Q of the 74th Amendment requires that municipal areas shall be declared having regard to the population of the area, the density of population therein, the revenue generated for local administration, the percentage of employment in non-agricultural activities, the economic importance or such other factors as may be specified by the state government by public notification for this purpose.

Among all urban local governments, municipal corporations enjoy a greater degree of fiscal autonomy and functions although the specific fiscal and functional powers vary across the states, these local governments have larger populations, a more diversified economic base, and deal with the state governments directly. On the other hand, municipalities have less autonomy, smaller jurisdictions and have to deal with the state governments through the

Directorate of Municipalities or through the collector of a district. These local bodies are subject to detailed supervisory control and guidance by the state governments.

Responsibilities of ULBs

The municipal bodies of India are vested with a long list of functions delegated to them by the state governments under the municipal legislation. These functions broadly relate to public health, welfare, regulatory functions, public safety, public infrastructure works, and development activities.

Public health includes - Water supply, Sewerage and Sanitation, eradication of communicable diseases etc.; welfare includes public facilities such as Education, recreation, etc.; regulatory functions related to prescribing and enforcing Building regulations, encroachments on public land, Birth registration and Death certificate, etc.; public safety includes Fire protection, Street lighting, etc.; public works measures such as construction and maintenance of inner city roads, etc.; and development functions related to Town planning and development of commercial markets.

In addition to the legally assigned functions, the sectoral departments of the state government often assign unilaterally, and on an agency basis, various functions such as Family planning, Nutrition and slum improvement, disease and Epidemic control, etc.

The Twelfth Schedule of Constitution (Article 243 w) provides an illustrative list of eighteen functions that may be entrusted to the municipalities.

Besides the traditional core functions of municipalities, it also includes development functions like planning for Economic development and Social justice, urban poverty alleviation programs and promotion of cultural, educational and aesthetic aspects. However, conformity legislation enacted by the state governments indicate wide variations in this regard. Whereas Bihar, Gujarat, Himachal Pradesh, Haryana, Manipur, Punjab and Rajasthan have included all the functions as enlisted in the Twelfth Schedule in their amended state municipal laws, Andhra Pradesh has not made any changes in the existing list of municipal functions. Karnataka, Kerala, Madhya Pradesh, Maharashtra, Orissa, Tamil Nadu, Uttar Pradesh and West Bengal states have amended their municipal laws to add additional functions in the list of municipal functions as suggested in the twelfth schedule.

There is a lot of difference in the assignment of obligatory and discretionary functions to the municipal bodies among the states. Whereas functions like planning for the social and economic development, urban forestry and protection of the environment and promotion of ecological aspects are obligatory functions for the municipalities of Maharashtra, in Karnataka these are discretionary functions.

Provision of water supply and sewerage in several states has either been taken over by the state governments or transferred to state agencies. For example in Tamil Nadu, Madhya Pradesh and Gujarat, water supply and sewerage works are being carried out by the state level Public Health Engineering Department or Water Supply and Sewerage Boards, while liability for repayment of loans and maintenance are with the municipalities. Besides these state level agencies, City Improvement Trusts and Urban Development Authorities, like Delhi Development Authority (DDA), have been set up in a number of cities. These agencies usually undertake land acquisition and development works, and take up remunerative projects such as markets and commercial complexes, etc. The Municipal bodies in most cases have been left only with the functions of garbage collection, garbage disposal, street lighting, construction and maintenance of roads, etc.

In terms of fiscal federalism, functions whose benefits largely confine to municipal jurisdictions and may be termed as the essentially municipal functions. Similarly, functions that involve substantial economics of scale or are of national interest may not be assigned to small local bodies. For valid reasons, certain functions of higher authorities are appropriate to be entrusted with the Municipalities ¡V as if under principal-agent contracts and may be called agency functions that need to be financed by intergovernmental revenues. Thus instead of continuing the traditional distinction between *obligatory and discretionary functions* the municipal responsibilities may be grouped into essentially *municipal, joint and agency functions*.

Suggested municipal functions

The suggested functions to municipal corporations, municipalities and nagar panchayats are listed in the table below.

Essentially Municipal Functions	**Municipal Corporation**	**Municipal Council**	**nagar panchayat**
Urban planning including town planning	Yes	Yes	Yes
Regulation of land-use and construction of buildings	Yes	Yes	Yes
Planning for economic and social development	Yes	Yes	Yes
Roads and bridges	Yes	Yes	Yes
Water supply domestic, Industrial and commercial purposes	Yes	Yes	Yes
Public health, sanitation, conservancy and solid waste management	Yes	Yes	Yes
Fire services	Yes	Yes	No
Urban forestry	Yes	Yes	Yes
Preventive Health Care	Yes	Yes	Yes

Provision of urban amenities and facilities such as parks, gardens, playgrounds	Yes	Yes	Yes
Burials and burial grounds, cremations, cremation ghats/grounds and electric crematoria	Yes	Yes	Yes
Cattle pounds, prevention of cruelty to animals	Yes	Yes	Yes
Vital statistics including registration of births and deaths	Yes	Yes	Yes
Street lighting	Yes	Yes	Yes
Parking lots, bus stops and public conveniences	Yes	Yes	Yes
Regulation of slaughter houses and tanneries	Yes	Yes	Yes
Slum improvement and up gradation	Yes	Yes	Yes
Agency Functions			
Protection of the environment and promotion of ecological	Yes	Yes	Yes

aspects			
Safeguarding the interests of weaker sections of society, including the handicapped and the mentally retarded	Yes	Yes	Yes
Urban poverty alleviation	Yes	Yes	Yes
Promotion of cultural, education and aesthetic aspects	Yes	Yes	Yes
Primary Education	Yes	Yes	No
Primary Health Care	Yes	Yes	No

Nagar nigam (municipal corporation)

nagar nigam a.k.a. (Municipal Corporation) in India are state government formed departments that works for the development of a city, which has a population of more than 1 Million. The growing population and urbanisation in various cities of India were in need of a local governing body that can work for providing necessary community services like health centres, educational institutes and housing and property tax.

They are formed under the Corporations Act of 1835 of panchayati raj system which mainly deals in providing essential services in every small town as well as village of a district/city. Their elections are held once in five year and the people choose the candidates. The largest corporations are in the four metropolitan cities of India, namely Delhi, Mumbai, Kolkata and Chennai. These cities not only have a large population, but are also the administrative as well as commercial centres of the country.

Nagar panchayat (city council)

A nagar panchayat is an urban local body in India comparable to a Municipality. An urban centre with more than 30,000 and less than 100,000 inhabitants is classified as a nagar panchayat.

Source : various internet sites

Chapter 1.D

INTRODUCTION TO HEALTH SYSTEM IN INDIA

VOLUNTARY HEALTH AGENCIES IN INDIA

Learning objectives

At the end of this chapter participants will be able to:

1. Know about various types of Voluntary national health agencies

2. Understand the contribution of these agencies in delivering of health services in India.

In the developing nation's non-governmental organizations have played an important role in promoting health. Often governments in developing countries are constrained from specific activities by political and economic limitations. Non-governmental agencies, because they are not subject to these constraints, often play a key role in disease intervention and promotion of health.

Other than government health agencies in nearly every community there are nongovernmental or voluntary agencies that supplement the work of the health department. Health services in India had their beginning with voluntary groups only. Eg. Missionaries from abroad who came and established services for women, children etc.

Even today these agencies are playing a vital role in health care system of India. Voluntary health agencies have their own administrative body or committee which raises fund through its membership or through private sources. It has staff either paid or on voluntary basis, Works for health promotion, health education, research & health legislation etc.

Type of voluntary health agencies:

National Agencies:

Working in the field of MCH: Family planning association of India, Indian council of child welfare & kasturba memorial fund.

Working for specific disease problem: Hind kushta nivaran sangh, Indian cancer society etc.

Working for general health care: Indian red cross society, central social welfare and all India women & apos;s conference

Professional bodies: INC, IMA, IDA, TNAI etc.

