UNIT I

ORGANIZATIONAL AND ADMINISTRATIVE SET UP OF HEALTH SYSTEM IN INDIA AT CENTRAL, STATE AND DISTRICT LEVEL

OBJECTIVES

1. To know the organizational and administrative set up of health system in district and state level.
2. To know the role and responsibility of government in respect of health system at district as well as state level.
3. To know the various activities of the different sub-division, municipalities and corporation on a much wider scale.
4. To know the various elementary services which are rendered by health expert, institutes, workers and nurses etc.

INTRODUCTION

States are largely independent in matters relating to the delivery of health care to the people. Each state has developed its own system of health care delivery, independent of the Central Government. The Central Government's responsibility consists mainly of policy making, planning, guiding, assisting, evaluating and coordinating the work of the State Health Ministries. The organization at state level is under the State Department of Health and Family Welfare in each state headed by Minister and with Secretariat under the charge of Secretary/ commissioner (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS).

Introduction:

- ❑ India is a Union of 29 States and 7 Union territories.
- ❑ Under the Constitution of India, the States are largely

Independent in matters relating to the delivery of health care to the people Each State, therefore, has developed its own system of health care delivery, independent of the Central Government.

The Central responsibility consists mainly of

- policy making, planning, guiding, assisting, evaluating, and coordinating the work of the State Health Ministries, so that health services cover every part of the country, and no State lags behind for want of these services.
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- The health system in India has 3 main links, i.e., Central, State and Local or peripheral.

I - AT THE CENTRE

- The official "organs" of the health system at the national level consist of :
- The Ministry of Health and Family Welfare.
- The Directorate General of Health Services.
- The Central Council of Health and Family Welfare.

1. Union Ministry of Health and Family Welfare

1) ORGANIZATION

- The Union Ministry of Health and Family Welfare is headed by a Cabinet Minister, a Minister of State and a Deputy Health Minister. These are political appointments.
- Currently, the Union Health Ministry has the following departments:
- (1) Department of Health and
- (2) Department of Family Welfare.
- 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.
- The Department of Family Welfare was created in 1966 within the Ministry of Health and Family Welfare.
- The Secretary to the Govt. of India in the Ministry of Health and Family Welfare is in overall charge of the Department of Family Welfare.
- He is assisted by an Additional Secretary & Commissioner (Family Welfare), and one Joint Secretary.

FUNCTIONS

- The functions of the Union Health Ministry are set out in the seventh schedule of Article 246 of the Constitution of India under
- (a) the Union list and
- (b) The Concurrent list.

(a) Union list: The functions given in the Union list are:

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; National Institute for the Control of Communicable Diseases, Delhi, etc.

3) Promotion of research through research centre and other bodies.

(4) Regulation and development of medical, pharmaceutical, dental and nursing professions

(5) Establishment and maintenance of drug standards

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

(7) Immigration and emigration

(8) Regulation of labor in the working of mines and oil fields

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

(b) Concurrent list:

- The functions listed under the concurrent list are the responsibility of both the Union and State governments.
- The Centre and the States have simultaneous powers of legislation; the powers of the latter are restricted to the framework of such legislation as may be undertaken by the Centre.
- The concurrent list includes:

(1)Prevention of extension of communicable diseases from one unit to another
(2) Prevention of adulteration of food stuffs
(3) Control of drugs and poisons
(4) Vital statistics
(5) Labor welfare
(6) Ports other than major
(7) Economic and social planning, and
(8) Population control and Family Planning.

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.

Functions:

- The GENERAL functions are surveys, planning, coordination, programming and appraisal of all health matters in the country.
- (1) International health relations and quarantine
- (2) Control of drug standards
- (3) Medical store depots
- (4) Post graduate training
- (5) Medical education
- (6) Medical Research
- (7) National Health Programmes
- (8) Central Health Education Bureau
- (9) Health Intelligence
- (10) National Medical Library

1) International health relations and quarantine:

All the major ports in the country (Kolkata, Chennai, Mumbai) and International air ports (Mumbai-Santa Cruz, Kolkata-Dum Oum, Delhi-Palam) are directly controlled by the Directorate General of Health Services.

(2) Control of drug standards:

- The Drugs Control Organization is part of the Directorate General of Health Services, and is headed by the Drugs Controller.
- Its primary function is to lay down and enforce standards and control the manufacture and distribution of drugs through both Central and State Government Officers.

(3) Medical store depots:

- The Union Government runs medical store depots at Mumbai, Chennai, Kolkata, Kamal, Gauwahati and Hyderabad.
- 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, which also provide post-graduate training to different categories of health personnel.
- 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, etc.

(5) Medical education:

- The Central Directorate is directly in charge of the following medical colleges in India the Lady Hardinge, The Maulana Azad and the Medical Colleges at Puducherry , health system in india .
- Besides these, there are many medical colleges in the country which are guided and supported by the Centre.

(6) Medical Research :

- Medical Research in the country is organized largely through the Indian Council of Medical Research, founded in 1911 in New Delhi.
- The Council plays a significant role in Aiding, promoting and coordinating scientific research on human diseases, their causation, prevention and cure.

(7) National Health Programmes:

- The various national health programmes for the eradication of malaria and for the control of tuberculosis, AIDS and other communicable diseases involve expenditure of crores of rupees.
- Health programmes of this kind can hardly succeed without the help of the Central Government.
- The Central Directorate plays a very important part in planning, guiding and coordinating all the national health programmes in the country.

(8) Central Health Education Bureau:

- An outstanding activity of this Bureau is the preparation of education material for creating health awareness among the people.
- The Bureau offers training courses in health education to different categories of health workers.

(9) Health Intelligence:

- The Central Bureau of Health Intelligence was established in 1961 to centralize collection, compilation, analysis, evaluation and dissemination of all information on health statistics for the nation as a whole.

(10) National Medical Library:

- The Central Medical Library of the Directorate General Health Services was declared the National Medical Library in 1966.
- 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**

- The Central Council of Health was set up by a Presidential Order on 9 August, 1952 under Article 263 of the Constitution of India for promoting coordinated and concerted action between the Centre

and the States in the implementation of all the programme and measures pertaining to the health of the nation.

