CHAPTER – III

HEALTH CARE SERVICE IN INDIA: AN OVERVIEW

3.1 Health Care Service in India

Healthcare in India is the responsibility of the state. It is realize that for ensuring economic growth of a country, health of its citizen must primarily be focused. Funding of health services may differ from country to country but focus is always laid down on providing optimum health services to the people.

Health Sector in India is tremendously booming since last few years. This sector is thus contributing a lot both in terms of revenue and employment of the Indian economy. Indian Healthcare system is thus ranked as 112 out of 191 countries by the World Health Organization reports. At present, the ambit of healthcare like the older times is not confined to only patient's treatment it embraces hospitals, medical equipments, health insurance, clinical trials, outsourcing, telemedicine, medical tourism, health insurance, and so on and thus health sector is making remarkable achievements from time to time.

In this chapter, an effort is made to throw light on the existing health care service system and its utilization in India. But, before going to the details, it is desirable to have a glimpse on its historical aspect.

3.2 Evolution of the Health Care System in India

The genesis of healthcare system in India can be traced back since long. It is evident from the excavations in the Indus valley (Mohenjo-Daro and Harappa) civilization that health occupies an important position since then. Planned cities with drainage, house and public bath built of bricks, sanitation by the ancient people are glaring instance of health consciousness. With the invasion of India by the Aryans around 1400BC there was a remarkable advancement in the healthcare system. The Aryan period had witnessed emergence of Ayurveda and Siddha system of medicine which developed the concept of health comprehensively. In the Post Vedic period, teaching of Jainism and Buddhism had also profoundly influenced healthcare service. Realizing the need and importance to make people aware of the health related issues, medical education was started to be provided at ancient universities like Nalanda and Takhsshila. Rahula, son of Buddha went a step further and developed the hospital system and its infrastructure which later on was expanded by the great king Asoka.

The next development in healthcare sector can be traced back in Moghul Empire period, when Unani system of medicine was introduced. During British Period modern medicine and healthcare system was upgraded. In this period efforts were made to provide healthcare training to the people.

This period also witnessed establishment of first hospital in British India in the year of 1664 at Fort St. George in Madras which was later on followed by the hospital in Bombay and Calcutta. During this period death rate also reached an alarming rate. Thus necessity of more organized medical establishment was realized. Result of it was Indian Medial Service (IMS), founded on 1st January 1764 which was initially known as Bengal Medical Service (Jaggi, 1979 xiv, 27).

At the time of Independence, Indian healthcare system was inherited from the healthcare system existed during British rule which was confined to only providing services to defence forces and colonial administration. The healthcare system was primarily urban based elite and curative oriented giving less emphasis on health care of general masses. The healthcare of rural people was neglected then but after independence it was realized that to ensure socioeconomic development of the country, health for all must be achieved. Thus after independence from time to time the government of India, has undertaken several measures to improve health status in India. In this regard, several provisions were enumerated in the constitution of India, several committees were also setup, and various provisions in this concern were also embedded if different five years plan. Let us have a brief discussion about these aspects

3.3 Healthcare and Constitution of India

Healthcare in India is the responsibility of constituent states and union territories. The constitution of India charges every state with "rising of the

level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". In the Constitution of India, the Right to Health though not explicitly included, but judiciary has widely interpreted the scope of right to health under article 21, (Right to Life) and has thus established right to health as an implied fundamental right. Not only article 21 but some other articles of fundamental rights can also be linked to right to health. For example article 23(1) prohibits traffics in human beings. Since trafficking of women leads to prostitution which in turn is the major factor in spreading AIDS. Similarly article 24 says that no child bellow the age of 14 years shall be employed to work in any factory or mine or engaged in any other hazardous employment. Thus it is directly related to child health.

Though most provisions related to health are incorporated in Part IV directive principles of State policy. Some of these are:

Article 38 says that the state will secure a social order for the promotion of welfare of the people. Providing affordable healthcare is one of the ways to promote welfare.

Article 39(e) calls the state to make sure that health and strength of workers, men and women, and the tender age of children are not abused.

Article 41 imposes duty on state to provide public assistance in case of unemployment, old age, sickness and disablement etc.

