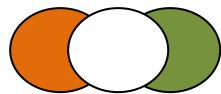


**Post Graduate Certificate Course in Health System and Management - 2013**



## Module 1: Chapter 8

### **Five Year Plans**



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**Indian Association of Preventive and Social Medicine  
Gujarat Chapter**

## **Five Year Plans and 12<sup>th</sup> Five Year Plan**

### **Learning objectives:**

1. To study the achievement during five year plan periods
2. To study the investment by Government during various five year plans
3. To study the performance of 11<sup>th</sup> five year plan
4. To study the achievements and gaps during 11<sup>th</sup> five year plan
5. To study the strategy of 12<sup>th</sup> Five year plan
6. To study the core instruments for service delivery in 12<sup>th</sup> plan

Planning, policy formulations, administration and management are areas with which every person working for public health must be thoroughly familiar. As a matter of fact, proper planning and management are essential for achieving high standard of public health. Planning is defined as an organized, conscious and continual attempt to select the best available alternatives to achieve specific goals.

The Government of India set up a Planning Commission in 1950 to make an assessment of the material, capital and human resources of the country and to draft developmental plans for the most effective utilization of these resources. The Planning Commission has been formulating successive Five Year Plans.

The Planning Commission consists of Chairman, Deputy Chairman and 5 members. The Planning Commission works through 3 major divisions- Programme Advisers, General Secretariat and Technical Divisions which are responsible for scrutinizing and analyzing various schemes and projects to be incorporated in Five Year Plans.

Planning Commission also reviews from time to time the progress made in various directions and to make recommendations to Government on problems and policies relevant of the pursuit of rapid and balanced economic development.

### **Goals for the Eleventh FYP**

- Reducing Maternal Mortality Ratio (MMR) to 1 per1000 live births.
- Reducing Infant Mortality Rate (IMR) to 28 per1000 live births.
- Reducing Total Fertility Rate (TFR) to 2.1.
- Providing clean drinking water for all by 2009
- Reducing malnutrition among children of age group 0–3 to half its present level.

- Reducing anaemia among women and girls by 50%.
- Raising the sex ratio for age group 0–6 to 935 by 2011–12 and 950 by 2016–17.

In 12<sup>th</sup> Five year plans there are three volumes for different aspects of planning.

Volume I: 1). Inclusive growth

Volume II: 1). Health, 2). Education, 3). Employment and Skill Development,  
4). Women's Agency and Child Rights, 5). Social Inclusion

Volume III: 1). Agriculture, 2). Rural development, 3). Industry, 4). Services and  
5). Physical infrastructure

Volume II is concerned with Social sectors. Social Sectors includes: Education; Health and family Welfare and AYUSH: Youth affairs and sports and art and culture; Nutrition and Social Safety Net; Drinking water, sanitation and clean living conditions; Towards women's agencies and Child Rights.

**Table 1**  
**Achievement during plan periods plan periods (in Rs. Crores)**

Sr No.	Particulars	1 <sup>st</sup> Plan (1951-56)	11 <sup>th</sup> Plan (2007-2012) March 2008
1	PHC'S	725	23,458
2	Sub. Centre	NA	146,036
3	CHC'S	-	4,276
4	Total Beds(2002)	125,000	914,543
5	Medical College	42	300
6	Annual admission in MC	3,500	34,595
7	Dental College	7	290
8	Doctors	65,000	757,377
9	Nurses	18,500	1,043,363
10	ANM's	12,780	557,022
11	Health visitors	578	51,776
12	Health Worker-F	-	153,568
13	Health Worker-M	-	60,247

14	Health Assistant-F	-	17,976
15	Health Assistant-M	-	17,608
16	Village Health Guide	-	323,000

**Source:** Govt. of India, Bulletin of Rural Health in Statistics in India, Ministry of Health and Family Welfare, New Delhi

**Table 2**  
**Investment in different plan periods (Rs. In Crores)**

<b>Number of plan</b>	<b>Year</b>	Total plan investment	Investment on Health and Family Welfare	Water supply and Sanitation
First Plan	1951-1956	1960	65.3	NA
Second Plan	1956-1960	4672	143.0	NA
Third Plan	1961-1966	8576	249.9	10.7
Fourth Plan	1969-1974	15778.8	619.9	458.9
Fifth Plan	1974-1979	39322	1179.4	971.0
Sixth Plan	1980-1985	97500	2831.0	3922.0
Seventh Plan	1985-1990	180000	6649	6522.47
Eighth Plan	1992-1997	798000	14075.9	16711.0
Ninth Plan	1997-2002	859200	25938.6	----
Tenth Plan	2002-2007	1484131	58145.3	---
Eleventh Plan	2007-2012	3750978	131645.0	175000
<b>Twelfth Plan</b>	<b>2012-2017</b>	<b>8050123</b>	<b>300018</b>	<b>132760</b>