- The **Union Health Minister** is the **Chairman** and the **State Health Ministers** are the **members.**

FUNCTIONS

(1) To consider and recommend broad outlines of policy in regard to matters concerning health in all its aspects such as the 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 fields of activity relating to medical and public health matters and to lay down the pattern of development for the country as a whole.

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

(4) To establish any organization or organizations invested with appropriate functions for promoting and maintaining cooperation between the Central and State Health administrations

II.AT STATE LEVEL

- Historically, the first milestone in State health administration was the year 1919, when the States obtained autonomy, from the Central Government, in matters of public health.
- By 1921-22, all the States had created some form of public health organization.
- The Government of India Act, 1935 gave further autonomy to the States.
- The health subjects were divided into three groups**: federal, concurrent and state.**
- The **"state"** list which became the responsibility of the State included provision of medical care, preventive health services and pilgrimages within the State.

- The position has largely remained the same, even after the new Constitution of India came into force in 1950.
- The State is the ultimate authority responsible for all the health services operating within its jurisdiction.

1) State health administration

- At present there are 29 States 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.

2) 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.

3) State Health Directorate

- For a long time, two separate departments, medical and public health, were functioning in the States; the heads of these departments were known as Surgeon General and Inspector General of Civil Hospitals and Director of Public Health respectively.
- The Bhore Committee (1946) recommended that the medical and public health organizations should be integrated at all levels and therefore, should have a single administrative officer for the curative and preventive departments of health. the process was completed by Maharashtra in May 1970.
- 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.
- A recent development in some States is the appointment of a Director of Medical Education in view of the increasing number of medical colleges.
- Some experts feel that there is no justification for the removal of medical education from general health services under the Director of Health Services.
- The health services and training institutions should develop into one logical whole designed to an end - the protection of the health of the people.
- 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 and Functional.
- **The Regional Directors** inspect all the branches of public health within their jurisdiction, irrespective of their specialty
- The Functional Directors are usually specialists in a particular branch of public health such as mother and child health, family planning, nutrition, tuberculosis, leprosy, health education etc.

- The Public Health Engineering Organization in most States is part of the Public Works Department of the State Government.
- It has been recommended by experts in the public health that the public health engineering organization in every State should be part of the State Health Department, and that the Chief Engineer of Public Health should have the status of an Additional Director of Health Services.

III. AT THE DISTRICT LEVEL

- The District The principal unit of administration in India is the district under a Collector.
- There are 614 (year 2007) districts in India. Within each district again, there are 6 types of administrative areas
  1. Sub-divisions
  2. Tahsils (Talukas)
  3. Community Development Blocks
  4. Municipalities and Corporations
  5. Villages
  6. Panchayat
- Most districts in India are divided into two or more subdivisions, each in charge of an Assistant Collector or sub Collector.
- Each division is again divided into tahsils (talukas), in charge of a Tahsildar.
- A tahsil usually comprises between **200 to 600** villages.
- Since the launching of the Community Development Programme in India in 1952, 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 a 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 panchayat, which are institutions of rural local self-government
- The urban areas of the district are organized into the following institutions of local self-government :
- 1. Town area committees - (in areas with population ranging between 5,000 and 10,000)
- 2.Municipal Boards - (in areas with population ranging between 10,000 and 2 lakhs)
- 3. Corporations - (with population above 2 lakhs)

The functions of Municipal Board are as follows:

1. Construction and maintenance of roads.
2. Sanitation and drainage.
3. Street lighting.
4. Water supply.
5. Maintenance of hospital and dispensaries.
6. Education.

7. Registration of birth and death etc.
8. The corporation is headed by Mayors, elected by councilors, who are elected from different wards of the city. The executive agency includes the commissioner, the secretary, the engineers and the health officer. The activities are similar to those of municipalities on a much wider scale.

Within each districts, there are 6 types of administrative area. They are:

1. Sub- division.
2. Tehsil (Taluks).
3. Community development blocks.
4. Municipalities and Corporation.
5. Villages and
6. Panchayats

Panchayat Raj:

The panchayat raj is a 3-tier structure of rural local self-government in India linking the village to the district. It includes:

1. Panchayat (at the village level)
2. Panchayat Samiti (at the block level)
3. Zila Parishad (at the district level)

Panchayat (at the village level):

The Panchayat Raj at the village level consists of

1. The Gram Sabha
2. The Gram Panchayat

The Gram Sabha:

It is the assembly of all the adults of the village, which meets at least twice a year. The gram sabha considers proposals for taxation, and elect members of the Gram Panchayat.

The Gram Panchayat:

It is the executive organ of the gram sabha and an agency for planning and development at the village level. The population covered varies from5000 to 15000 or more. The members of panchayat hold offices for a period of 3 to 4 years. Every panchayat has an elected president (Sarpanch or Sabhapati or Mukhia), a vice president and panchayat secretary. It covers the civic administration including sanitation and public health and work for the social and economic development of the village.

Panchayat Samiti (at the block level):

The block consists of about 100 villages and a population of about 80,000 to 1,20,000. The panchayat samiti consists of Sarpanch, MLAs, and MPs residing in block area, representative of women, SC, ST and cooperative societies. The primary function of The Panchayat Samiti is to execute the community development programme in the block. The Block development Officer and his staff give technical assistance and guidance in development work.

Zila Parishad (at the district level):

The Zila Parishad is the agency of rural local self government at the district level. The members of Zila parishad include all heads of panchayat samiti in the district, MPs, MLAs, representative of SC, ST and women and 2 persons of experience in administration, public life or rural development. Its functions and powers vary from state to state.

UNIT 2.