International NGO / PVO:

Multilateral Organizations: receive found from multiple governments and non-governmental sources and support developmental effort of governments and organization in less-developed nations of the world. Examples are WHO, UNICEF, World bank, UNFPA, ILO, UNDP, FAO

Bilateral Single government agency: That provides aid to lesser developed countries. They usually deal directly with other government Eg. are USAID, DANIDA, Colombo plan, SIDA

Non-governmental: They include humanitarian (philanthropic agencies) and professional organizations concerned with global health. These are not under government sponsorships or control. Eg: International Red Cross, Rockefeller foundation, ford foundation, CARE etc.

Functions in general of VHA/NGO:

1. Direct services or assistance to individual. This includes the activities such as patient care, nursing, visiting service, provision of consultations. Training and supervision of voluntary workers, Preparation and dissemination of public information materials, provides materials for H.E and carries on mass health education works.

2. Supplementing the work of official agencies

3. Contributing the funds for special equipments or other supplementary assistance to service agencies.

4. Financial assistance through scholarships or training grants

5. Guide the work of official agencies and provides constructive ideas

6. Advances the health legislation

7. Exhibits demonstration and experimental project. Demonstration of Bore- hole latrine by RF to solve the problem of hookworm in India. RCA latrine has become essential part of environmental sanitation program

8. Supplement the effort of govt. During any disasters these agencies come forward and share the responsibility to solve the problem.

9. Effective policy formulation through interpretation of public opinions.

10. Carries on research to explore ways and means of doing new thing, autonomous board helps flexibility to adopt the program

11. Channelize human resources. Help in efficient program implementation.

12. Initiative and leadership. VHA take initiation and believes in self help rather than help from outside, they encourage the local potential leaders to develop as agents of socio economic change.

13. Creating greater understanding and + ve attitude among the beneficiaries

Some of the well known voluntary health agencies in India are:

1. INDIAN RED CROSS SOCIETY

2. HIND KUSHT NIVARAN SANGH

3. INDIAN COUNCIL FOR CHILD WELFARE

4. TUBERCULOSIS ASSOCIATION OF INDIA

5. BHARAT SEVAK SAMAJ

6. CENTRAL SOCIAL WELFARE BOARD

7. THE KASTURBA MEMORIAL FUND

8. FAMILY PLANNING ASSOCIATION OF INDIA

9. ALL INDIA WOMEN'S CONFERENCE

10. PROFESSIONAL BODIES

11. INTERNATIONAL AGENCIES

INDIAN RED CROSS SOCIETY

It was established in 1920. It has 400 branches in India. Executing programmes are, promotion of health, prevention of disease and mitigation of suffering among the people.

Activities

a) Relief work

b) Milk and Medical supplies

c) Armed forces

d) Maternal and child welfare services

e) Family Planning

f) Blood Bank and First Aid

HIND KUSHT NIVARAN SANGH

It was founded in 1950. Its Headquarters is at New Delhi.

Its precursor was the Indian Council of the British Empire Leprosy Relief Association which was dissolved in 1950.

INDIAN COUNCIL FOR CHILD WELFAE

It was established in 1952. It is affiliated with the International union for Child Welfare.

The services of I.C.C.W. are devoted to secure for India's children those "OPPORTUNITIES AND FACILITIES, BY LAW AND OTHER MEANS" which are necessary to enable them to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity.

Activities

a) Rendering of financial assistance to various leprosy homes and clinics, health education thro' publications and posters, training of medical workers and physiotherapists, conducting research and field investigations

b) Organising All-India Leprosy Workers Conference and Publication of "LEPROSY IN INDIA", a quarterly journal.

TUBERCULOSIS ASSOCIATION OF INDIA (TAI)

It was formed in 1939. It has branches in all the states in India.

Activities are

Organising a T.B. seal campaign every year to raise funds, training of doctors, health visitors and social workers in anti T.B work, promotion of health education, promotion of consultations and conferences.

Institutions under TAI

a) The New Delhi Tuberculosis Centre,

b) the lady Linlithgow Sanatorium at Kasauli

c) The King Edward VII sanatorium at Dharampur

d) Tuberculosis Hospital at Mehrauli

BHARAT SEVAK SAMAJ (BSS)

It is a non-political and non-official organization was formed in 1952.

Primary aims are - Help people to achieve health by their own actions and efforts

Improvement of sanitation in villages is one of the important activities of the B.S.S.

CENTRAL SOCIAL WELFARE BOARD

It is an autonomous organisation under the general administrative control of the Ministry of Education. It was set up by the GOI in august 1953.

Its functions are

- Surveying the needs and requirements of voluntary welfare organizations in the country
- Promoting and setting up of social welfare organizations on a voluntary basis
- Rendering of financial aid to deserving existing organizations and institutions.

Activities

- Teaching of craft, social education, literacy classes, maternity aid for women, distribution of milk, balwadis, and organisation of play centres for children.
- It also started a scheme of Industrial cooperatives to help the lower-middle class women in urban areas supplement their income by doing paid work.

THE KASTHURBA MEMORIAL FUND

It was created in commemoration of kasturba gandhi, after her death in 1944.

The fund was raised with the main object of improving the lot of women, especially in the villages, through gram-sevikas.

FAMILY PLANNING ASSOCIATION OF INDIA

It was formed in 1949, HQ in mumbai.

Propagating the family planning in India

These branches are running FP clinics.

It has trained several hundred doctors, health visitors and social workers.

ALL INDIA WOMEN'S CONFERENCE

It is the only women's voluntary welfare organisation in the country. Established in 1926. Most of the branches are running M.C.H. clinics, medical centres, and adult education centres, milk centres and family planning clinics

THE ALL-INDIA BLIND RELIEF SOCIETY

Established in 1946.

It organise eye relief camps and other measures for the relief of the blind.

PROFESSIONAL BODIES

- The Indian Medical Association
- All India Licentiates Association,
- All India Dental Association,

TNA of India are all voluntary agencies of men and women who are qualified in their respective specialties and possess registerable qualifications.

Functions

1. Conduction of annual conferences,

2. publish journals,

3. arrange scientific sessions and exhibitions,

4. foster research,

5. set up standards of professional education and

6. organise relief camps during periods of natural calamities

INTERNATIONAL AGENCIES

The Rockfeller Foundation, Ford Foundation, and CARE are the examples of voluntary international health agencies.

They are already mentioned in Module 1.

Chapter 2
HEALTH POLICY

Learning Objectives:

At the end of this chapter participants will be able to:

1. Describe what is policy
2. What are the factors affecting formation of health policy
3. Challenges towards formation of Health policy in India
4. Formulate their own innovative ways of dealing with current health problems
5. Comment on the health policy of India

What is Policy? ……... Policy is a system which provides logical framework and rationality (sensible) of decision making for the achievement of intended objectives. It is a guide to action, a decision about allocation of resources in relation to priorities. It is a statement of intension. Policy must state clearly how its aims will be achieved & which resources are to be utilized for that purpose. It may be set by heads of Govt., Legislatures, regulatory agencies empowered by constituted authorities.

To be more precise & in a more comprehensive way we can say that policy is – **A statement of intentions (objectives) along with description of the strategy & the resources to be utilised to achieve those intentions.**

Ministry of Health and Family Welfare, Govt. of India has evolved various policies from time to time in India with aims and objectives of better health status of India. The main objective of these health policies is to achieve an acceptable standard of good health amongst the general population of the country. Govt. of India has declared certain policies related to health like - population policy, nutrition policy, drug policies, HIV testing policy, Health policy etc.

Concept of Health Policy:

The basic aim of all health policies has been the maintenance and improvement of the health status of populations. This means in order to understand human health and disease we must know the major biological, political, social, environmental, and lifestyle factors that influence the health status and the burden of disease. The risk factors that influence health differ from country to country & region to region. Thus policies for health will be influenced by different factors in each country and region.