**Table 3**  
**Pattern of Central Allocation of Funds on Health**

<b>Plan</b>	<b>Health (%)</b>	<b>Family Welfare (%)</b>	<b>AYUSH (%)</b>	<b>Total (%)</b>	<b>GDP (%)</b>
First	3.3	0.1	-	3.4	0.22
Second	3.0	0.1	-	3.1	0.49
Third	2.6	0.3	-	2.9	0.63
Fourth	2.1	1.8	-	3.9	0.61
Fifth	1.9	1.2	-	3.1	0.74
Sixth	1.8	1.3	-	3.1	0.81
Seventh	1.7	1.4	-	3.1	0.91
Eighth	1.7	1.5	0.02	3.2	1.05
Ninth	2.31	1.76	0.03	4.02	0.96
Tenth	2.09	1.83	0.05	3.97	0.88
Eleventh	6.3	Merged with Health	0.18	6.5	0.91(03-04)

At present, India's health care system consists of a mix of public and private sector providers of health services. The system suffers from the following weaknesses:

1. **Availability** of health care services from the public and private sectors taken together are quantitatively inadequate.
2. **Quality** of healthcare services varies considerably in both the public and private sector
3. **Affordability** of health care is a serious problem for the vast majority of the population, especially in tertiary care. Out of pocket expenditures arise even in public sector hospitals
4. The problems outlined above are likely to worsen in future. Health care costs are expected to rise because, with rising life expectancy, a larger proportion of our population will become vulnerable to chronic Non Communicable Diseases (NCDs), which typically require expensive treatment.

The total expenditure on health care in India, taking both public, private and household out of-pocket (OOP) expenditure was about 4.1 per cent of GDP in 2008–09

When the Eleventh Plan was formulated and an effort was made to increase Central Plan expenditures on health. The increase in Central expenditures has not been fully matched by

a comparable increase in State Government expenditures. The Twelfth Plan proposes to take corrective action by incentivizing States.

## REVIEW OF ELEVENTH PLAN PERFORMANCE

A review of the health outcome of the Eleventh Plan and of NRHM is constrained by lack of end-line data on most indicators. Analysis of available data reveals that though there has been progress, except on child-sex ratio.

1. **Maternal Mortality Ratio (MMR)** is a sensitive indicator of the quality of the health care system. The decline in MMR during the 2004–06 to 2007–09 of 5.8 per cent per year (that is, 254 to 212) has been comparable to that in the preceding period (a fall of 5.5 per cent per year, over 2001–03 to 2004–06). MMR of 212 from 301 (2007–09) is well short of the Eleventh Plan goal of 100.
2. **Infant Mortality Rate (IMR)**, death of children before age one per 1000 live births, is a sensitive indicator of the health and nutritional status of population. IMR fell by 5 per cent per year over the 2006–11 period, an improvement over the 3 per cent decline per year in the preceding five years, but short of the target of 28
3. **Total Fertility Rate (TFR)**, which measures the number of children born to a woman during her entire reproductive period, fell by 2.8 per cent per annum over the 2006–10 period from 2.8 to 2.5, which is faster than the decline of 2 per cent per year in the preceding five years, but short of the Eleventh Plan goal of 2.1.
4. On the goal of raising **child sex ratio**, there has been a reversal. Child sex ratio is unfavorable in India.
5. Progress on goals on reducing *malnutrition* and *anaemia* cannot be assessed for want of updated data, but localised surveys indicated that the status has not improved.

## **FINANCING FOR HEALTH**

During the Eleventh Plan funding for health by Central Government has increased to 2.5 times and of States to 2.14 times that in Tenth Plan, to add up to 1.04 per cent of GDP in 2011–12. When broader determinants of health (drinking water ICDS and Mid-Day Meal) are added, the total public spending on health in Eleventh Plan comes to 1.97 per cent of GDP

**An analysis of performance reveals achievements and gaps of 11<sup>th</sup> Five year plan. These follow.**

### **1. INFRASTRUCTURE**

There has been an increase in number of public health facilities over the 2007–11 period: Sub-Centers by 2 per cent, PHC by 6 per cent, CHC by 16 per cent and District Hospitals by 45 per cent. Yet, shortfalls remain 20 per cent for Sub-Centers, 24 per cent for PHCs and 37 per cent for CHCs, particularly in Bihar, Jharkhand, Madhya Pradesh and Uttar Pradesh. Though most CHCs and 34 per cent Primary Health Centers (PHCs) have been upgraded and operationalised as 24 × 7 facilities and First Referral Units (FRU) have doubled, yet the commitment of Eleventh Plan to make all public facilities meet IPHS norms, and to provide Emergency Obstetric Care at all CHCs have not been achieved. Access to safe abortion services is not available in all CHCs, a gap which is contributing to maternal mortality.