HEALTH CARE DELIVERY SYSTEM IN INDIA

Health Care Concept & Trends

Health Care concepts

- **Healthcare**
    - Organized services to maintain or improve health through prevention, diagnosis, treatment, and rehabilitation.
- **Primary, Secondary, and Tertiary Care**
    - **Primary:** First contact care (e.g., family doctor)
    - **Secondary:** Specialized care (e.g., dermatologist)
    - **Tertiary:** Advanced care (e.g., cancer treatment, surgeries)
- **Preventive vs. Curative Care**
    - **Preventive:** Immunizations, screenings
    - **Curative:** Medications, surgeries
- **Public vs. Private Healthcare**
    - **Public:** Government-funded, often free or subsidized
    - **Private:** Paid services, often faster or specialized
- **Universal Health Coverage (UHC)**
    - Ensuring all individuals have access to needed health services without financial hardship.
- **Health Promotion**
    - Empowering individuals to take control of their health through education, policy, and supportive environments.

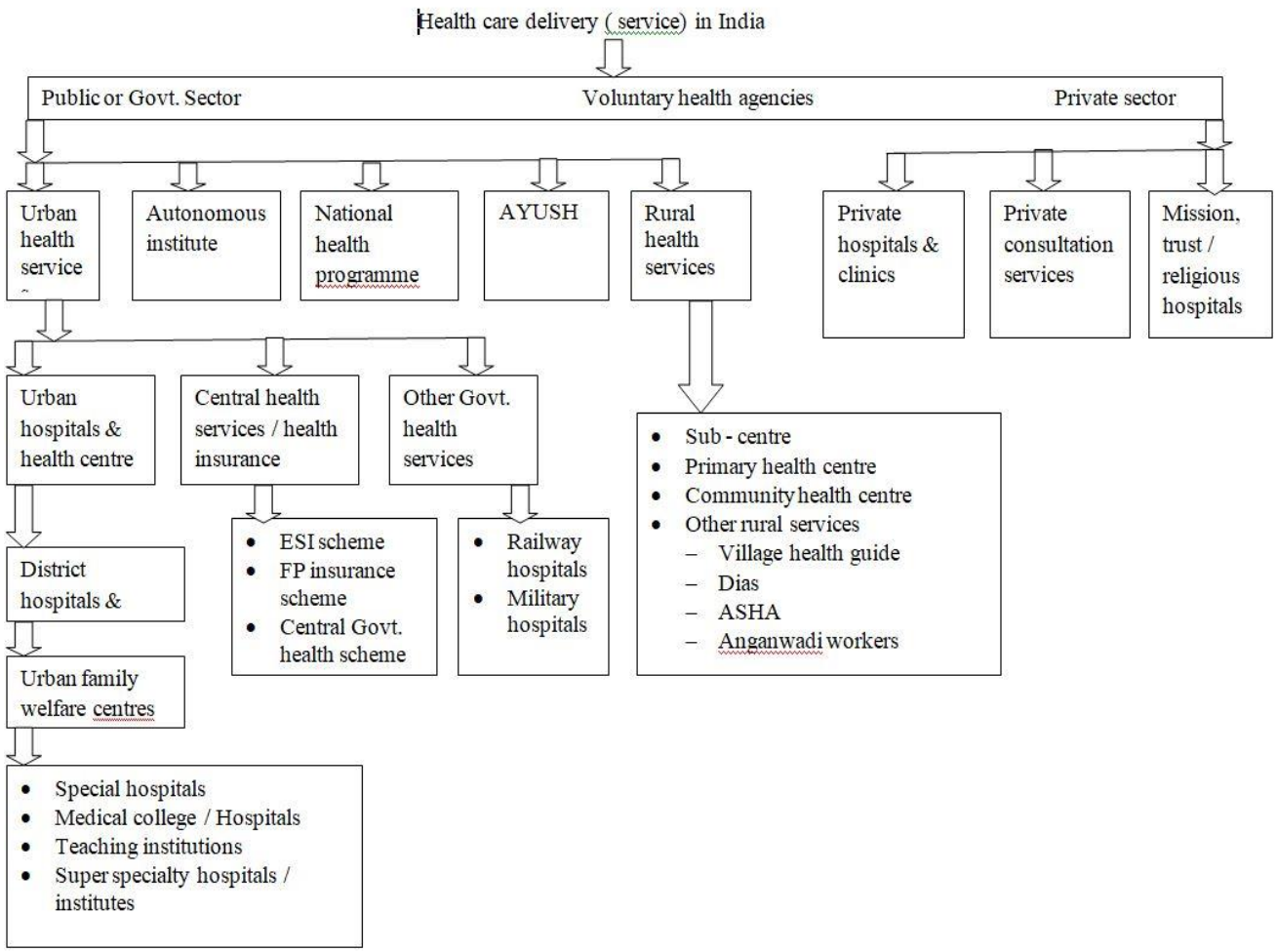
Current Healthcare Trends

- **Telemedicine & Digital Health**
    - Online consultations, remote monitoring, and mobile health apps.
- **Artificial Intelligence (AI) in Healthcare**
    - Used in diagnostics, treatment planning, patient monitoring, and predictive analytics.
- **Personalized/Precision Medicine**
    - Treatments tailored to the individual's genetic profile and lifestyle.
- **Value-Based Care**
    - Focus on patient outcomes rather than the volume of services provided.

- **Mental Health Awareness**
    - Growing focus on psychological well-being and integration of mental health services in primary care.
- **Wearable Technology**
    - Devices like smartwatches track vitals, encourage fitness, and monitor chronic diseases.
- **Aging Population & Geriatric Care**
    - Demand for elder care services, home healthcare, and chronic disease management is rising.
- **Sustainable & Green Healthcare**
    - Eco-friendly hospitals, reduced waste, and sustainable medical practices.
- **Health Equity & Social Determinants**
    - Emphasis on reducing disparities based on income, race, gender, or geography.
- **Pandemic Preparedness**
    - Focus on global cooperation, supply chain resilience, and infectious disease surveillance post-COVID-19.

Emerging Concepts

- **Smart Hospitals** – Integrating IoT (Internet of Things) for efficient patient care.
- **Holistic Care** – Addressing body, mind, and spirit.
- **Blockchain in Health Records** – Securing data and improving transparency.
- **Global Health Initiatives** – Cross-border collaboration to tackle health challenges (e.g., WHO, UNICEF programs).