Article 42 makes provision to protect the health of infant and mother by maternity benefit.

Article 47 make it duty of the State to improve public health, securing of justice, human condition of works, extension of sickness, old age disablement and maternity benefits Further, State's duty includes prohibition on consumption of intoxicating drinking and drugs as these are injurious to health.

Article 48A ensures that State shall Endeavour to protect and impose the pollution free environment for good health.

3.4 Recommendations of Different Committees

Since independence several committees were setup by the government of India to provide advice on different health problems, to analyze the efficacy of different health related policies. Basing on the reports of these committees, health related provisions are enumerated in several five years plan.

Bhore Committee (1946): Bhore Committee, also familiar as Health Survey and Development Committee was appointed in the year 1943 under the chairmanship of Joseph Bhore. It laid emphasis on integration of curative and preventive medicine at all level. Some of the important recommendations of this committee were

i) No individual should to access fail adequate medical care because of financial crisis.

ii) The health programme must from the beginning lay special emphasis on preventive work.

iii) High nexus must exist between health services and general masses so that maximum benefits to the community can be served.

iv) Active cooperation of the people in the development of health programme must essentially be secured.

v) Three month training in preventive and social medicine must be provided to prepare social physician.

The report of Bhore Committee had provided comprehensive guidelines for remodeling of health services in India.

Mudaliar Committee (1962)

The Mudaliar Committee was appointed under the chairmanship of Dr. A L Mudaliar to assess the effectiveness and performance in health sector since the submission of Bhore Committee reports. This committee has found that quality of services provided by the primary health centre are inadequate and suggested for strengthening of existing primary health centre. The primary recommendations of Mudaliar Committee were

i) Equipping district hospitals with specialized services.

ii) To set up regional structure between the state and district headquarters.

iii) Each primary health centres should not cater the need of more than 40,000 people.

iv) Curative, preventive and promotive services should be provided at all PHC's.

v) Quality of healthcare services provided in primary health centres must be improved.

vi) Medical and health services must be integrated so that recommendations suggested by Bhore Committee can be achieved.

vii) All India health services must be created on the pattern of Indian administrative service so that erstwhile Indian Medical Service can be replaced.

Chadha Committee (1963)

This committee was established under the chairmanship Dr. M.S. Chadha to advice about the necessary arrangements for the maintenance phase of the National Malaria Eradication Programme (NMEP). Some important recommendations of the committees were

i) Vigilance operation in the NMEP should be carried out by basic health worker for i.e. workers of primary health centres at block level.

ii) This basic health worker should carry out the vigilance operation 10,000 populations per each.

iii) The basic health workers would perform he functions as multipurpose workers. Thus in addition to Malaria vigilance, duties of collection of vital statistics data and family planning were also entrusted on it. Family planning health assistance would supervise 3-5 basic health workers.

iv) At district level duties of general health services must also be performed by basic health purpose.

Mukharjee Committee (1965)

Mukharjee Committee was created under the chairmanship of Mukharjee to review the recommendations of Chada Committee. It was realized that performance of multipurpose function by basic health workers was impracticable. Thus this committee had suggested the following measures,

i) Separate stuffs for the family planning programme should be provided. Family planning assistance was to look after the family planning work exclusively.

ii) The basic health workers were to be utilized for purposes other than family planning.

iii) The Malaria Eradication Activity should be delinked from family planning, so that concentration can be provided on family planning programme.

Jungalwalla Committee (1967)

This committee also familiar as "Committee on Integration of health services" was established under the chairmanship of Dr. N. Jungalwalla. This committee had looked into various problems associated with integration of health services. After scrutinizing the problems, it was suggested that the following steps to be complied with to ensure integration of health services.

i) Special pay for specialized work.

ii) Common seniority.

iii) Recognition of extra qualification.

iv) Equal pay for equal work.

v) Unified cadre.

vi) Abolition of private practice by government doctors.

vii) Improvement in their service conditions.

But this committee did not mention about the step to be taken to ensure the integration recommended by it.