### **2. HEALTH PERSONNEL**

ASHAs positioned under NRHM have been successful in promoting awareness of obstetric and child care services in the community. Better training for ASHA and timely payment of incentive have come out as gaps in evaluations. Despite considerable improvement in health personnel in position (ANM 27 per cent, nurses 119 per cent, doctors 16 per cent, specialists 36 per cent, pharmacists 38 per cent), gap between staff in position and staff required at the end of the Plan was 52 per cent for ANM and nurses, 76 per cent for doctors, 88 per cent for specialists and 58 per cent for pharmacists. These shortages are attributed to delays in recruitment and to postings not being based on work-load or sanctions.

### **3. TRAINING CAPACITY**

Setting up of 6 AIIMS like institutes and upgradation of 13 medical colleges has been taken up under Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). Seventy-two State Government medical colleges have been taken up for strengthening to enhance their capacity for PG training. Huge gaps, however, remain in training capacity for all category of health personnel.

#### **4. COMMUNITY INVOLVEMENT**

Though Rogi Kalyan Samitis (RKS) are in position in most public facilities, monthly Village Health and Nutrition Days are held in most villages, Jan Sunwais (public hearings) and Common Review Missions have been held yet, their potential in terms of empowering communities, improving accountability and responsiveness of public health facilities is yet to be fully realized.

#### **5. SERVICE DELIVERY**

1. To reduce maternal and infant mortality, institutional deliveries are being promoted by providing cash assistance to pregnant women under Janani Suraksha Yojana (JSY). Though institutional deliveries have increased in rural (39.7% to 68%) and urban areas (79% to 85%) over the 2005–09 period, low levels of full Ante-Natal care (22.8% in rural, and 26.1% in urban in 2009, CES) and quality of care areas of concern.
2. Full immunization in children has improved from 54.5% in 2005 (CES) to 61% 2009 (CES) during the Eleventh Plan.
3. The Eleventh Plan commitment of providing access to essential drugs at public facilities has not been realized

#### **6. GOVERNANCE OF PUBLIC HEALTH SYSTEM**

The *Eleventh Plan* had suggested *Governance* reforms in public health system, such as performance linked incentives, devolution of powers and functions to local health care institutions and making them responsible for the health of the people living in a defined geographical area. NRHM's strategy of decentralization, PRI involvement, integration of vertical programmes, inter-sectoral convergence and Health Systems Strengthening have been partially achieved. Despite efforts, lack of capacity and adequate flexibility in programmes forestall effective local level planning and execution based on local disease priorities.

#### **7. DISEASE CONTROL PROGRAMMES**

India bears a high proportion of the global burden of TB (21 per cent), leprosy (56 per cent) and lymphatic filariasis (40 per cent). Though there has been progress in the Eleventh Plan in reducing rate of new infections, case load and death from these diseases, a robust surveillance system at the community level is lacking and considerable hidden and residual disease burden remains.

Among the NCDs, Cardiovascular Diseases (CVD) account for 24 per cent of mortality followed by Respiratory Disease, and malignant cancers. During the Eleventh Five Year Plan National Programme for the Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS) was initiated in 100 selected districts in 21 states. So far, 87 lakh people have been screened for diabetes and hypertension, out of which 6.5 per cent are suspected to be diabetic and 7.7 per cent are suspected to be suffering from hypertension. Despite enhanced allocations for the National Mental Health Programme, it has lagged behind due to non-availability of qualified mental health professionals at district and sub-district levels.

## **8. HMIS**

During the Eleventh Plan, a web based Health Management Information System (HMIS) application software has been developed and made operational for online data capture at district and sub-district levels on RCH service delivery indicators. The data captured is scanty, restricted to public facilities and is not always used for programme planning or monitoring.