Health care delivery (service) in India
Public or Govt. Sector
Voluntary health agencies
Private sector
Urban health service
Autonomous institute
National health programme
AYUSH
Rural health services
Private hospitals & clinics
Private consultation services
Mission, trust / religious hospitals
Urban hospitals & health centre
Central health services / health insurance
Other Govt. health services
District hospitals &
Urban family welfare centres
Special hospitals
Medical college / Hospitals
Teaching institutions
Super specialty hospitals / institutes
ESI scheme
FP insurance scheme
Central Govt. health scheme
Railway hospitals
Military hospitals
Sub - centre
Primary health centre
Community health centre
Other rural services
Village health guide
Dias
ASHA
Anganwadi workers

Level	Rural Area	Urban Area
Primary Level	Sub-Centres (SC), Primary Health Centres (PHC)	Urban Health Posts, Urban Primary Health Centres (UPHC)
Secondary Level	Community Health Centres (CHC)	Urban Community Health Centres (UCHC)
Tertiary Level	District Hospitals, Medical Colleges	Multi-specialty Hospitals, Medical Colleges

Health Care Services – Public Sector: Rural & Urban

Public sector healthcare refers to health services provided and funded by the government. It is structured to serve both **rural** and **urban** populations through a tiered system to ensure equitable access.

Public Healthcare Structure

Urban Public Healthcare Services

Features:

- Focus on **non-communicable diseases**, pollution-related illnesses, accidents, and population control.
- Higher population density demands greater infrastructure and services.

Key Institutions:

- **Urban Primary Health Centres (UPHC):** Focused on slum populations.
- **Urban Community Health Centres (UCHC):** Intermediate care services.
- **Municipal Hospitals & Tertiary Care:** Serve wider urban population with specialty services.

Challenges:

- Overcrowding in government hospitals.
- Inequity in services across slums and formal housing areas.
- Dual disease burden (communicable + lifestyle diseases).

URBAN HEALTH SERVICES

- Important means to provide health services to urban population are dispensaries and district hospitals. In order to reduce the pressure of patients in district hospitals and medical college hospitals, satellite hospitals are established in some places.
- There is a proposal to convert big dispensaries and hospitals working at the sub-divisional level into sub-divisional health centres.
- To convert district hospitals to district responsibility of community health.
- MOHFW is focusing on the health needs of urban people and for this, proposals of National Urban Health Mission (NUHM) are being examined.

Urban Family Welfare Centres

- Urban family welfare centres are functioning in urban areas from 1950 to provide family planning services for urban population.
- Urban family welfare centres will be gradually reorganised into health centres. Till April 1, 2007, 1083, urban family welfare centres were functioning.

Speciality Hospitals

- In these hospitals, only certain diseases, age groups or patients with specific problems are treated and specialists and specially trained nurses care for the patients.
- TB hospitals, children's hospitals, women's hospitals etc. come under this group.

Teaching Hospitals

- Hospitals associated with medical colleges come under this category.
- Along with teaching and training of doctors and nurses, these hospitals provide complete care to people of that area.
- At present there are 300 teaching hospitals/medical colleges in India (Till Dec. 2009).

Super Speciality Hospitals or Institutes

- Super speciality hospitals come under this group. In these hospitals super specialists of different system/organs or diseases are trained and patients are also treated.
- All India Institute of Medical Science (AIIMS) is an example of such institute. Actually these institutes are centre of excellence
- To enhance the super speciality and tertiary urban health services and to decrease the patient load on AIIMS Delhi, Govt. of India has a plan to open such 6 institutes in the various states.
- Selected places for proposed self-dependent AIIMS are;
- Jodhpur (Rajasthan)
- Bhopal (MP)
- Raipur (Chhatisgarh)
- Patna (Bihar)
- Bhuvaneshwar (Odisha) and
- Rishikesh (Uttaranchal).

These institutes will be established under **Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)**, PMSSY has two components, in its first phase

(i)Setting of 6 AIIMS like institutions and (ii) upgradation of 13 existing government medical college institutions.

- Out of 6 AIIMS like institutions, each institution will have a 960 bedded hospital. The distribution of beds are as following.

500 beds for medical college hospital

300 beds for speciality / super speciality

100 beds for ICU / accident trauma

30 beds for Physical medicine and rehabilitation

30 beds for AYUSH

Health Insurance Schemes

- ❖ The MOHFW has setup a task force to explore new health financing mechanisms.
- ❖ The ministry has advised to State/UT governments to prepare health insurance models as per their local needs.
- ❖ GOI will provide support to state governments for health insurance schemes / projects, under NRHM.
- ❖ The role of health insurance is much limited in India as compared to foreign countries.
- ❖ Privatization of insurance and the arrival of foreign insurance companies as a result of globalisation are expected to bring about lot of improvement in health insurance sector.

(i) **Employees State Insurance Scheme**

- Employees State Insurance Scheme (ESIS Scheme) was started in 1948 by an act passed in the parliament.
- This programme provides health care to industrial labour and their families. This gives safety at the time of delivery, diseases, accidents, etc. Similarly if a labour dies in accident, family pension is given.
- For this scheme, money is contributed by the management as well as employees.
- Previously the scheme was limited to those who were getting the salary below Rs. 10,000 per month. Now this limit has been raised up to workers, who are getting salary Rs. 15000 per month (1 May 2010).

ii)Family Planning Insurance Scheme

- Government of India has launched family planning insurance scheme from 29 11-2005 for acceptors of sterilization and indemnity insurance cover for doctors performing sterilization procedure both in govt. and accredited private / NGO / Corporate health facilities.