Kartar Singh Committee (1973)

This committee also familiar as "the committee on multipurpose worker under health and family planning" was constituted to provide a frame

work for integration of health and medical services at peripheral and supervisory level. The main recommendation of this committee were

i) Various categories of peripheral worker should be amalgamated into a single cadre of multipurpose worker.

ii) One primary health centre should be established to cover a population of 50,000 each the PHC should again be divided into 16 sub centre.

Srivastav Committee (1974)

Srivastav Committee, also known as "group on medical education and support manpower" was established to determine the steps needed to reorient medical education in accordance with the need and priorities of the nation and develop a curriculum form health assistance that were to work as a link between medical officers and MPWs. This committee has recommended immediate actions for

i) Creating bond of para professional and semiprofessional health workers from within the community itself so that simple protective, preventive and curative services needed by the community care efficiently is provided.

ii) Pre cadres of health worker must be established.

iii) Developments of Referral Services Complex.

iv) A medical and health education commission must be established so that planning and implanting reforms needed in health and medical education on the line of University Grant Commission can be provided.

Acceptance of the recommendations of this committee led to the launching of the rural health service.

Bajaj Committee (1986)

Bajaj Committee also known as an "expert committee for Health Man power, planning, production and management" was constituted under the chairmanship of Dr. J S Bajaj. Major recommendations of this committee were

i) Formulation of national medical and health education policy

ii) Formulation of national health man power policy

iii) Establishment of an educational commission for health sciences on the lines of UGC.

iv) Establishment of health science universities in various states and union territories.

v) Establishment of health manpower cell at central and states.

vi) Vocationalization of education regarding health related field for which appropriate incentives should be provided so that good quality of paramedical personal may be adequately available.

vii) Carrying out a realistic health manpower survey.

3.5 Health Services in India through Five Years Plans

In India the era of scientific planning in health services started with the establishment of planning commission in 1950. Planning in health sectors is of utmost importance. It provides for the economic utilization of manpower, material and financial resource. The main purpose of planning in health sectors must be to provide for health services at all levels, identify health needs of all people and set goals basing on priority.

Through Five Years plans, government has made efforts to coordinate planning with the state, sponsored major health programs and made provisions for effective implementation of various health related policies.

The health related issues covered by different Five Years Plans are briefly discussed below:

3.5 a) First Five Year Plan (1951-56)

At the time of First Five Year Plan, several impediments were existed on the way of development e.g. limited financial resources available in the country, lack of hygienic environment , low resistance due to poor nutrition, unsafe water supply, lack of medical care and so on. Under the guidance of WHO, the Indian government addressed that child health, reduced infant mortality were indirect contributors of population growth. However during this period the need for imparting training facilities to all types of health personnel were recognized.

The ratio of health care personnel and number of personnel trained during the period of First Five Year Plan are tabulated below:

Table 2.1: Ratio of Health care Personnel during First Five Year Plan

Sl. No.	Health Care Personnel	Population
1	Doctor	1 : 6300
2	Nurse	1: 43000
3	Health Visitor	1: 40,00,000
4	Midwife	1: 60000
5	Dentist	1: 3,00,000
6	Pharmacist	1: 40,00,000

Number of personnel trained during First Five Year Plan under medical schemes:

Table 2.2: Number of Personnel Trained during First Five Year Plan

Health Personnel	1950-51	1955-56
Doctors	2504	2782
Compounders	894	1621
Nurses	2121	3000
Midwives	1407	1932
Vaids and Hakims	914	1117

The above table depicts the number of personnel imparted with training annually during the execution of First Five Year Plan.

b) Second Five Year Plan (1956-1961)

The Second Five Year Plan attempts at expanding existing healthcare services so that all sections of people can enjoy its benefits. With this purpose it provides for establishment of institutional facilities, control

widely prevalent communicable diseases in the community, running family planning and other supporting programme to raise the standard of health.

c) Third Five Year Plan (1961-1966)

Third Five Year Plan concentrates on expanding health services to bring about progressive improvement in the health of the people. To achieve this objectives various programs were formulated for control of communicable diseases, organization of institutional facilities for providing health services, environmental hygiene, making provisions for maternal and child welfare, health education and nutrition.

d) Fourth Five Year Plan (1969-1974)