## **9. AIDS CONTROL**

Against a target to halt and reverse the HIV/ AIDS epidemic in India, there has been a reduction of new HIV infections in the country by 56 per cent. Still, an estimated 24 lakh People were living with HIV/AIDS (PLHA) in 2009. Gaps in the programme include low rate of coverage of Anti-Retroviral Therapy among infected adults and children, low levels of opioid substitution therapy among injection drug users (3 per cent), testing of pregnant women for HIV and Syphilis (23 per cent) and low Anti-Retroviral coverage for preventing mother to child transmission. There is scope for greater integration with NRHM to avoid duplication of efforts, as in reaching non-high risk groups and distribution of condoms.

## **10. INDIAN SYSTEMS OF MEDICINE AND HOMOEOPATHY (AYUSH)**

Against the Eleventh Plan objective of 'mainstreaming AYUSH systems to actively supplement the efforts of the allopathic system', 40 per cent PHCs, 65 per cent CHCs and 69 per cent District hospitals have co-located AYUSH facilities. Though considerable progress has been made in documenting identity and quality standards of herbal medicines, scientific validation of AYUSH principles, remedies and therapies has not progressed

## **11. HEALTH RESEARCH**

The newly established department of Health Research, and Indian Council of Medical Research (ICMR) have piloted several innovations, including an on-line Clinical Trials Registry, Uniform Multidrug Therapy Regimen (UMDT) for Leprosy and lymphatic

filariasis, kits for improved diagnosis of malaria, dengue fever, TB (including drug resistant), cholera, Chlamydia infection, Leptospirosis; and development of indigenous H1N1 vaccine. Yet, health research in India has yet to make a major impact on the health challenges facing the country

## **TWELFTH PLAN STRATEGY**

The Twelfth Plan seeks to strengthen initiatives taken in the Eleventh Plan to expand the reach of health care and work towards the long term objective of establishing a system of **Universal Health Coverage (UHC)** in the country. This means that each individual would have assured access to a defined essential range of medicines and treatment at an affordable price, which should be entirely free for a large percentage of the population.

Based on the recommendations of the HLEG and other stakeholder consultations, it is possible to outline the key elements of the strategy that should be followed in the Twelfth Plan. These elements should be seen as a part of a longer term plan to move towards UHC

1. There must be substantial expansion and strengthening of the public sector health care system if we are to meet the health needs of rural and even urban areas.
2. Health sector expenditure by the Centre and States, both Plan and Non Plan, will have to be substantially increased by the end of the Twelfth Plan. It has already increased from 0.94 per cent of GDP in the Tenth Plan to 1.04 per cent in the Eleventh Plan. The percentage for this broader definition of health sector related resources needs to be increased to 2.5 per cent by the end of the Twelfth Plan. Since expenditure on health by the State Governments is about twice the expenditures by the Centre, the overall targets for public sector health expenditure can only be achieved if, along with the Centre, State Governments expand their health budgets appropriately.
3. Financial and managerial systems will be redesigned to ensure more efficient utilisation of available resources, and to achieve better health outcomes.
4. Efforts would be made to find a workable way of encouraging cooperation between the public and private sector in achieving health goals. This would include contracting in of services for gap filling, and also various forms of effectively regulated and managed PPP,
5. The present Rashtriya Swasthya Bima Yojana (RSBY) which provides 'cash less' in-patient treatment for eligible beneficiaries through an insurance based system will need to

be reformed to enable access to a continuum of comprehensive primary, secondary and tertiary care.

6. Availability of skilled human resources remains a key constraint in expanding health service delivery. A mere expansion of financial resources devoted to health will not deliver results if health personnel are not available. A large expansion of medical schools, nursing colleges, and so on, is therefore necessary. Present distribution of such colleges is geographically very uneven; a special effort will be made to expand medical education in States which are at present under-served. In addition, a massive effort will be made to recruit and train paramedical and community level health workers.
7. A series of prescription drugs reforms, promotion of essential, generic medicines, and making these universally available free of cost to all patients in public facilities as a part of the Essential Health Package will be a priority.
8. Effective regulation in medical practice, public health, food and drugs is essential to safeguard people against risks, and unethical practices.
9. The public and private sectors also need to coordinate for delivery of a continuum of care. A strong regulatory system would supervise the quality of services delivered. Standard treatment guidelines should form the basis of clinical care across public and private sectors, with adequate monitoring by the regulatory bodies to improve the quality of care and control the cost of care.