- MOHFW is also implementing a central sponsored Family Welfare Linked Health Insurance Scheme since 1981 to compensate the acceptors of the sterilization for the loss of wages for the day on which he/she attended the medical facility for undergoing sterilization.

iii)Central Government Health Scheme(CGHS)

- Central Government Health Scheme (CGHS) was started in 1954. Some facts regarding the scheme are given below:
- Objectives of the Scheme
- 1. To give extensive medical facilities to central govt. employees and their family members.
- 2. To save government from heavy expenses on medical refund
- **Beneficiaries of Scheme**
- In the beginning, scheme was only limited to central government employees and their family members. With the extended programmes, new beneficiaries are:
- 1. Central government employees and their family members
- 2. Members of parliament (present and former).
- 3. Judges of Supreme Court and High Courts (present and retired).
- 4. Freedom fighters.
- 5. Pensioners of central semi, autonomous units/employees of government,semi government organisations.
- 6. Journalists.
- 7. Governors and Ex-vice Presidents. Facilities under the Scheme

Facilities under the Scheme

- 1. Outdoor treatment facilities in all medical systems.
- 2. Emergency services in allopathy system.
- 3. Free medicines
- 4. Facilities for laboratory tests and radiological investigations.
- 5. Treatment facility for serious patients
- 6. Specialist consultation facilities.
- 7. Family welfare services.
- 8. Treatment facilities in government orgovernment recognised private hospitals where specialists are available.
- 9. Facility for 90% advance payment, incase of need.

Defense Medical Services

- For defense services, there are separate hospital and health service system which provides medical care to military personnel and their family members.
- Defense health services come under armed force medical services (AFMS).
- Defense health services come under armed force medical services (AFMS).
- They are responsible for providing all preventive, curative and pro motional health services.
- Defense services have their own medical college, nursing college and nursing schools.

Railway Medical Services

- Indian railways is a biggest government organization with highest number of rail way employees in the world.
- Railway provides wide range of health services to its employees through railway hospitals, clinics and health units.
- Similarly organizations like postal department, atomic energy department etc.
- Also provide limited health services to their employees. These services are usually linked to urban health services

Autonomous Institutes

- Under this category, all such institutions are included which receive central government aid but except few important matters, all other decisions are made by the institute itself.
- AIIMS Delhi, NIMHANS Bengaluru etc. are examples of such central sponsored autonomous health institutes.

Objectives of AIIMS

- To develop a pattern of teaching in undergraduate and postgraduate medical education in all its branches so as to demonstrate high standard of medical education to all medical colleges and other allied institutions in India.
- To bring together in one place educational facilities of the highest order for the training of the personnel in all important branches of the health activity.
- To attain self-sufficiency in postgraduate in medical education.

Functions of AIIMS

- Undergraduate and postgraduate teaching in medical and related physical biological sciences.
- Nursing and dental education
- Innovations in education.
- Producing medical teachers for the country.
- Research in medical and related sciences.
- Health care : preventive, promotive and curative; primary, secondary & tertiary.
- Community based teaching and research

National Health Programmes

- Government of India with the co-operation of state, other institutions, global agencies, is trying to face the challenges of communicable, non-communicable and other serious diseases.
- For the fulfilment of this purpose, the Central Government is conducting several national health programmes.
- This can be helpful in bringing down mortality and morbidity rates.
- Through these programmes, quality of life and health of our citizens also can be improved.
- In the health services of the country, national health programmes are very significant.

Reproductive, Maternal,Neonatal, Child and Adolescent health

- Janani Shishu Suraksha Karyakaram (JSSK)
- Janani Suraksha Yojana (JSY)
- Rashtriya Kishor Swasthya Karyakram(RKSK)
- Rashtriya Bal Swasthya Karyakram (RBSK)
- Universal Immunisation Programme
- Mission Indradhanush / Intensified Misson Indradhanush
- Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA)
- Navjaat Shishu Suraksha Karyakram (NSSK)
- National Programme for Family planning

National Nutritional Programmes

- National Iodine Deficiency Disorders Control Programme
- MAA (Mothers' Absolute Affection) Programme for Infant and Young Child Feeding
- National Programme for Prevention and Control of Fluorosis (NPPCF)
- National Iron Plus Initiative for Anaemia Control
- National Vitamin A prophylaxis Programe
- Integrated Child Development Services (ICDS)
- Mid-Day Meal Programme
- **Communicable diseases control programme**
- Integrated Disease Surveillance Programme (IDSP)
- Revised National Tuberculosis Control Programme (RNTCP)
- National Leprosy Eradication Programme (NLEP)
- National Vector Borne Disease Control Programme
- Programme for Prevention and Control of leptospirosis
- National AIDS Control Programme (NACP)
- Pulse Polio Programme
- National Viral Hepatitis Control Program
- National Rabies Control Programme
- National Programme on Containment of Anti-Microbial Resistance (AMR)
- **Non-communicable diseases**
- National Tobacco Control Programme(NTCP)
- National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS)
- National Programme for Control Treatment of Occupational Diseases
- National Programme for Prevention and Control of Deafness (NPPCD)
- National Mental Health Programme
- National Programme for Control of Blindness& Visual Impairment
- Pradhan Mantri National Dialysis Programme
- National Programme for the Health Care for the Elderly (NPHCE)
- National Programme for Prevention & Management of Burn Injuries (NPPMBI)

- National Oral Health programm
- **Health system strengthening programs**
- Ayushman Bharat Yojana
- Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)
- LaQshya' programme (Labour Room Quality Improvement Initiative)
- National Health Mission
- Ayushman Bharat Digital Mission (ADHM)

AYUSH – INDIGENOUS SYSTEM OF MEDICINE

INTRODUCTION:

- India has a population of 1.38 billion people and there is a high degree of socio-cultural, linguistic, and demographic heterogeneity.
- There is a limited number of health care professionals, especially doctors, per head of population.
- The National Rural Health Mission has decided to mainstream the Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy (AYUSH) system of indigenous medicine to help meet the challenge of this shortage of health care professionals and to strengthen the delivery system of the health care service.
- Multiple interventions have been implemented to ensure a systematic merger; however, the anticipated results have not been achieved as a result of multiple challenges and barriers.
- To ensure the accessibility and availability of health care services to all, policy-makers need to implement strategies to facilitate the mainstreaming of the **AYUSH** system and to support this system with stringent monitoring mechanisms.

AYUSH:

- The Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy system.
- In India, other than allopathic medicine, different forms of scientifically appropriate and acceptable systems of indigenous medicine, such as
    - The Ayurveda, Yoga, Naturopathy, Unani, Siddha, and Homeopathy **(AYUSH)** system, are practiced in different parts of the nation.