During Fourth Five Year Plan, emphasis were laid down on i) Controlling and Eradicating Communicable diseases ii) To provide for curative and preventive healthcare services in rural areas through the establishment of primary healthcare iii) To provide for training programmes of medical and para-medical personnel. During the periods specified above primary health centres were strengthened.

e) Fifth Five year Plan (1974-1979)

During this Five Year Plans efforts were made to integrate health facilities with family planning and nutrition programme for vulnerable groups like children, pregnant women, lactating mothers. Here minimum needs program was provided highest priority. One primary health centre was

required to be provided for each community development block. A sub centre must be able to cater the needs of 10,000 populations etc.

f) Sixth Five Year Plan (1980-1985)

During 6th Five Year Plan in addition to strengthening the existing health related activities, provisions were made for construction of new buildings for rural family planning centres, new sub centres, urban family planning centres at different levels. Incomplete task of 5th Five Year Plan were taken to be accelerated over the successive plan period.

g) Seventh Five Year Plan (1985-1990)

The primary emphasis of 7th Five Year Plans were

i) Improvement in the quality of services rendered for minimum needs programme.

ii) Effective coordination in the health related programmes.

iii) Community participation would be given much priority.

iv) Comprehensive coverage of urban health services, school health services and mental and dental health services.

v) Strict adherence to the norms for sharing the cost of the programmes by state government for control and eradication of communicable diseases.

vi) Medical research

India was the first country in the world having a government level family planning programme.

h) Eight Five Year Plan (1992-1997)

During Eight Five Year Plan, concentration was made to develop man power in terms of national needs.

i) Draft of a national policy on education in health sciences would form the basis of new initiatives in manpower development.

ii) The existing situation in terms of manpower was felt need to be reviewed in the light of national policy on education in health sciences.

iii) Appropriate steps must be adopted to bridge the gap between the supply and demand of paramedical services.

Thus Eight's Five Year Plan advocated for expanding educational facilities to those areas of healthcare providers which was lagging behind the district level.

i) **Ninth Five Year Plan (1997-2002)**

Ninth Five Year Plan aimed at exploring the health status of the masses by optimizing coverage and quality of healthcare. By identifying and rectifying the critical gaps in infrastructure, manpower, equipment essential diagnostic and drugs. Thus it approached towards

i) Enhancing the quality of primary healthcare in urban and rural areas

ii) Improving efficiency of existing healthcare infrastructure.

iii) Increasing involvement of voluntary and private organization in the provisions of healthcare.

iv) Enabling the Panchyat Raj institutions in planning and monitoring existing health program at local level

j) Tenth Five Year Plan (2002-2007)

In the Tenth Five Year Plan various provisions were enumerated for the development of the nation. Some of the provisions of this plan, pertaining matter of health had included Infant mortality rate, maternal mortality rate, clinging of all major polluted rivers to make easy asses to drinking water and so on.

k) Eleventh Five Year Plan (2007-2012)

Health constitutes a matter of concern in all five year plans. Eleventh Five Year Plan provides for

i) Reducing infant mortality rate to 28 and maternal mortality rate to 21 per 1000 live births.

ii) Reducing total fertility rate to 2.1

iii) Providing pure and clean drinking water for all

iv) Reducing malnutrition among children of age group 0-3 years.

v) Reducing anemia among female by 50% by the end of the plan.

L) Twelve Five Year Plan (2012-2017)

The Twelve Five Year Plan concentrates on millennium development goal. During this five year plan high level expert group was appointed for universal health coverage by 2020-2022 its vision is to

i) Universal health entitlement every citizen

ii) To guarantee access to an essential health package (including cashless in-patients and out patients care provided free of cost).

iii) People will be provided with the option to choose the public sectors facilities and contracted in private providers.

iv) Under this plan recommendations are made

a) To develop a national health package.

b) Reorient healthcare provisions to focus significantly on primary healthcare.

c) Strengthen districts hospital

d) Ensure equitable asses to health facilities in urban areas.

This recommendation generally provides equitable distribution of human resources and to provide for more new jobs. There by contributing in eliminating the problem of unemployment.