## **TOWARDS UNIVERSAL HEALTHCOVERAGE**

The Twelfth Plan strategy outlined is a first step in moving toward Universal Health Care (UHC). All over the world, the provision of some form of universal health coverage is regarded as a basic component of social security. There are different ways of achieving this objective and country experiences vary. We need to ensure much broader coverage of health services to provide essential health care and we need to do it through a system which is appropriate to our needs and within our financial capability.

## **HLEG'S RECOMMENDATIONS**

The **High Level Expert Group** has defined UHC as follows: 'Ensuring equitable access for all Indian citizens in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable and appropriate, assured quality health services (promotive, preventive, curative and rehabilitative) as well as services addressing wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider of health and related services.'

### **Recommendations of High Level Expert Group on Universal Health Coverage**

- 1. *Health Financing and Financial Protection:*** Government should increase public expenditure on health from the current level of 1.2 per cent of GDP to at least 2.5 per cent by the end of the Twelfth Plan, and to at least 3 per cent of GDP by 2022. Expenditures on primary healthcare should account for at least 70 per cent of all healthcare expenditure.
- 2. *Access to Medicines, Vaccines and Technology:*** Price controls and price regulation, especially on essential drugs, should be enforced. The Essential Drugs List should be revised and expanded, and rational use of drugs ensured. Public sector should be strengthened to protect the capacity of domestic drug and vaccines industry to meet national needs. MoHFW should be empowered to strengthen the drug regulatory system.
- 3. *Human Resources for Health:*** Institutes of Family Welfare should be strengthened and Regional Faculty Development Centres should be selectively developed to enhance the availability of adequately trained faculty and faculty-sharing across institutions. District Health Knowledge Institutes, a dedicated training system for Community Health Workers, State Health Science Universities and a National Council for Human Resources in Health (NCHRH) should be established.
- 4. *Health Service Norms:*** A National Health Package should be developed that offers essential health services at different levels of the healthcare delivery system. There should be equitable access to health facilities in urban areas by rationalizing services and focusing particularly on the health needs of the urban poor.
- 5. *Management and Institutional Reforms:*** All India and State level **Public Health Service Cadres** and a specialized State level **Health Systems Management Cadre** should

be introduced in order to give greater attention to Public Health and also to strengthen the management of the UHC system. The establishment of a National Health Regulatory and Development Authority (NHRDA) a, National Drug Regulatory and Development Authority (NDRDA) and a, National Health Promotion and Protection Trust (NHPPT) is also recommended.

**6. Community Participation and Citizen Engagement:** Existing Village Health Committees should be transformed into participatory Health Councils.

**7. Gender and Health:** There is a need to improve access to health services for women, girls and other vulnerable genders.

In order to achieve health goals UHC must build on universal access to services that are determinants of health, such as safe drinking water and sanitation, wholesome nutrition, basic education, safe housing and hygienic environment. To aim at achieving UHC without ensuring access to the determinants of health would be a strategic mistake, and plainly unworkable. Therefore, it may be necessary to realise the goal of UHC in two parallel steps: the first, would be clinical services at different levels, defined in an Essential Health Package (EHP), which the Government would finance and ensure provision through the public health system, supplemented by contracted-in private providers whenever required to fill in critical gaps; second the universal provision of high impact, preventive and public health interventions

## OUTCOME INDICATORS FOR TWELFTH PLAN

The Twelfth Plan must work towards national health outcome goals, which target health indicators.

The national health goals, which would be aggregates of State wise goals (Table 20.4), are the following:

1. *Reduction of Infant Mortality Rate (IMR) to 25.*
2. *Reduction of Maternal Mortality Ratio (MMR) to 100*
3. *Reduction of Total Fertility Rate (TFR) to 2.1:*
4. *Prevention, and reduction of under-nutrition in children under 3 years to half of NFHS-3 (2005–06) levels:* At the current rate of decline, the prevalence of underweight children is expected to be 29 per cent by 2015, and 27 per cent by 2017
5. *Prevention and reduction of anaemia among women aged 15–49 years to 28 per cent*
6. *Raising child sex ratio in the 0–6 year age group from 914 to 950:*
7. *Prevention and reduction of burden of Communicable and Non-Communicable diseases (including mental illnesses) and injuries:* State wise and national targets for each of these

conditions will be set by the Ministry of Health and Family Welfare (MoHFW) as robust systems are put in place to measure their burden.

*8. Reduction of poor households' out-of-pocket expenditure:* Out-of-pocket expenditure on health care is a burden on poor families, leads to impoverishment and is a regressive system of financing. Increase in public health spending to 1.87 per cent of GDP by the end of the Twelfth Plan, cost-free access to essential medicines in public facilities, regulatory measures proposed in the Twelfth Plan are likely to lead to increase in share of public spending.