At present on one hand the developing countries are struggling to provide even the basic health facilities & on the other developed nations are aiming to provide high quality sophisticated services to its population focusing on the demands of its population. Dealing with the problem of providing comprehensive health care to its citizens, India faces crisis of resources & is prioritizing its needs & demands.

The process of policy making is not that simple. It must take into account the existing scenario like – political, socio-economic, and cultural & other technical (Health care delivery related) circumstances. The process of policy-making for the health sector has become increasingly complex. Health practitioners, policy-makers, and planners have to deal with three main issues: diversity, complexity, and change.

Diversity (variety, multiplicity)

There is often great diversity within countries, as well as between and within different geographical areas. Environmental and geographical factors account for some of the variation in the pattern of distribution of health and disease but socio-economic factors as well as cultural determinants also add to the diversity.

Complexity

The rapid advances in medical knowledge and latest health technologies have noticeably increased the complexity of health care. The ever increasing role of preventive, diagnostic, and therapeutic options demands a rapid change in specific programs along with generating the need for specialist personnel, new categories of support staff, high-technology equipment, and infrastructure.

The complex interaction of medical and non-medical factors in the dynamics of health and disease requires a critical analysis of needs and opportunities as the basis for designing and managing health programs. In addition to medical inputs from the health sector it is necessary to mobilize intersectoral action because of the important influence of non-medical factors on health, such as: i). agriculture (food security and nutrition), ii). education (especially women's education), iii). waterworks and sanitation, iv). labour and industry (health of workers, pollution), etc.

Change

Policy-making in developing countries has to be flexible enough to adapt to many changes that are occurring in the environment.

Epidemiological transition

The developing countries are undergoing epidemiological transition. The age old health problems, such as childhood diseases and communicable diseases, are declining, whilst chronic non-communicable diseases, such as cancers, cardiovascular diseases, diabetes, etc., are increasing. However many developing countries present a mixed picture with the persistence of infectious diseases compounded by malnutrition and the emergence of chronic diseases especially among the urban population.

Epidemics and other emergencies

In addition to this slowly evolving epidemiological transition, more rapid changes occur in the form of epidemics and other acute problems, for example natural disasters (floods, drought, etc.).

Socio-economic variables

Changes in the economic and social situation in the country may have a profound effect on the health sector. Health policies have to be modified as per development in some countries and economic recession in others.

Major challenges and issues:

Although policy-making in the health sector of developing countries involves many complex problems. In this chapter we have focused on a few of the critical issues:
(1) Health reform with special emphasis on structural reform and decentralization;
(2) tools for policy-making—assessment of burden of disease, cost-effectiveness, and health accounts;
(3) Financing health care—cost recovery schemes, user fees, and private insurance;
(4) public–private partnerships in the delivery and financing of health care and in drug policy;
(5) Health research;
(6) international agencies such as the World Health Organization (WHO), the World Bank, the United Nations International Children's Emergency Fund (UNICEF), and bilateral donor agencies;
(7) Equity in health.

Health reform: special emphasis on structural reform/decentralization

The rapid advances in health technologies, the increasing demands and expectations of populations and the escalating costs of health care are challenging governments in both developed and developing countries.

Health reform has been defined as 'sustained purposeful change to improve efficiency, equity and effectiveness of the health sector' (Berman 1995). For large countries with diverse socio-cultural factors & differing health needs, it becomes very difficult to provide effective health care to all. So the major change in policy is to decentralize policy decisions.

Models of decentralization
What it means

The way in which decentralization policy is adopted by countries of the world varies. But the theme remains the same.

Decentralization means providing the responsibility of decision making at local levels in relation to guidelines provided by central level.

However for decentralization to be effective there needs to be some support given to the local authority by the central agency.

Certain important issues need to be addressed as follows:

- autonomy
- financial resources
- professional and technical capacity
- information system
- other health-related sectors
- Relationship with other Health care providers

Authority:

What is the meaning of decentralization if local government doesn't have the authority to implement the changes as per local needs? E.g. the district authority has no right what so ever to deploy human resource at peripheral levels. Say FHW belonging to a particular village will be working under another PHC village as her place of posting is decided by central authority.

Allocation of Financial resources:

Mere giving the power of decision making will not make any changes if it is not backed by sufficient amount of fund to implement these changes. Say, the fee of a private practitioner for conducting delivery is different in urban & rural area or tribal areas against dense corporation areas. However the current Chiranjivi Yojana does not take the local variations into account & so in some places private practitioners are willing to join while at other places they refrain to do so.

We also have RKS which generates revenue through user charges & this is used by local authority to implement changes.

Management Information System:

We have multiple IMS like E-Mamta, HMIS, SIMS, NIKSHAY, DLIMS, etc. A lot of data is generated but it all goes to centre which utilizes the data for collective action & policy making. But what about the local levels? Does the local authority have the ability to analyze the data of their own district – like the health conditions, demographic profile & various factors affecting the health status of the district. If the district authority can analyze & interpret the data, locally relevant action can be taken which will be more relevant & have greater impact. The local authority needs to be trained as well as supported by the central authority for taking locally relevant actions.

Other health-care providers

In addition to the public sector, private providers, both for profit as well as non-profit agencies, are involved in health care. In developing countries, traditional healers still play a prominent role and as in developed countries, practitioners of alternative medicine are also increasingly popular. Local authorities must also interact with the private sector which can supplement in effective implementation of various public health programs.

Other health-related sectors

It is now well-known that socio-economic and environmental factors have a significant effect on health. National policies in such sectors as education, agriculture, welfare, and environment are also implemented through local authorities. Decentralization of these health-related sectors would facilitate interaction with their colleagues in the health sector & result in improved health outcomes.

How to fix priority:

In the earlier days policy making was purely dependent on the views of influential people. Then after the independence, many of the policies in India were formed imitating that of the western countries. This led to the development of large tertiary hospitals serving only a few people. This was a great economic burden to the country with minimal impact on the health status of the population.

So the focus was shifted to prioritizing the disease conditions. However it was relatively easy to fix priorities based on mortality rates & exactly that was done. But is that only the mortality that health conditions. It was realized that fixing priorities based on mortality rates was not a correct way of forming policy. So currently we have evidence based policy making system. It focuses on multiple aspects for fixing priority, but the three important aspects described here are:

1. Situational Analysis
2. Measurement of burden of disease
3. Cost effectiveness of chosen interventions
4. Analysis of national health accounts.

Situational Analysis:
Choosing a new intervention for improvement in a health system will always take place against a background of existing policies &b priorities. For this reason a critical part of this cycle is to conduct a situational analysis. Situational analysis is a mapping process which allows a clear baseline to be established before any new interventions are considered or existing ones are adopted. While the main focus of the situational analysis is on the health system, it also needs to make connections between health & other sectors & issues which will impact on the performance of the health system. The situational analysis will need to cover many areas, which might include the following:
Current structures & system within the ministry of health.
Does there exists a clear leadership & accountability
Are services in an integrated way or is there a problem of fragmentation?
Current health goals & priorities. The aim would be to understand the nature of these goals & priorities, how they are being addressed, & particularly the contribution that quality improvement is making to their achievement.
Current performance of health system. How does the system perform overall, & particularly against the dimensions of quality? Is health cost effective as well as efficient, accessible and acceptable equitable & safe? How does the payment system influence quality? How does the performance compare with that of others with similar circumstances?
What impact are the current activities having on the performance of health status of the masses?

Burden of disease
It is not only the mortality of a disease condition but multiple other factors like individuals own health status, Risk factors affecting any individual & possibility to control them also helps in fixing priorities. So a composite index to fix the priority & measure the impact of any intervention was developed. It attempts to measure a specific health problem in terms of

disease, disability & premature death. This approach was further refined to a new measure, the disability-adjusted life year (DALY) which combines losses from death and disability but also makes allowance for: a) discount rate, so that future years of healthy life are valued at progressively lower level b) age weights, so that years lost at different ages are given different values .
The WHO & World bank together funded in this joint venture to measure the global burden of disease conditions. However it was not a simple operation. It was rather a complex process, particularly in developing countries like India where obtaining reliable data on the frequency & distribution of various health problems is difficult. So DALY for various conditions was estimated based on extrapolation from available studies & rough approximations.