3.6 Organizational Setup of Health System in India

India is a union of 28 states and seven union territories. The government vision is to ensure "Health for All". Thus issues pertaining to health are matter of concern for each wing of government. The role performed by each set of government is briefly discussed as below:

Role of Central Government: In the matter of health central government responsibility consists of primarily policy making, planning, guiding, assisting, evaluating and coordinating, the work of the states.

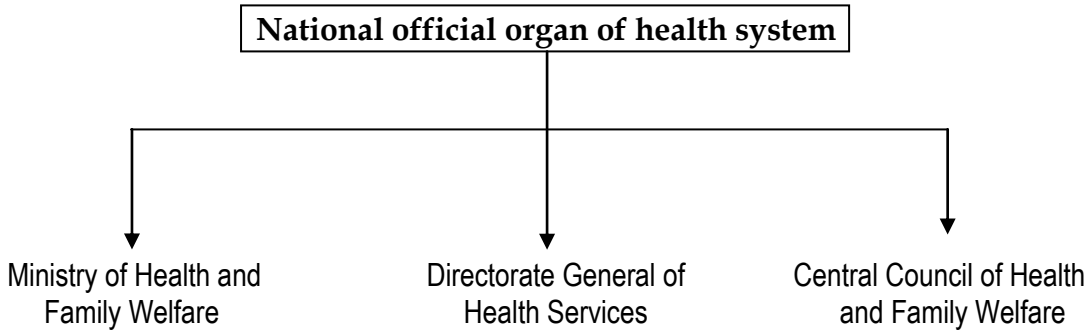


Diagram: Central level organizational structure

3.7 National Official Organ of Health System

The department of Family welfare has been established in the year 1966, headed by Secretary of the Government of India. It covers mainly medical care and hospital, public health and general administration. It is entrusted with the responsibility to consider and recommend board outline and policy in the matter pertaining to health. It can also make proposes for making new legislation in the fields of health related issues. It can also recommend central government on matters related to health. It can also

establish an organization and entrust it with appropriate functions to improve health condition.

3.8 State Level Health Care

In state level health administration can be traced back in the year 1919. After independence, in matters concerning health, every state is empowered to a large extent. Each state has developed its own system of healthcare independent of the central government. The State list emphasizes on provisional medical care, preventive health care, health care service.

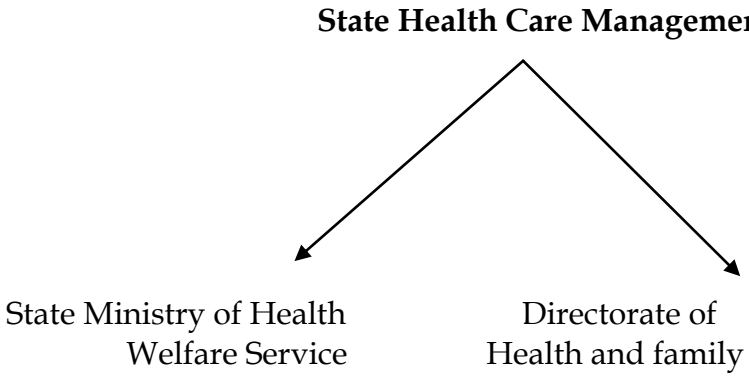
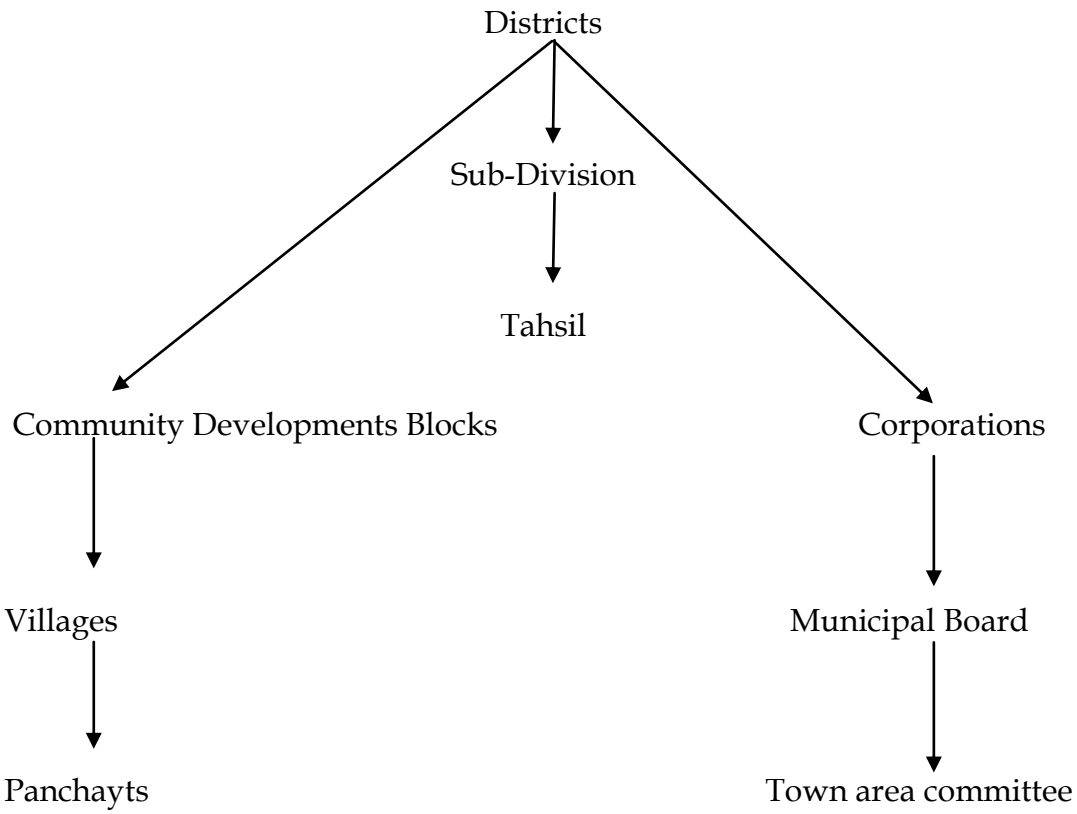