### **Various components of 12th Five year plan**

#### **1. FINANCING FOR HEALTH**

For financing the Twelfth Plan the projections envisage increasing total public funding, plan and non-plan, on core health from 1.04 per cent of GDP in 2011–12 to 1.87 per cent of GDP by the end of the Twelfth Plan. In such an event, the funding in the Central Plan would increase to 3 times the Eleventh Plan levels involving an annual increase by 34 per cent. The Central and State funding for Health, as a proportion of total public sector health funding will remain at 2011–12 levels of 33 per cent and 67 per cent respectively.

When viewed in the perspective of the broader health sector, which includes schemes of Ministries other than Health aimed at improving the health status of people, namely Drinking Water and Sanitation, Mid-day Meal and Integrated Child Development Services Scheme the total Government expenditure as a proportion of GDP in the Twelfth Plan is likely to increase from 1.94 per cent of GDP in the last year of the Eleventh Plan to 3.04 per cent in the corresponding year of the Twelfth Plan.

In the Approach Paper to the Twelfth Plan, it was stated that we should aim at raising the total expenditure on health in the Centre and the States (including both Plan and Non-Plan) to 2.5 per cent of GDP by the end of the Twelfth Plan period

#### **2. OTHER MODELS OF FINANCING**

***Public-Private Partnerships:*** PPPs offer an opportunity to tap the material, human and managerial resources of the private sector for public good. But experience with PPP has shown that Government's capacity to negotiate and manage it is not effective. Without effective regulatory mechanisms, fulfillment of contractual obligations suffers from weak oversight and monitoring. It is necessary, as the HLEG has argued, to move away from ad hoc PPPs to well negotiated and managed contracts that are regulated effectively keeping

foremost the health of the '*aam-admi*'. RASHTRIYA SWASTHYA BIMA YOJANA (RSBY): Health insurance is a common form of medical protection all over the world and until the Eleventh Plan, it was available only to government employees, workers in the organized sector; private health insurance has been in operation for several years, but its coverage has been limited.

### **3. HEALTH AND MEDICAL REGULATION**

Regulations for food, drugs and the medical profession requires lead action by the Central Government not only because these subjects fall under the Concurrent List in the Constitution, but also because the lack of consistency and well enforced standards hugely impacts the common citizen and diminishes health outcomes. Keeping in view the need to place authority and accountability together, the proposed Public Health Cadre in States would be expected to be the single point for enforcement of all health related regulations.

There is also an urgent need to strengthen the regulatory systems in the States, where most of the implementation rests. This would entail the strengthening of and establishment of testing labs and capacity building of functionaries. Such proposals will be part-funded under the National Health Mission (NHM). Regulation can be made affordable and effective by encouraging self-regulation, and entrusting responsibility to Public Health officers.

#### **3.1 DRUG REGULATION**

E-governance systems that inter-connect all licensing and registration offices and laboratories, GPS based sample collection systems and online applications for licensing would be introduced. A repository of approved formulations at both State and national levels would be developed. The drug administration system would build capacity in training, and encourage self regulation.

The MoHFW would ensure that irrational Fixed Dose Combinations (FDCs) and hazardous drugs are weeded out in a time bound manner.

Pharmaco-vigilance, post-marketing surveillance, Adverse Drug Response Monitoring, quality control, testing and re-evaluation of registered products would be accorded priority under drug regulation.

Use of generic names or the International Non-proprietary Name (INN) would be made compulsory and encouraged at all stages of Government procurement, distribution, prescription and use, as it contributes to a sound system of procurement and distribution, drug information and rational use at every level of the health care system.

### **3.2 FOOD REGULATION**

The newly established Food Safety and Standards Authority of India (FSSAI) would strive to improve transparency in its functioning and decision making. Bio-safety would be an integral part of any risk assessment being undertaken by FSSAI. An appropriate module on food safety and bio-safety will be introduced in the Medical and Nursing curriculum.

### **4. REGULATION OF MEDICAL PRACTICE**

The provisions for registration and regulation of clinical establishments would be implemented effectively; all clinical establishments would also be networked on the Health Information System, and mandated to share data on nationally required parameters. The Government would consider mandating evidence based and cost-effective clinical protocols of care, which all providers would be obliged to follow.