DALY is a very useful tool but still work is required to redefine & simplify it.

By estimating DALY for various conditions we can:

- rank diseases and conditions by the burden of disease;

- estimate the cost-effectiveness of interventions by comparing the cost of averting a DALY.

National health accounts

Previously, policy-makers concentrated mainly on spending within the public sector, not considering private spending through insurance, corporate arrangements, employees' schemes, and out-of-pocket expenditure. Health economists now obtain a more comprehensive view of health expenditures by compiling national health accounts. These analyses attempt to obtain an overview of health spending from all sources—public and private, corporate and personal—into comprehensive health accounts. The results affect the choices made within the public sector but also influence the public role in providing guidelines to the private sector and communities on the most cost-effective uses of their personal expenditure.

Financing health care

Health neither was nor is a priority for the governments for allocating resources. This unfortunately leads to a very limited availability of resources for health. So there is a huge gap in health demands of the people & availability of financial resources to meet them. So it is a very demanding responsibility of health sector to prioritize the problems & have an equitable distribution of resources.

User Charges

User charges enable the public sector to reallocate the resources by withdrawing subsidies from those who can afford to pay and redirecting the savings to expand cost-effective public health services to the poor.

Public–private partnerships

"Why to buy a car where you can hire a taxi?"

On one hand we have limited financial resources for health & on the other hand there is a huge burden of public health problems like MCH issues, communicable & NCDs etc.

In such a scenario, we can't wait for development in public sector to occur which may take decades to solve current problems. The other option is to hire services of private practitioners & not for profit organizations. This will have an immediate impact on the health status. However the health sector must be cautioned against this alternative as it is counter-productive in the long run & will permanently hinder the development of public sector. So parallel measures for the improvement of public sector to meet these health challenges are a necessesity. "In the long run, it does not make sense to always hire the taxi."

Equity

The health status of the people of different demographic characteristics is not the same. Different people have varying health requirements. So what is needed is not equal distribution of health resources but an equitable distribution of health resources.

A consistent finding is the strong association between poverty and poor health status as defined by such indicators as the expectation of life, the incidence of acute diseases and injuries, and the prevalence of chronic diseases and disabilities. This consistent association of poverty with poor health strengthens the case in favour of programmes for the alleviation of poverty as important strategies for health promotion.

Equity in health can be achieved by two approaches:

A. allocation of resources(Vertical Equity)
B. access to and utilization of services(Horizontal Equity)

Vertical Equity

Equity is also measured in terms of the allocation of resources to different sections of the population. On moral and ethical grounds, the objective of allocative equity is for public resources to be shared out in a fair manner. The simplest formula would be a uniform per capita allocation. However, if large differences in health status already exist, an equal allocation would tend to perpetuate the inequalities. It can be argued that it is the responsibility of governments to perform a redistributive function by allocating resources from the more affluent sector of society to meet the needs of lower-income individuals and families, so-called 'vertical equity'.

Horizontal Equity

Another view of equity is that everyone should have an equal opportunity of receiving care. This so-called 'horizontal equity' proposes that individuals in like situations should be treated in like manner. Access is often defined in terms of the availability of services and its geographical coverage but experience has shown that the potential access, that is the services are within geographical range, does not necessarily correspond to real access as measured by the utilization of services.

Marked disparities are often found in the geographical distribution of health facilities: between regions, between urban and rural areas, between rural areas, and within urban areas. The differential ratios of people per facility—hospital beds, nurses, and doctors—are used to measure the disparities. The distribution of health centers and other institutions in relation to the population—how far people have to travel to reach such facilities—are also used to indicate the uneven distribution of resources.

Ensuring equity in Health

Optimization of equity requires conscious attention to a number of important issues:

1. political commitment
2. policy formulation
3. allocation of resources
4. intersectoral action
5. community involvement
6. information system
7. monitoring of equity.

Political commitment

The political commitment of the government is the essential basis for promoting equity in health. The objective of equity in health is providing universal coverage of comprehensive health care for the entire population from birth to death. Political commitment is also required to correct the inequities that result from discrimination on the basis of gender, race, ethnic group, and religion. Often, inequalities in health status reflect the marginalization of disadvantaged groups.

Policy formulation

Reforms of the health sector aim at improving efficiency, effectiveness, cost-effectiveness, and equity. It is not always easy to reconcile (settle or bring together) these goals. For example, the delivery of care to the populations in remote areas is relatively expensive and less cost-effective than services to dense urban areas. However, in the interest of equity, health services should reach the underserved populations even in remote settings.

There is increasing recognition of the role of health policy and health systems research in identifying and solving problems on the planning and operation of health services. The Global Forum for Health Research, a new independent entity, focuses specifically on promoting health research with particular reference to the problems that affect the poor.

Allocation of resources

Within the health budget, there is the difficult task of allocating resources to the needs of the various groups within the community. With finite resources, even the most affluent nations have to accept limits to the services that the public sector can provide. This is discussed earlier

Community involvement

With limited funds available, it is very essential to know what are the demands & necessities of the community so that there can be an effective impact on the health status. This can be done through community involvement in varying ways. E.g.; gram sabha, monitoring of health services by PRI, Involvement of ASHAs, RKS, etc. The involvement of communities in decisions that affect their health care is widely recommended: it does not often work effectively in practice. Even in developed countries, the communities are often unable to participate effectively in decision making because:

- authorities may not consult them
- they lack relevant information
- the society may not be well organized.

Monitoring and evaluation

The health system should include mechanisms for monitoring equity objectively. Interest in measuring equity has generated some useful tools and some valuable experience is accumulating. In the first instance, monitoring equity is the responsibility of health authorities at each level of care. They must build into their service sensitive indicators that would inform them of their performance with regard to equity and access to care.

National policies related to Health:

1. National Health Policy 2002
2. National Population Policy 2000
3. Nat. AIDS Prevention & control policy 2002
4. National Blood policy 2002
5. National policy for empowerment of women 2001
6. National policy & charter for children 2003
7. National youth policy 2003
8. National policy for old person 1999
9. National policy for person with disabilities
10. National nutrition policy 1993
11. National health research policy draft
12. National policy on education
13. National pharmaceutical policy
14. National policy on ISM & H 2002
15. National water policy
16. National environment policy 2006
17. National housing & habitat policy 1998
18. National conservation strategy & policy statement on environment & development 1992
19. National policy on resettlement & rehabilitation for project affected families 2006.

Self assessment:

1. Define Policy
2. What are the major challenges in formation of the health policy in India?
3. Considering the epidemiological transition on what aspects would you focus on if India became a developed country?
4. Describe decentralization
5. Describe Health Equity
6. What is the difference between two health policies formed by India?
7. How would you ensure equitable distribution of resources?
8. What was the need of national health policy?
9. What changes within the district health care system do you suggest to achieve the stated goals of national health policy 2002?

Source: Oxford textbook of Public Health, AFMC Pune, S.L. Gohel – Health care system & Management

Chapter 3

HEALTH INDICATORS

Learning objectives:

After learning this chapter participants will be able to

1. Know what are health indicators and their types

2. How they are formed & what are their uses

3. Able to form indicators on other health programs on their own

Introduction

Definition: A variable which helps to **measure changes**, directly or indirectly (WHO, 1981).

Health indicators summarize data which have been collected to answer questions that are *relevant to the planning and management* of health programmes. The indicators provide a useful tool to *assess needs, and monitor and evaluate* programme implementation and impact. The indicators capture the occurrence of events such as live births, the prevalence of a characteristic in persons such as the use of contraceptive methods or the prevalence of characteristics of a health facility, for example, health centres which provide family planning services. The indicators are expressed in rates, proportions, averages, categorical variables or absolute numbers.

In order *to assess the achievements of goals* and targets, it is necessary to establish a system for monitoring and evaluation. This involves the definition of essential indicators and guidelines on how to use them. With the expansion and evolution of health services, many agencies have been working on developing indicators. As a result, there have been a number of indicators put forward by these organizations, in addition to existing national indicators.