Fig: National official organ of health system

i) **State Ministry of Health and Family Welfare:** It is headed by cabinet minister and deputy minister and entrusted with the function of formulating policies and programmes and ensure about the implementation of this policies and programme.

ii) **Directorate of Health and Family Welfare Service:** Its function is to advise the matters related to health issues.

iii) **District Level Health Care Service:** The main task of it is to identify the health related issues and provide service thereto. Every districts has six type of administrative areas which are mentioned bellow



Source: *http://en.m.wikipedia.org*

Its main duty is to identify the health related issues and provide service there too.

3.9 District Level Healthcare Delivery System in India

At district healthcare delivery system, level Chief Medical and Health Officer (CM & HO) or District Medical and Health Officer (DM & HO) are entitled to exercise overall control in matters pertaining to health and

family welfare programmes in the districts. Health care programmes in districts are linked between the state and regional structure at one end and peripheral level structures such as PHC or Sub Centers on the other.

3.10 Block Level Healthcare Delivery System in India:

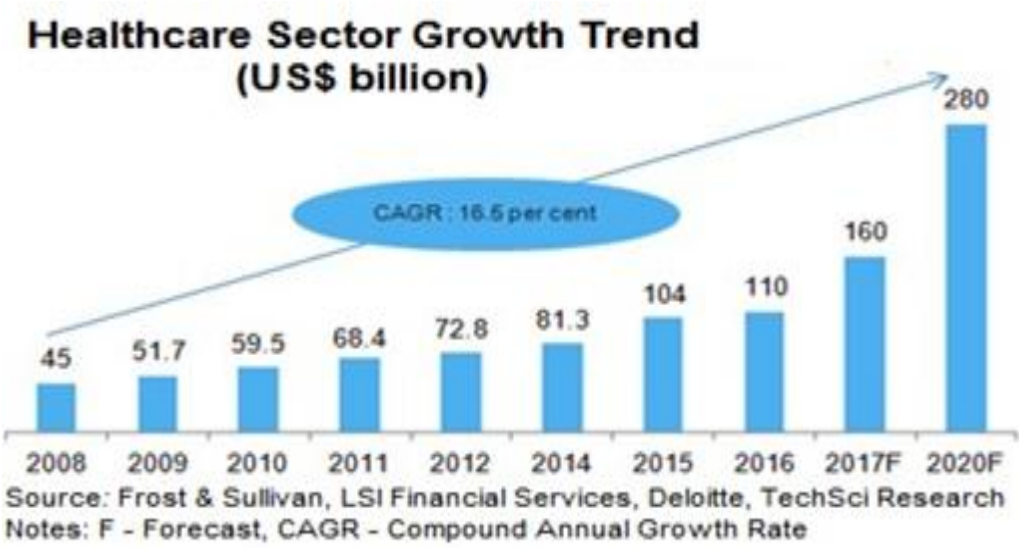
Community Health Centers: In block level, generally one community health centre are staffed by group of general practitioners and nurses who are entrusted with the duty to provide healthcare services to people in a certain area. Earlier the services provided by it was generally confined to family practice and dental care, but now a day's these centres have expanded the ambit of their functions and comprises internal medicine, women's care, family planning, pharmacy, optometry, lab, and so on.