  The **National Rural Health Mission** has decided to mainstream the **AYUSH** system of indigenous medicine to help meet the challenge of the shortage of health care professionals and to strengthen the health care service delivery system

  Strategies for ensuring mainstreaming of the AYUSH system

- Mainstreaming of the AYUSH system is one of the key strategies under the National Rural Health Mission, under which it is envisaged that;
    - All primary health centers
    - Block primary health centers

    - And community health centers will provide AYUSH treatment facilities under the same roof.
- The staff required for the AYUSH system are arranged either by the relocation of AYUSH doctors from existing dispensaries or from contractual hiring; these staff are then trained in the primary health care and national health programs.
- In addition, other measures have been proposed and implemented with varying range of success, such as:
    - Mobilizing existing AYUSH establishments
    - Motivating AYUSH practitioners to spread awareness about their branch of medicine
    - Fostering partnerships with multiple stakeholders
    - Strengthening the existing infrastructure
    - Promoting cross-referral between different streams of medicine
    - Integrating AYUSH with different cadres of outreach workers such as accredited social health activists.
    - Strengthening quality control mechanisms to avoid both the manufacture and sale of counterfeit drugs
    - Streamlining the method of drug standardization to ascertain the potency of the drug
    - Building herbariums and crude drug museums
    - Directing state governments to decide which system of medicine should be set up in their respective states
    - Establishing higher centers in district hospitals and medical colleges, such as yoga centers
    - Promoting research work by exploring the local health traditions
    - Expanding the existing legal framework to supervise the manufacture and sale of Ayurveda, Siddha, Unani, and homoeopathic drugs
    - And making way for an administrative officer to facilitate the effective monitoring and supervision of different activities.
    - Implementing special initiatives for the development of AYUSH drugs (e.g., ensuring the ready availability of AYUSH drugs at all levels

. <u>Ayurveda</u>

- **Origin:** India, over 5,000 years ago
- **Core Concept:** Balance of 3 doshas – **Vata, Pitta, Kapha**
- **Focus:** Use of **herbs**, diet, lifestyle, panchakarma (detox), and natural therapies
- **Strengths:** Chronic diseases, digestive issues, wellness
- **Institutes:** National Institute of Ayurveda, Jaipur

2. <u>Yoga and Naturopathy</u>

Yoga:

- **Origin:** Ancient India

- **Components:** Asanas (postures), pranayama (breathing), meditation
- **Benefits:** Mental health, flexibility, stress reduction, lifestyle disorders

Naturopathy:

- **Belief:** Body has self-healing power
- **Therapies:** Diet therapy, hydrotherapy, mud therapy, fasting, sunlight, massage
- **Focus:** Detoxification and prevention

3. Unani Medicine

- **Origin:** Ancient Greece → Arab world → India
- **Concept:** Balance of 4 humors – blood, phlegm, yellow bile, black bile
- **Treatment:** Herbal medicines, cupping, diet, regimental therapy
- **Popular For:** Skin diseases, arthritis, reproductive health
- **Institutes:** National Institute of Unani Medicine, Bengaluru

4. Siddha Medicine

- **Origin:** Tamil Nadu, one of the oldest systems (southern India)
- **Concept:** Balance of 3 humors – **Vata, Pitta, Kapha** (similar to Ayurveda)
- **Special Features:** Use of **metals, minerals, and herbs** in medicine
- **Focus:** Longevity, rejuvenation, lifestyle-based treatment
- **Popular For:** Bone diseases, liver disorders, skin issues

5. Homeopathy

- **Origin:** Germany (Dr. Samuel Hahnemann, 18th century)
- **Principle:** "**Like cures like**" – a substance causing symptoms in large doses can cure them in small, potentized doses
- **Remedies:** Diluted substances (sugar pills, tinctures)
- **Strengths:** Allergies, chronic conditions, behavioral issues
- **Institutes:** National Institute of Homoeopathy, Kolkata

Rural Public Healthcare Services

Features:

- Focus on **primary and maternal-child health** services.
- First point of contact for rural people.
- Preventive and promotive care with limited curative facilities.

Key Institutions:

- **Sub-Centre (SC):** For every 5,000 population (3,000 in tribal/hilly areas). Staffed by ANMs and ASHAs.
- **Primary Health Centre (PHC):** For every 30,000 population. Staffed by medical officers and support staff.
- **Community Health Centre (CHC):** For every 1,20,000 people. Provides specialist services (OBG, medicine, surgery, pediatrics).

Challenges:

- Shortage of doctors and equipment.
- Accessibility issues due to geography.
- Low health literacy and awareness.

Other Rural Services

At village level:

At the village level, elementary services are rendered by (a) Village health guides (b) Local dais (c) Anganwadi workers and (d) Accredited Social Health Activist **(**ASHA)

Village Health Guide Scheme

Village health guides:

Village health guide is a person with an aptitude for social service and is not full time government functionary. Village health guides scheme was introduced on 2nd October, 1977.

Guidelines for their selection:

1. They should be permanent resident of the local community, preferably women.
2. They should be able to read and write, having minimum formal education at least up to the VI standard.
3. They should be acceptable to all sections of community.
4. They should be able to spare at least 2 to 3 hours every day for community health work. After selection the health guide undergo a short training in primary health care. The training is arranged in the nearest PHC, sub-center or other suitable place for the duration of 200 hours, spread over a period of 3 months. During the training period they receive a stipend of Rs.200 per month.

Functions of Village health guides:

1. Provide treatment for common minor ailments.
2. First aid during accidents and emergency.
1. Maternal and Child Health (MCH) care.
3. Family planning.
4. Health education.

Local dais:

Most deliveries in rural areas are handled by untrained dais. The training for dais is given for 30 working days. Each dais is paid stipend of Rs. 300 during the training period. The training is given at Primary Health Centre (PHC), sub-centers or Maternal and Child Health (MCH) care center for 2 days in a week and on the remaining four days of the week they accompany the health worker (female) to the village. During her training each dais is required to conduct at least 2 deliveries under the supervision and guidance of health worker (female), ANM, health assistant (female).