With the trend towards the *integration* and development of comprehensive health programmes and their *decentralization*, the responsibility for planning and management of programmes has been placed at the sub national level. Therefore, indicators are not only required at the *national level* but also at the *sub national level* to monitor the effective implementation and evaluate the impact of programmes.

The Indicators need to be decided at the beginning of the programme during the planning process as the measurements are important throughout the life cycle and it is preferable to use the same measuring tools throughout to ensure consistency and comparison.

There are three primary reasons why we need Indicators. They are to:
1. Measure the baseline
2. Measure achievement (of objectives and overall impacts) and
3. Monitor performance.

The planning framework used, primarily dictates the type of Indicators. Irrespective of the framework, the indicators correspond to the hierarchy of objectives and are defined by the level at which they correspond.

Indicators are expressed as:

There are five ways which can be used to express indicators:

1. Count / Number → Measure without any denominator

2. Proportion (%) → Numerator is part of denominator

3. Rate → Frequency of occurrence of an event *during a specific time*, usually expressed per *"k" population* (k=1000, 10000, …). Rate is used to estimate probability or risk of occurrence of a disease or to assess the accessibility or coverage of health care system.

4. Ratio (per k) → Measure for which *numerator is not included in denominator* (e.g.: sex ratio per 100 ; beds population per 1000, MMR, etc) .

5. Index → Aggregation of measurement of specific indicators or *multiple indicators* combined together form an index indicator. (e.g.: Health development index , summary measures for Health Population, malarial indices)

CRITERIA FOR SELECTING INDICATORS

A good indicator has a number of important attributes and those recommended by the World Health Organization (WHO, 1997c) are outlined below:

1. To be useful an indicator must be able to act as a "*marker of progress*" towards improved health status, either as a *direct or proxy* measure of impact or as a measure of progress towards specified process goals.

2. To be scientifically robust an indicator must be a *valid, specific, sensitive and reliable* reflection of that which it purports to measure.

- A valid indicator must actually measure the issue or factor it is supposed to measure.
- A specific indictor must only reflect changes in the issue or factor under consideration.
- The sensitivity of an indicator depends on its ability to reveal important changes in the factor of interest.
- A reliable indicator is one which would give the same value if its measurement was repeated in the same way on the same population and at almost the same time.

3. To be *representative* an indicator must adequately encompass all the issues or population groups it is expected to cover.

4. To be *understandable* an indicator must be *simple* to define and its value must be easy to interpret in terms of health status.

5. To be *accessible*, the data required for an indicator should be *available* or relatively easy to acquire by feasible data collection methods that have been validated in field trials.

6. To be *ethical* an indicator requires data which are ethical to collect process and present in terms of the rights of the individual to confidentiality, freedom of choice in supplying data, and informed consent regarding the nature and implications of the data required.

CONCEPTUAL FRAMEWORK

An important objective of a conceptual framework is to depict clearly the desired programme and population outcomes targeted by an intervention. A conceptual framework for any health program helps those involved in programme design, management and implementation to select the appropriate input, process, output and impact indicators to monitor and evaluate whether and how these interventions have helped to achieve the objectives.

FIVE INDICATORS CATEGORIES:

(1) SOCIO-ECONOMIC ENVIRONMENT Indicators focusing on demographic profile of study population, population structure, economics, education, employment, water, sanitation, pollution, etc.

(2) INPUT indicators

In a health programme, specific interventions directed at achieving the desired outcomes need to be supported by a conducive environment, where policies and organizational resources are in place. The inputs needed to meet the desired implementing processes are *resources and the policy environment*. Resources include *manpower, material and financial* resources. Policies and administrative procedures include *national policies and legislation* with regard to health to create an enabling environment for the effective implementation of activities. Health indicators directed at policies and administrative issues are designed to show whether the enabling national policy conditions and guidelines are in place to support appropriate Health interventions. All these policy indicators require qualitative information on the existence of policy statements or legislation in support of Health goals.

(3) PROCESS Indicators refers to *quality of health activities*.

Implementation of Health activities is the process through which the desired interventions are carried out to achieve programme outputs. The process indicators of health program address operational issues and questions that can be answered with programme level data and measures. The process indicators may enable policy makers and programme managers to assess and improve Health services so that clients can achieve their health intentions.

Examples:
Recruitment of healthcare workers
Training of health personnel

(4) **OUTPUTS Indicators** refers to the results achieved in terms of services, cares or goods. Output Indicators measure the short term results of the projects. The services offered by the project are the output. The Output Indicators are the ones that are to be regularly monitored, e.g. availability of drugs and availability of trained staff.
They could be divided in following three types:

(a) *Functional output indicators*: which measures the number of activities conducted in each functional area.

(b) *Service outputs indicators*: which measures the adequacy of the service delivery system in terms of accessibility, quality and image.

(c) *Service utilization indicators:* which measures the extent to which the services are used.

If the activities of a Health programme are implemented as desired, then the resulting outputs should contribute to achieving expected impacts. The output indicators of a Health programme are knowledge, utilization of services, etc.

Examples:
Increased first hour breastfeeding rates
Availability of a higher number of adequate quality Nutritional Rehabilitation Centres

(5) **OUTCOMES Indicators** refer to "changes" observed at the population as a "result" of given interventions. These indicators measure the mid-term achievements of the project. They are also measured periodically during Evaluation exercises and are not useful for regular monitoring purposes, e.g., knowledge levels of the community on nutrition issues , coverage of Mass Drug Administration of DEC.
There are two following types of outcomes: EFFECT Indicators and IMPACT Indicators

(a) *Effects Indicators* relating to measure of change in knowledge, attitude and practice (behavior change including coverage) occurred in short and medium term (2-5 years).

(b) *Impact Indicators* focusing on change in health status due to the effects of interventions/actions and occurred over the long-term (over 5 years). e.g. rates of underweight in children of 5 years of age, anaemia prevalence rates, infant mortality and maternal mortality ratio. These indicators are essential to keep the project focused over the duration of the project, but are not very useful for the purposes of regular monitoring. This is because:

1. Impact Indicators are not measurable in the short term. It often takes years to get measurable effects.

2. They are expensive to measure. They often need large scale cross-sectional bio-behavioural studies.
3. They are influenced by multiple factors. It is difficult to attribute the Impact solely to the intervention.

The effect of Health intervention introduced through programme activities and the resulting outputs must have an impact on the population. Therefore, the outcomes of a programme must be eventually measured at the population level. The impact indicators that measure changes at the population level are fertility, mortality and morbidity rates.

Proxy Indicators

During the project life cycle we are often faced with parameters that are not measurable. Yet it is important for these parameters to be reflected in some understandable terms, as they are key parameters of intervention. In such cases we use Proxy Indicators that measure a closely related parameter and are used as a Proxy to the Intervention parameter - e.g. once a child is discharged from a Nutritional Rehabilitation Centre, it is important to know whether the child is maintaining her/his nutritional status. But it is practically impossible to follow up each child discharged from the facility. Hence, we use NRC re-admission rates as a proxy indicator to look at failure rates. *This gives an indication of how well the nutrition status is being sustained after being discharged from a facility*. Even though it does not give us individual level data, it does give a fairly good indication of practices at the household level and informs programme managers of content required for the outreach.

1. Environmental indicators: demographic characteristics, economic & socio-cultural context.

2. **Inputs** →	**3. Process** →	**4. Outputs** →	**5. Outcomes**
Resources	Services	Results	Impacts
Manpower	Contacts	Knowledge	Fertility
Material	Visits	Acceptance	Mortality
Money (Finance)	Examinations	Practice	Morbidity
Policies	Referrals	Utilization	prevalence
Legislation			

Input → at Government Level

Process → at system level (Quality of services)

Output → at system level (service delivery or utilization)

Outcome → at beneficiary level

Impact → at society level

Specific use of different indicators:

The INPUTS and PROCESS indicators and secondly the OUTPUTS indicators are used for MONITORING process.