3.11 Present Growth in Healthcare Industry in India

India has achieved a remarkable position in terms of healthcare industry during these decades. This sector has contributed significantly in employment and revenue generation for India. During 2008-2020, the market is expected to record a CAGR of 16.5 per cent. The total industry size is expected to touch US$ 160 billion by 2017 and US$ 280 billion by 2020. Though the healthcare industry is categorized into two types viz public and private but it is seen that private sector has gained much importance in this realm and brought reputation for the country both nationally and internationally. It accounts for almost 74 per cent of the country's total healthcare expenditure. The government of India aims to

develop India as a global healthcare hub. The growth trend of healthcare sector can be understood from the diagram given below:

Fig. 1.1



From the above diagram it can be understood that healthcare sector is making promising growth with each passing year. But this sector is also not free from road blocks. Some of this is enlisted bellow

Though the vision is "Health for All", but the rural people are at quite disadvantageous position than that of urban ones. There is a wide gap between these two classes. In urban areas numbers of private hospitals, clinics providing quality healthcare can be traced while in rural areas due to non-availability of these, population thereto largely depends on alternative medicine and programmes of rural health clinic organized by the government.

Word Bank and National Commission's report on macroeconomics highlights that only 5% of India's total populations are covered by health insurance policies. Apart from rural-urban divide, high expenditure, which constitutes about 70%, is another landscape in India's healthcare system. In India the scope of payment arrangement is very low which make bound people to pay for their hospital visits and doctors' appointments with cash which results in nascent health insurance market centers around only urban middle and high income group of people.

Basic health related issues like HIV, Malaria Tuberculosis, and Diarrhea etc. are need to be solved at earliest. The government should emphasis the importance of providing basic health concerns to its people. In India children fewer than 5 are born underweight and approximately 7% of them die before their 5th birthday. Quality sanitation is also access to few on primary healthcare government contribute only 30% of the country's total healthcare budget.

The total plan expenditure incurred by the government for public health for the years 2007-08 to 2010-11 is as follows:

Table 3.1: Total Plan Expenditure Incurred by the Government for Public Health

Year	Allocation (Rs. in Crores)	Expenditure (Rs. in Crores)
2007-08	15291	12947.47
2008-09	16543	15130.08
2009-10	19534	17636.49
2010-11 (upto 28.02.2011)	22300	17589.84
2011-12	26760	NA

Source:http://www.medindia.net/health_statistics/general/budgetallocation.asp

This problem can be resolved by scandalizing diagnosis procedures, building rural clinics and developing streamlined health IT system and improving efficiency. Medical institutions like Apollo, AIIMS, have adopted telemedicine services and thus enter into public private partnership.

As per Indian Brand Equity Foundation India is the third largest exporter of pharmaceutical products around 80% of the market is composed of generic low cost drugs. The rising population, growing income of middle class and development of primary healthcare facilities are expected to mould the pharmaceutical industry. Government also has provided green signal in direct foreign investment in this area which shapes the growth of Indian pharmaceutical markets.

3.12 Government Various Healths' Related Policies

Policy is a system which provide logical framework of decision for making further achievement of intended objectives. Health policy of a nation is a strategy for controlling and optimizing the social uses of its health knowledge and health resources. For time to time government has introduced various health related Yojanas to promote healthcare service in the country.