### **5. INFORMATION TECHNOLOGY IN HEALTH**

Information Technology can be used in at least four different ways to improve health care and systems:

1. Support public health decision making for better management of health programmes and health systems at all levels
2. Support to service providers for better quality of care and follow up
3. Provision of quality services in remote locations through Tele-medicine
4. Supporting education, and continued learning in medicine and health

### **6. NATIONAL HEALTH MISSION (NHM)**

The Prime Minister in his Independence Day speech, 2012 had declared: 'After the success of the National Rural health Mission, we now want to expand the scope of health services in our towns also. The National Rural Health Mission will be converted into a National Health Mission (NHM) which would cover all villages and towns in the country.' The gains of the flagship programme of NRHM will be strengthened under the umbrella of NHM which will have universal coverage

A major component of NHM is proposed to be a Scheme for providing primary health care to the urban poor, particularly those residing in slums. Modalities and institutional mechanisms for roll-out of this scheme are being worked out by the Ministry of Health and Family Welfare in consultation with Planning Commission. NHM would give the States greater flexibility to make multi-year plans for systems strengthening, and addressing threats to health in both rural and urban areas through interventions at Primary, Secondary and Tertiary levels of care.

**The National Health Mission will incorporate the following core principles.**

## **CORE PRINCIPLES**

### **1. Universal Coverage**

The NHM shall extend all over the country, both in urban and rural areas and promote universal access to a continuum of cashless, health services from primary to tertiary care. Separate strategies shall be followed for the urban areas, using opportunities such as easier access to secondary and tertiary facilities, and better transport and telecommunication services.

### **2. Achieving Quality Standards**

The IPHS standards will be revised to incorporate standards of care and service to be offered at each level of health care facility. Standards would include the complete range of conditions, covering emergency, RCH, prevention and management of Communicable and Non-Communicable diseases incorporating essential medicines, and Essential and Emergency Surgical Care (EESC).

All government and publicly financed private health care facilities would be expected to achieve and maintain these standards. An in-house quality management system will be built into the design of each facility, which will regularly measure its quality achievements. The service and quality standards shall be defined, made consistent with requirements under the Clinical Establishments Act, and performance of each registered facility made public, and periodically ranked. The work of quality monitoring will be suitably institutionalised.

### **3. Continuum of Care:**

A continuum of care across health facilities helps manage health problems more effectively at the lowest level. For example, if medical colleges, district hospitals, CHCs, PHCs and sub-centres in an area are networked, then the most common disease conditions can be assessed, prevented and managed at appropriate levels. It will avoid fragmentation of care, strengthen primary health care, reduce unnecessary load on secondary and tertiary facilities and assure efficient referral and follow up services. Continuum of care can lead to improvements in quality and patient satisfaction. Such linkages would be built in the Twelfth Plan so that all health care facilities in a region are organically linked with each other.

#### **4. Decentralized Planning**

A key element of the new NHM is that it would provide considerable flexibility to States and Districts to plan for measures to promote health and address the health problems that they face.

New health facilities would not be set up on a rigid, population based norm, but would aim to be accessible to populations in remote locations and within a defined time period. The need for new facilities of each category would thus be assessed by the districts and States using a 'time to care' approach. This will be done based on a host of contributing factors, including geographic spread of population, nature of terrain, availability of health care facility in the vicinity and availability of transport network. For example, a travel time of 30 minutes to reach a primary healthcare facility, and a total of two hours to reach a FRU could be a reasonable goal.

## **INSTRUMENTS FOR SERVICE DELIVERY**

### **1. Effective Governance Structures**

The broad and flexible governance structure of the National Health Mission would be used. States would be advised to merge the existing governance structures for social sector programmes, such as drinking water and sanitation, ICDS, AIDS control and NRHM at all levels, pool financial and human resource under the leadership of local PRI bodies and make multi-sectoral social plans to collectively address the challenges.

The existing National Programme Coordination Committee (NPCC) of NRHM will be expanded to serve the National Health Mission. It will be made more representative of all social sectors, sub-sectors within the health sector, and include expertise on monitoring and independent evaluation.

### **2. Accountability for Outcomes**

In order to ensure that plans and pronouncements do not remain on paper, a system of accountability shall be built at all levels, namely Central Government reporting to the Parliament on items which are its business, States reporting on service delivery and system reforms commitments undertaken through the MoU system, district health societies reporting to States, facility managers reporting on health outcomes of those seeking care, and territorial health managers reporting on health outcomes in their area.

Accountability shall be matched with authority and delegation; the MoHFW shall frame model accountability guidelines which will suggest a framework for accountability to the local community, requirement for documentation of unit cost of care, transparency in operations and sharing of information with all stakeholders.