The OUTCOMES Indicators are especially used for EVALUATION process which uses also the general findings of monitoring particularly the outputs indicators achievements.

THE 'IF-THEN' TEST

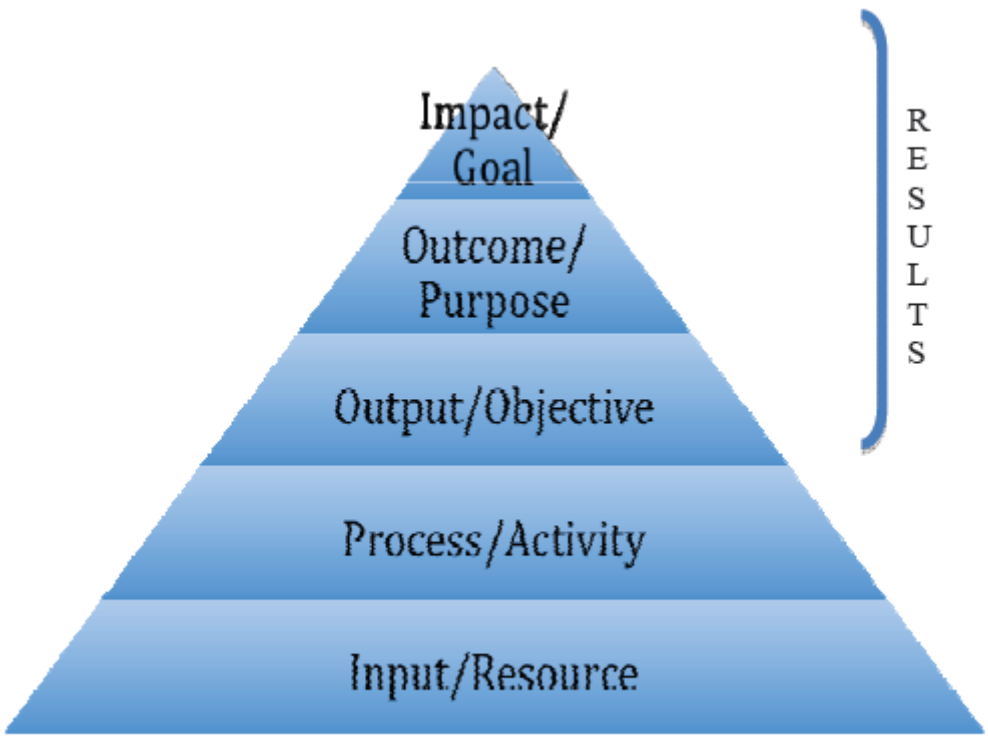
When the objectives have been detailed for each level, it is important to ensure that the statements are logically linked to each other. To do this, use the 'If-Then' test:

- If all Input is provided, then the activities can be carried out
- If all Activities are carried out, then the Output would be met
- If all Output is achieved, then the Purposes would be achieved
- If all Purposes are met, then the Goal would be achieved

For example:

- If we train members of the community to maintain and repair hand pumps (activities), then sources of safe water would be improved (output).
- If sources of safe water are improved (output), then access to safe water would be improved (purpose).
- If access to safe water is improved (purpose), then the incidence and impact of diarrhea would decrease (goal).

The answer to the If-then question at each level must lead to an unequivocal "yes". If not, the result statement would have to be relooked at.



III. METHODS OF DATA COLLECTION

For the purpose of understanding, we shall relate examples to reproductive health indicators only.

Indicators summarize data collected to answer questions relevant to the planning and management of health programmes. Thus the compilation of indicators depends on the availability of data (both quantitative and qualitative) from a number of sources. These include routine service statistics, census and vital statistics reports, special studies and sample surveys.

Indicators based on programme level *record keeping* are important to ongoing management concerns as well as to evaluate programme outputs.

Population based indicators are needed to measure programme effects and impacts.

A. Management information and service statistics systems

Through the above systems, data are collected on such indicators as the number of clients, number of visits, methods of family planning accepted, workers employed, facilities used, etc. This data source also provides information on internal programme features, such as training, logistics, supervision, etc. The programme level measurements of inputs and activities provided by these data sources enable the construction of input and process indicators, which in turn serve as the basis for evaluation.

B. Population census

The data collected at population censuses such as population by age and sex, marital status, and urban and rural residence *provide the denominator* for the construction of process, output and impact indicators.

C. Vital registration system

The vital registration system collects data on births, deaths and marriages. These data are available by age, sex and residence. These data provide the numerator for the construction of process, output and impact indicators.

D. Population-based surveys

The programme-based data very often lack representativeness in that they provide information only on those who use services. Similarly, data from the vital registration systems and censuses also may be deficient in coverage and content. Therefore, the need for population-based data not only fills the gaps in data systems of other sources but also validates programme indicators such as contraceptive use rates, fertility rates, etc.

IV. LIST OF SELECTED INDICATORS

The following provides illustrative lists of selected input, process, output, and impact indicators to enable readers to understand the concepts that are used to monitor and evaluate health programmes. For the purpose of understanding we shall relate examples to reproductive health indicators developed by UNFPA into input, process, output and impact indicators (Abeykoon, 1999).

A. Input indicators

(a) Percentage of health personnel trained in midwifery

Definition:

The number of health personnel who are trained in midwifery as a percentage of all health personnel who attended delivery in a given period and in a given geographical area.

It is calculated as:

Number of health personnel who are trained in midwifery

---------- x 100

Number of all health personnel who attended delivery

Data requirements:

The number of health personnel who are trained in midwifery in a given period and in a given geographical area; and the total number of health personnel who attended delivery in the same period and in the same geographical area.

Data sources:

Health service statistics; Facility-based surveys

Uses and limitations:

It is an indicator of the quality of services. The WHO defines “trained midwifery” as those who have successfully completed a prescribed course of midwifery and are able to give the necessary supervision, care and advice to women during pregnancy and labour, and in the post-partum period, and conduct deliveries and provide care for infants.

(b) Percentage of public sector expenditures on contraceptive commodities

Definition:

It is defined as the percentage of public sector expenditure on contraceptive commodities to the total expenditure on contraceptive procurements during a given year.

Data requirements:

Public sector expenditure on contraceptive procurements during a year; and the total expenditure on contraceptives procurements during the same year.

Data sources:

Ministry of Health statistics on expenditures on contraceptives; Donors, NGOs and commercial sector expenditures on contraceptive commodities.

Uses and limitations:

This is a measure of the commitment of resources by a country to its reproductive health programme.

(c) Percentage of service delivery points offering at least two methods of family planning.

(d) Percentage of service delivery points (SDPs) which routinely screen and provide referral for infertility

(e) Percentage of trainees provided with knowledge and skills on RH in a given year

(f) Percentage of service delivery points stocked with family planning commodities according to needs.

(g) Number of referral facilities providing essential and emergency obstetric care per 100,000 married women in the reproductive age group

(h) Number of service delivery points offering family planning services per 10,000 women in the reproductive age group.

(i) Existence of the national population and reproductive health Policy

(j) Government policy on abortion

B. Process indicators

(a) Proportion of service providers trained in family planning and reproductive health

Definition:

The number of service providers trained as a percentage of all service providers in family planning and reproductive health during a given period.

Data requirements:

The number of persons in service delivery points who were trained in family planning and reproductive health during the reference period; and the total number of service providers in the area of family planning and reproductive health.

Data sources:

Service statistics; Records on training programmes.

Uses and limitations: The indicator provides information on the strength of IEC (information, education and communication) and reproductive health services.

(b) Percentage of births attended by trained health personnel

Definition: Percentage of births attended by trained health personnel in a given period.

The indicator is calculated as:

Number of births attended by trained health personnel in a year

---------- x 100

Total number of live births occurred during the same year

Data requirements: Number of births attended by trained personnel during a specific year; and the total number of live births occurred during the same year.

Data sources: Health service statistics; Birth registration data.