Functions of dais:

1. Maternal and Child Health (MCH) care
2. Family planning.
3. Immunization.
4. Education about health.
5. Referral services.
6. Safe water and basic sanitation.
7. Nutrition.

Anganwadi worker:

Under the ICDS scheme there is an anganwadi worker for a population of 1000.There are about100 such workers in each ICDS project. The anganwadi worker is selected from the community and she undergoes training in various aspect of health, nutrition and child development for 4 months. She is a part time worker and paid an honorarium of Rs.200-250per month for the services.

Functions of anganwadi worker:

1. Maternal and Child Health (MCH) care.
2. Family planning.
3. Immunization.
4. Education about health.
5. Referral services.

6. Safe water and basic sanitation.
7. Supplementary nutrition.
8. Non-formal education of children.

Accredited Social Health Activist (ASHA):

One of the key components of the National Rural Health Mission is to provide every village in the country with a trained female community health activist – 'ASHA' or Accredited Social Health Activist. Selected from the village itself and accountable to it, the ASHA will be trained to work as an interface between the community and the public health system. Following are the key components of ASHA.

SELECTION OF ASHA:

In general, the norm for appointing ASHA will be 'One ASHA per 1000 population'. But in tribal inhibited area, hilly area or the desert areas, the norm could be relaxed to one ASHA per habitation depends upon workload etc. The States is also responsible to work out the district and block-wise coverage/phasing for selection of ASHAs. It is envisaged that the selection and training process of ASHA will be given due attention by the concerned State to ensure that at least 40 percent of the ASHA in the State are selected and given induction training in the first year as per the norms given in the guidelines. Rest of the ASHAs can subsequently be selected and trained during second and third year.

Criteria for Selection:

1. ASHA must be primarily a woman resident of the village 'Married/Widow/Divorced' and preferably in the age group of 25 to 45 years.
2. ASHA should have effective communication skills, leadership qualities and be able to reach out to the community. She should be a literate woman with formal education up to Eighth Class.

Roles and responsibilities of ASHA:

1. Provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living.
2. She will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child.
3. ASHA will mobilize the community and facilitate them in accessing health and health related services available at the village/sub-center/primary health centers, such as Immunization, Ante

Natal Check-up (ANC), Post Natal Check-up (PNC), ICDS, sanitation and other services being provided by the government.

4. ASHA will provide primary medical care for minor ailments such as diarrhea, fevers, and first aid for minor injuries.
5. She will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy(ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits(DDK), Oral Pills & Condoms, etc. She will inform about the births and deaths in her village and any unusual health problems/disease outbreaks in the community to the Sub-Centers/Primary Health Centre.
6. She will promote construction of house hold toilets under Total Sanitation Campaign.

Voluntary Health Services (VHS)

Voluntary Health Services are non-profit, non-governmental organizations (NGOs) that offer healthcare and health-related services to the community, usually with the aim of promoting public health, awareness, prevention, and care.

- They work on a voluntary basis — supported by donations, grants, or charitable contributions, not government funding.
- VHS offers affordable medical care services to people belonging to poorer backgrounds and low income groups based on their health care needs rather than their ability to pay.

Types of Voluntary Health Organizations

Type	Example Activities
Service-Based	Clinics, hospitals, rehab centers
Educational	Campaigns on AIDS, nutrition, hygiene
Advocacy Groups	Promote health rights & patient welfare
Professional NGOs	Train nurses, health educators

Main Characteristics :

Feature	Description
Non-profit	Not focused on making money; all funds used for health work
Voluntary	Run by committed individuals or groups, often with volunteers(e.g. live love laugh foundation to combat the stigma surrounding mental illness)
Community-based	Serve the needs of specific populations or local areas
Supplement Government	Fill gaps where public health services are lacking
Focus on Education & Prevention	Health awareness, sanitation, family welfare

Roles & Functions of VHS:

- Health Education & Awareness
- Preventive Services
- Curative Services
- Rehabilitation
- Advocacy
- Training & Research

Benefits of Voluntary Health Services :

- Reach remote and poor populations
- Flexible and innovative approaches
- Cost-effective service delivery
- Bridge gaps in government health programs
- Build community trust and involvement

Challenges:

- Limited funding and resources
- Dependence on volunteers
- Need for proper training and regulation
- May lack infrastructure for large-scale service

Other Agencies in Healthcare

These include **non-governmental organizations (NGOs), international bodies, academic institutions, philanthropic organizations**, and **professional councils**.

1. Non-Governmental Organizations (NGOs) Role:

- Deliver services in underserved areas
- Create awareness and health education
- Run immunization, nutrition, maternal-child health, and HIV/AIDS programs

Examples:

- **Smile Foundation** – Mobile hospitals, child health
- **CARE India** – Maternal and child health
- **CRY (Child Rights and You)** – Child welfare, nutrition
- **Medicines Sans Frontiers (MSF)** – Emergency and disaster relief

International Agencies Role:

- Provide funding, technical support, and policy guidance
- Help during health emergencies and pandemics
- Support disease control, immunization, nutrition
- **Examples : WHO , UNICEF, UNDP, etc.**

3. Professional Councils & Regulatory Bodies Role:

- Regulate education, licensing, ethics, and practice standards of healthcare professionals

Examples : National medical commission(NMC), INC, Pharmacy council of India (PCI), etc.

4. Academic & Research Institutions Role:

- Conduct medical research
- Train healthcare professionals
- Innovate public health solutions

Examples: AIIMS, ICMR, NIH, etc.

5. Philanthropic & Corporate Agencies Role:

- Fund hospitals, research, and health outreach programs
- CSR (Corporate Social Responsibility) in health campaigns

Examples: Tata Trust, Reliance Foundation, etc.

Health Care Services –Private Sector

The **private sector** in healthcare includes all medical services provided by individuals, clinics, hospitals, and companies not owned or directly operated by the government. It is a key part of many

healthcare systems, especially in countries like India, where it plays a **dominant role in urban and peri-urban healthcare delivery**.