Gaps in the management capacity at the state level need to be addressed. States will be encouraged to set up efficiently functioning agencies/cells for procurement and logistics, recruitment and placement of human resource, human resource management, design, construction and upkeep of health care buildings, use of Information Technology, Financial management, transport systems, standards setting and quality control, monitoring and evaluation of process and outcomes. States shall be advised to expand the roles and responsibilities of Medical Officers in charge of public health facilities to cover all determinants of health, with a focus on improving national health outcome indicators.

States can empower facility managers with more financial and hiring powers so that they can take quick decisions on service related local issues. The Rogi Kalyan Samiti model of

facility autonomy launched under NRHM would be expanded to enable investment in facility upkeep and expansion, or even filling temporary HR gaps.

### **3. Health Delivery Systems**

Trained and competent human capital is the foundation of an effective health system. Without adequate human resources, additional expenditure on health will not lead to additional services and will only bid up wages. In this context it is important for the Twelfth Plan to embark on a clear strategy to expand the supply of appropriately trained health workers to support health care objectives being targeted.

Effectively functioning health systems depend on human resource, which range from medical, AYUSH and dental graduates and specialists, graduate and auxiliary nurses, pharmacists to other allied health professionals.

A peculiar feature of India's healthcare system is the presence of a large number of non-qualified practitioners, such as traditional birth attendants (dais), compounders and RMPs. As per law, they are neither authorised to practice Medicine, nor to prescribe drugs. Nonetheless, they work everywhere in the country and address a huge unfulfilled demand for ambulatory care, particularly in rural areas. The challenge is to get them into the formal system. The plan recommends giving these practitioners, depending on their qualifications and experience, an opportunity to get trained and integrate them into the health workforce in suitable capacities by mutual consent.

Another opportunity lies in utilising the services of AYUSH graduates for providing primary care. There are two pre-requisites before this can be done—first by amendment of the legal framework to authorize the practice of modern medicine for primary care by practitioners of Indian Systems of Medicine; and secondly by supplementing skills of AYUSH graduates by imparting training in modern Medicine through bridge courses.

It is generally accepted that the doctor to nurse ratio should be at least 1:3 for the team to perform optimally. This ratio is currently 1:1.6 and is expected to improve to 1:2.4 by end of Twelfth Plan if no new colleges are started. If we adopt a goal of 500 health workers per lakh population by the end of Thirteenth Plan, we would need an additional 240 medical colleges, 500 General Nursing and Midwifery (GNM)/nursing colleges and 970 ANMs training institutes. If work on these new teaching institutions begins from the 2013–14 annual plan, and is completed by the end of the Twelfth Plan, the flow of nurses and ANMs would begin within this plan, while doctors from these institutions would be available only

from the beginning of the Thirteenth Plan. The ratio of doctors to nurses will then rise from 1:1.6 in 2012 to 1:2.8 in 2017 and reach 1:3 in 2022.

#### **4. Expansion of Teaching Facilities:**

The Government shall take the lead role in creating teaching capacity in health, while private sector colleges would also be allowed. Initiatives would be taken to upgrade existing District hospitals and CHCs into knowledge centers, where medical, nursing and para-medical teaching and refresher courses can be held side-by-side with patient care. States shall be encouraged to take this up through the incentive fund of the NHM.

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#### **5. Community Participation and PRI Involvement**

Government health facilities at the level of blocks and below can become more responsive to population needs if funds are devolved to the Panchayati Raj Institutions (Village Council or its equivalent in the Scheduled Areas), and these institutions made responsible for improving public health outcomes in their area. States should formalise the roles and authority of Local Self-Government bodies in securing convergence so that these bodies become stakeholders for sustainable improvements in health standards. The States would be advised to make Village Health, Sanitation and Nutrition Committees as the guiding and operational arms of the Panchayats in advancing the social agenda.

#### **6. Strengthening Health Systems**

A major objective of enhanced funding, flexibility to and incentivisation of States is to build health systems

## **CONCLUSION**

The Twelfth Plan faces a colossal task of putting in place a basic architecture for health security for the nation. It must build on what has been achieved through the NRHM and expand it into a comprehensive NHM. Since the primary responsibility for health care rests with the States, the strategy needs to effectively incentivize State Governments to do what is needed to improve the public health care system while regulating the private health care system, so that together they can work towards addressing the management of delivery of preventive, promotive, curative and rehabilitatory health interventions. This is not a task that can be completed within one Plan period. It will certainly span two or three Plan periods, to put the basic health infrastructure in place.