Uses and limitations: The indicator is useful in assessing maternal and child health programme.

(c) Percentage of clients given counselling on family planning at SDPs during a year

(d) Percentage of pregnant women who had at least two prenatal visits attended by trained health personnel during the last completed pregnancy

(e) Percentage of contraceptive supplies that are wasted

(f) Percentage of communication material disseminated to target Audiences

(g) Percentage of training programmes on RH that achieves the learning objectives

(h) Percentage of follow-up visits by contraceptive users to the total number of continued users of a particular method

(i) Proportionate share of contraceptives distributed to users by NGOs

C. Output indicators

(a) Contraceptive prevalence rate

Definition:

The proportion of currently married women aged 15-49 years who are currently using a contraceptive method at the time of the survey.

The indicator is calculated as:

Number of currently married women aged 15-49 years using a contraceptive method

---------- x 100

Total number of currently married women aged 15-49 years

Data requirements:

Number of currently married women aged 15-49 years using a contraceptive method; and the total number of currently married women aged 15-49 years; The data should refer to a given point in time. The contraceptive prevalence rate can also be calculated by specific method and by age group if the data are available.

Data sources:

Population-based surveys, such as Demographic and Health Surveys (DHS).

Uses and limitations:

The indicator measures the prevalence of contraceptive use taking into account all sources of supply and methods of contraception available to the target population. It is a widely used indicator to assess the level of contraceptive use in a given population.

(b) Number of new acceptors of modern methods of family planning

Definition:

Number of clients who accept for the first time in their lives any modern method of contraception in a given period, usually one year.

Data requirements:

Records of clients who accept a family planning method for the first time during the given period.

Data sources: Service statistics

Uses and limitations:

The indicator measures the effectiveness of the family planning programme to attract new clients form the target population. As the contraceptive prevalence rate reaches a high level (e.g. over 70 per cent) the number of new acceptors is likely to decrease because of the fact that most of the eligible couples have been recruited as users.

(c) Percentage of women in reproductive ages with knowledge of the modern methods of contraception

(d) Proportion of high-risk births to women

(e) Percentage of women aged 35 years and above with knowledge of the need for annual screening for breast and cervical cancer

(f) Proportion of children aged 9-12 months who are fully immunized

(g) Prevalence of breast cancer among women aged 35 years and over

(h) Unmet need for family planning

(i) Mean desired family size

D. Outcome indicators

(a) Total fertility rate (TFR)

Definition:

Total number of children a woman would have by the end of her reproductive period if she experienced the currently prevailing age-specific fertility rates throughout her childbearing life.

Data requirements:

Number of live births occurred during a reference period classified by five-year age group of women; and the total number of women classified also by five-year age group.

Data sources:

Vital registration; Population census; Population-based surveys, such as DHS.

Uses and limitations:

TFR is one of the most widely used fertility measures to assess the impact of family planning programmes. The measure is not affected by the age structure of the female population.

(b) Maternal mortality ratio

Definition:

Number of women who die as a result of childbearing in a given year per 100,000 live births. Maternal deaths are those caused by complications of pregnancy and childbirth.

Data requirements:

Number of maternal deaths occurred during a given period and given population; and the total number of live births during the same period and same population.

Data sources:

Vital registration; Health survey.

Uses and limitations:

The indicator is widely used as a measure of maternal health. It is also used to indirectly assess the effectiveness of antenatal and post-natal care for mothers.

(c) Neonatal mortality rate

(d) Induced abortion rate

(e) Adolescent fertility rate

(f) Infant mortality rate

(g) Perinatal mortality rate

(h) Annual population growth rate

(i) Life expectancy at birth

(j) Prevalence of RTIs/STDs by type in a defined target population

(k) Prevalence of HIV infection in a defined target population

Chapter 4
Health Legislation

Learning objective:

By the end of this chapter participants will be able to describe:

A. What are health legislations?

B. describe health related legislations

The health legislations protect public health at large and provide administrative control. Their actions are directed to improve the health status in the community. The characteristics of public health laws are:

1. Responsibility of government as a right to provide adequate health and health services to all citizens.
2. Public health laws protect community health rather than individual's health.
3. Public Health contemplates the relationship between the state and the population.
4. Public health laws deals with the delivery of public services based on scientific methodologies e.g. Purification of water.
5. The laws act as important guidelines for the state, community and individuals.

To achieve the fundamental goals of our constitution various acts and rules are enacted.

Act: Act means statutes or laws adopted (enacted) by a national or state legislative assembly or other governing body.

Rules: Rules are explicit statements that tell an individual what he or she ought to do or ought not to do.

Guidelines: It is the guiding principle for doing an action or course of action.

Important legislations in India pertaining to public health and its protection are grouped in the following categories for the purpose of better understanding:

A. Health Facilities and Services

B. Disease Control and Medical Care

C. Human Resources

D. Ethics and Patients Rights

E. Pharmaceutical and Medical Devices

F. Radiation Protection

G. Hazardous Substances

H. Occupational Health and Accident Prevention

I. Health of the Elderly, Disabled, Rehabilitation and Mental Health

J. Families, Women and Children

K. Smoking, Alcoholism and Drug Abuse

L. Social Security and Health Insurance

M. Environmental Protection

N. Nutrition and Food Safety

O. Health Information and Statistics

P. Intellectual Property Rights

Q. Custody, Civil and Human Rights

R. Other Aspects that could not be grouped by any heading above

Under the constitutional provisions, the government of India owes its population social security, health services, safety, environmental protection, equal opportunity and justice. The methods adopted by the government to deliver these services are through framing policies, execution of legislation and implementation of programs.

Public health officials enforce rules through following ways:
a) Permits, licenses and registrations
b) Administrative orders
c) Civil penalties
d) Injunction – ban, sanction, restriction

Often these legislations may not be able to bring about the desired result. There are many factors responsible for lack of effectiveness of these legislations, viz., Lack of awareness, Lack of **i**mplementation, Corruption, Lack of **i**nfrastructure**, i**nconsistency and **i**nadequacy. To overcome these problems Government of India has initiated **National Legal Literacy Mission in 2005** to impart knowledge and education on various legal aspects including those related to Public Health. This programme seeks to sensitise and create awareness among people about their legal rights, acts and regulations and interpretation of legal jargon.

A. Laws in relation to Health Facilities and Services

1. Indian Red Cross Society Act, 1920
2. All India Institute of Medical Sciences Act, 1956
3. Post Graduate Institute of Medical Education and Research, Chandigarh, Act, 1966
4. Bureau of Indian Standards Act and Rules, 1986, 1987
5. National Institute of Pharmaceutical Education and Research Act, 1998
6. Clinical Establishment Acts, 2010

a. Nursing Homes Registration Acts
b. State Clinical Establishment Acts and Rules

B. Laws in relation to Disease Control and Medical Care

1. Epidemic Diseases Act, 1897
2. Indian Aircraft Act and Rules, 1934, 1954
3. Indian Port Health Rules, 1955
4. Medical Termination of Pregnancy Act, 1971, 1975
5. Transplantation of Human Organs Act and Rules, 1994, 1995, 2002
6. Prenatal Diagnostic Techniques (Regulation and Prevention of Misuse) Act and Rules, 1994, 1996, 2002, 2003

C. Laws in relation to Human Health Care Resources

The professional ethics, quality control of education programmes, standards etc. are important for all the systems of medicine, hence there are acts and regulations which are enumerated below:

Allopathy

1. Indian Medical Council Act and Rules, 1956, 1957, 1965, 1993, 2001, 2002.
2. Medical Council of India 1994, 1998, 2000, 2001
3. Establishment of New Medical Colleges, Higher Course Regulations, 1993.
4. Eligibility Requirement for Taking Admission in Undergraduate Medical Course in Foreign Medical Institution Regulations, 2002.