➢ **Features of Private Healthcare Sector**

- **Profit or non-profit based:** Includes both corporate hospitals and charitable institutions.
- **Wide range of services:** From basic consultation to highly specialized treatments
- **Better infrastructure & technology:** Often more modern equipment and faster service delivery.
- **Out-of-pocket payment:** Patients usually pay directly or through private insurance.
- **Market-driven model:** Quality varies widely based on affordability

Role of Private Sector in Healthcare

- **Bridges gap in service availability** – especially in urban and semi-urban areas.
- **Drives innovation** in medical technology and treatments.
- **Supports medical tourism** and advanced surgeries.
- **Reduces pressure on public hospitals** in times of high demand.
- **Provides job opportunities** for healthcare professionals

Public vs Private Sector – Comparison

Aspect	Public Sector	Private Sector
Ownership	Government-funded and managed	Individually or corporately owned
Cost	Free or subsidized	High, out-of-pocket or insured
Reach	Wider rural reach	Concentrated in urban/semi-urban areas
Quality	Variable, often resource-constrained	Often better infrastructure
Speed of Service	Slower due to high load	Faster, appointment-based
Accountability	Monitored by public health departments	Self-regulated or loosely monitored

Public Private Partnership (PPP) in Health Care

Public-Private Partnership (PPP) in healthcare is a collaborative arrangement between the **government (public sector)** and **private entities** to deliver healthcare services, infrastructure, or technology with shared responsibilities, risks, and rewards.

Goal:

To combine the **public sector's reach and equity** with the **private sector's efficiency and innovation**.

Key Areas Where PPP is Used

- **Diagnostic Services** – Radiology, pathology, lab services
- **Dialysis Units** – Run by private firms in public hospitals
- **Telemedicine** – Remote consultations in rural areas
- **Mobile Health Units** – Outreach in underserved areas
- **Hospital Infrastructure** – Construction and operation of hospitals
- **Ambulance Services** – e.g., 108 Emergency Services
- **Health Insurance Delivery** – Empanelled private hospitals under schemes like **PM-JAY**

Benefits of PPP in Healthcare

Benefit	Impact
Improved Infrastructure	Better-equipped hospitals and diagnostics
Efficiency & Innovation	Faster service delivery, tech-enabled healthcare
Reduced Burden on Public System	Shares workload and improves patient access
Capacity Building	Training and skill development of healthcare staff
Expanded Reach	Brings quality care to remote and underserved regions

Examples of PPP in Healthcare(India-focused)

Project	Details
108 Ambulance Services	Operated by private players under government support
Free Diagnostics (Andhra Pradesh)	PPP model for radiology/laboratory services in public hospitals
Dialysis Services (e.g., PPP with NephroPlus)	Free dialysis for poor patients in government hospitals
PM-JAY (Ayushman Bharat)	Empanelled private hospitals provide free treatment to eligible patients
Telemedicine in NE States	Partnerships for virtual consultations in remote areas

Nurse's Role in Healthcare Services

1. CARE GIVER

- As a care giver, the nurse helps client to regain health through healing process.
- Nurse addresses the holistic health care needs of the client.
- She helps the client & families to set goals & meets those goals.
- She preserves the dignity of the client.
- She accepts a client as a person, not merely as mechanical beings.

2. ETHICAL DECISION MAKER

- The nurse uses critical thinking skills throughout the nursing process to provide effective care.
- Nurse makes decision in collaboration with the client & the family. She also collaborates & consults with other health professionals

3. CLINICAL ADVOCATE

- She protects client's human & legal rights & provides assistance in asserting those rights if the need arises.
- She advocated the client by keeping in mind the client's religion & culture.
- Nurse defends the client's right in general way by speaking out against policies that might endanger their wellbeing.

4. PROTECTOR

- A nurse provides a safe conducive environment to the client.
- She takes steps to prevent injury to the clients.
- She protects the client from every possible adverse effects of treatment.
- She asks about any allergy to medicine or food.
- She provides immunization against disease.

5. MANAGER

- As a manager, nurse coordinates the activities of other health team members.
- She manages the nursing care of not only one client but also of families & in communities.
- She delegates the nursing activities to auxiliary workers & other nurses.

6. REHABILITATOR

- Rehabilitation is a process by which individuals return to maximal levels of functioning after illness, accidents or other health events.
- Nurse helps the clients to adapt as fully possible who experiences physical or emotional impairment that change their lives.

7. COMFORTOR

- The role of a comforter is a traditional & historical one in nursing & has continued to be important as a nurses have assumed new roles.
- As a comforter, nurse provides comforts to the client by considering him as an individual with unique feelings & needs.
- She motivates clients to reach therapeutic goals.
- She promotes comfort to the client by staying near the patient

8. COMMUNICATOR

- Nursing involves communication with clients & families, other nurses, health care team members, resource persons & the community
- As a communicator, nurse provides information to other team members about the palled & unplanned nursing care.
- She conveys information verbally at change of shift.
- She reports while shifting the client from one unit to the other.

9. TEACHER

- Teaching refers to the activities by which the teacher helps the learner to learn a teacher.
- She determines that the client has fully understood.
- She also evaluates client's progress in learning.
- She incorporates other resources such as family, in teaching plans.
- Nurse gives health education on diet, about preventive measures of disease.

10. LEADER

- As a leader, she influences the client to make decisions regarding health.
- Nursing leadership is defined as a mutual process of interpersonal influence through which nurse helps client in making decisions for establishing & achieving the goals to improve the clients wellbeing.

11. COUNSELLOR

- Nurse helps the client to recognize & cope with stressful, psychological or social problems. She assists the clients for developing good inter personal relationship.
- Nurse counsels primary healthy individuals with normal adjustment difficulties.
- Nurse helps the person to develop new attitudes, feeling & behaviours.

12. RESEARCHER

- Nurse investigates problems in order to improve nursing care & expand the scope of nursing practice.
- She does many qualitative & quantitative researches.
- Based upon these findings, they practice nursing care in hospital as well as in the community setting.