Indian System of Medicine and Homeopathy

1. Indian Medicine Central Council Act and Regulations, 1970, 1989, 2005
2. Homeopathy Central Council Act, 1973, 2002
3. Homeopathy Education Courses, Standards, 1983
4. Homeopathy Practitioners (Professional Conduct, Etiquettes and Code of Ethics) Regulations, 1982

Dentistry

1. Dentist Act, 1948, 1993
2. Dental Council of India Regulations, 1955, 1956, 1984, 2006
3. Dental Council (Election) Regulations, 1952
4. BDS, MDS Course Regulations, 1983
5. Establishment of Dental Colleges, 1993

Pharmacy

1. Pharmacy Act, 1948
2. Pharmacy Council of India - Regulations

Nursing

1. Indian Nursing Council Act, 1947
2. Indian Nursing Council Regulations

Rehabilitation

1. Rehabilitation Council of India Act and Regulations, 1992, 1997, 1998

D. Laws in relation to Ethics and Patients Rights

1. Consumer Protection Act and Rules, 1986, 1987, 2002
2. Ethical Guidelines for Biomedical Research on Human Subjects, 2000
3. Right to Information Act and Rules, 2005
4. Central Information Commission (Appeal Procedure) Rules, 2005

E. Laws in relation to Pharmaceutical and Medical Devices

1. Drugs and Cosmetics Act, 1940, 2005, 2006
2. Drugs Control Act, 1950
3. Drug and Magic Remedies (Objectionable Advertisement) Act, 1954
4. Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (Ayush) Orders, 2005

F. Laws in relation to Radiation Protection

1. Atomic Energy Act and Rules, 1962, 1984
2. Radiation Protection Rules, 1971
3. Radiation Surveillance Procedures for Medical Application of Radiation, 1980, 1989
4. Atomic Energy (Working of the Mines, Minerals and Handling of Prescribed Substance) Rules, 1984, 1987
5. Safety Code for Medical Diagnostic X-Ray Equipment and Installations

G. Laws in relation to Hazardous Substances

1. Narcotic Drugs and Psychotropic Substances Act and Rules, 1985
2. Prevention of Illicit Traffic in Narcotic Drugs and Psychotropic Substances Act, 1988
3. Hazardous Wastes (Management and Handling) Rules, 1989, 2002

H. Laws in relation to Occupational Health and Accident Prevention

1. Workmen's Compensation Act, 1923
2. Factories Act 1948, 1987
3. Mines Act, 1952, 1957
4. Motor Transport Workers Act, 1961
5. Personal Injuries (Emergency Provisions) Act, 1962, 1963
6. Beedi and Cigar Workers Act, 1966
7. Child Labour (Prohibition and Regulation) Act, 1986
8. Dock Workers (Safety, Health and Welfare) Rules, 1990
9. Public Liability Insurance Act and Rules, 1991

10. Building and Other Construction Workers Act, 1996

11. Fatal Accidents Act, 1855

12. Contract Labour (Regulation and Abolition) Central Rules, 1971

I. Laws in relation to Elderly, Disabled, Rehabilitation and Mental Health

1. Mental Health Act, 1987

2. Central and State Mental Health Rules, 1990

3. Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, 1996

4. National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999, 2000

J. Laws in relation to Family, Women and Children

1. Special Marriage Act, 1954

2. Hindu Marriage Act, 1955

3. Children Act, 1960

4. Dowry Prohibition Act, 1961

5. Suppression of Traffic in Women and Girls Act, 1956

6. National Commission for Women Act, 1990

7. Juvenile Justice (Care and Protection of Children) Act, 2000

K. Laws in relation to Smoking, Alcoholism and Drug Abuse

1. Cigarettes (Regulation of Production, Supply and Distribution) Act, 1975

2. Cigarettes and Other Tobacco Products (Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution) Act and Rules, 2003, 2004

3. Cigarettes and Other Tobacco Products (Prohibition of Sale on Cigarettes and Other Tobacco Products around Educational Institutions) Rules, 2004

L. Laws in relation to Social Security and Health Insurance

1. Minimum Wages Act, 1948

2. Employees State Insurance Act and Rules, 1948, 1950

3. Life Insurance Corporation Act, 1956

4. Maternity Benefit Act, 1961, 1963

5. Insurance Regulatory and Development Authority Act, 1999, 2000, 2001, 2002

M. Laws in relation to Environmental Protection

1. Insecticides Act and Rules, 1968, 1971, 1993, 2000
2. Water (Prevention and Control of Pollution) Act and Rules, 1974, 1975, 1977, 1978, 2003
3. Air (Prevention and Control of Pollution) Act and Rules, 1981, 1982, 1983
4. Environment (Protection) Act, 1986, 2002
5. Bhopal Gas Leak Disaster Act, 1985, 1992
6. Central Board for the Prevention and Control of Water
7. Pollution (Procedure for Transaction of Business) Rules, 1975

N. Laws in relation to Nutrition and Food Safety

1. Prevention of Food Adulteration Act and Rules, 1954, 1955, 2001, 2002
2. Infant Milk Substitutes, Feeding Bottles and Infant Foods Act and Rules, 1992, 1993, 2003
3. Atomic Energy (Control of Irradiation of Food) Rules, 1996
4. Food Safety and Standards Act, 2006

O. Laws in relation to Health Information and Statistics

1. Births, Deaths and Marriages Registration Act, 1886
2. Registration of Births and Deaths Act, 1969
3. Collection of Statistics Act and Rules, 1953, 1959
4. Census Act, 1948, 1993

P. Laws in relation to Intellectual Property Rights

1. Patents Act and Rules, 1970, 1972, 2005
2. Arbitration and Conciliation Act, 1996
3. Trade Marks Act, 1999
4. Laws in relation to Custody, Civil and Human Rights
5. Indian Penal Code, 1860
6. Unlawful Activities (Prevention) Act, 1967
7. Protection of Human Rights Act, 1993

Q. Laws in relation to Other (Miscellaneous) Issues

1. Essential Commodities Act, 1955
2. Standards and Weights Measures Act, 1976

Modules & Chapters

Post Graduate Certificate Course in Health System and Management

Module 1 : Introduction To Public Health	
1	Terminologies Used In Health Care System And Management
2	Concept Of Health
3	Evolution Of Public Health
4	Primary Health Care To Millennium Development Goal
5	Health Planning In India
6	International Health Agencies
7	Five Year Plans And 12th Five Year Plan
Module : 2 : Basics Of Health Systems And Health Care Delivery	
1.A	Introduction To Health System In India : Health System In India
1.B	Introduction To Health System In India : Urban Health System
1.C	Introduction To Health System In India : Decentralised Health Administration By Local Self Government
1.D	Introduction To Health System In India : Voluntary Health Agencies In India
2	Health Policy
3	Health Indicators
4	Health Legislation
Module : 3 : Basic Of Management & Planning	
1	Basics Of Health Management
2	Managers : Level, Role & Skills
3	Health Planning Process
4	Strategic Management/Planning & Operational Planning
5	Project Management & Log Frame Analysis

POST GRADUATE CERTIFICATE COURSE IN HEALTH SYSTEM AND MANAGEMENT

Aim

PGCHSM is aiming to develop comprehensive knowledge and skills in the Health System and Management.

Objective

1. To equip students with an overall perspective on health system
2. To improve leadership skills in public health and create good health managers
3. To inculcate interdisciplinary approach to problem solving skills in public health

About Course

Module 1: Introduction to Public Health
Module 2: Basics of Health System and Health Care Delivery
Module 3: Basic of Management and Planning
Module 4: Organization and Human Resource Management
Module 5: Material Management in Health
Module 6: Monitoring and Evaluation in Health System & Health Economics

Student Speaks

We learned many of the newer knowledge and skills about Health System & Management.

- Dr. Snehal Vaghela

Sessions of Resource Persons who had worked in the field were very interesting. We came to know about field realities and practical solutions.

- Dr. Kanan Desai

Contact sessions were interactive and we got maximum insights and understanding about Health System & Management during these sessions.

- Dr. Jaimin Patel

Assignments were framed in completely different ways. They require more thought process and field understanding than mere book knowledge.

- Dr. Ankit Sheth