Government Initiatives

From time to time the government has undertaken major initiatives to promote Indian healthcare industry. Some of these are cited below:

- The government has announced that 3000 Jan Aushadhi Stores (JAS) will be opened across the country by the end of March 2017 across the country under Pradhan Mantri Jan Aushadhi Yojana.
- The Ministry of Science & Technology has launched the innovative and indigenously developed fecal incontinence management system 'Qora'.
- The Union Cabinet has approved signing of an agreement with the World Health Organization (WHO) under which WHO will take effort to develop technical documents on traditional medicines which is expected to lead to better acceptance of Indian systems of medicines at an international level.
- The NITI Aayog (National Institute for Transforming India) aims to bring reforms in India's public health care system like outsourcing primary healthcare to private doctors and promoting competition between government and private hospitals at the secondary level.

3.13 Healthcare Provisions Made in the Union Budget 2016-17

- National Dialysis Services Programme to be initiated to provide dialysis services in all district hospitals to accommodate the increasing demand for dialysis session in various hospitals.
- Establishing 3,000 medical stores across the country to provide quality medicines at affordable prices.
- Under the new scheme, Senior citizens will get additional healthcare cover of Rs. 30,000.

- 3000 generic drug stores to be opened under Pradhan Mantri Jan Aushadhi Yojana to be strengthened.
- 'Sehat', initiative for healthcare (Social Endeavour for Health and Telemedicine) introduced by the government to run Common Service Centre (CSC). It empowers rural citizen by providing access to information, skills, knowledge, and other, different sectors through the intervention of digital technologies and fulfilling the vision of a 'Digital India'.
- The Government of India has launched the National Deworming initiative which aimed to protect more than 24 crore children between the ages of 1-19 years from intestinal worms.
- The government would provide all citizens with free drugs and diagnostic treatment under the National Health Assurance Mission,.
- Mission Indradhanush was launched introducing to immunize children against several diseases namely cough, tetanus, diphtheria, whooping, polio, tuberculosis, measles and hepatitis B by 2020.
- The E-health initiative, a part of digital India aims to provide effective and economical healthcare services in all citizens. This programme aims to make use of technology to facilitate people to maintain health records and books.

Government of India has launched National Rural Health Mission (NRHM) programme on 12th April 2005, to provide accessible, affordable and

quality health care to the rural population. In the year 2013, the Union Cabinet has introduced National Urban Health Mission (NUHM) which will work along with National Rural Health Mission. Under NRHM some states were given special focus namely North Eastern States, Jammu and Kashmir and Himachal Pradesh. The mission focuses on establishing on fully functional decentralized health delivery system which will provide health services to all level and to ensure simultaneous action on a wide range of determinants of health like water, sanitation, education, nutrition, social and gender equality. Some of the major initiatives under National Health Mission (NHM) are enlisted as below:

a) **Accredited Social Health Activists:** To establish a link between general masses and health system Accredited Social Health Activists (ASHAs) have been engaged. ASHA is the first reachable port of call for the community in case of any need regarding health related demand. ASHA now a day is performing commendable job to restore people faith back to public health system and has increased the utilization of outpatient services, diagnostic facilities, institutional deliveries and inpatient care.

b) **The Rogi Kalyan Samiti (Patient Welfare Committee):** This is a Management committee of a hospital whose primary function is to manage the affair of the hospital. These committees generally receive financial assistance from UnitedGrants to undertake activities for patient welfare.

Untied Grants to Sub-Centers are generally used to fund grass-root improvements in health care. Some examples include:

1. Midwives and Nurses must be imparted training from time to time so that better antenatal care and other health care services can be provided

2. United Grants must also extend to Village Health Sanitation and Nutrition Committees (VHSNC) so that the needs of poor households and children can be properly addressed and meted out.

3. Need to train the Doctors and Nurses from time to so that their skill can be enhanced. Training should also be imparted to auxiliary workers such as ANMs.

c) **Janani Suraksha Yojana (JSY):** aims to reduce maternal mortality among pregnant women by encouraging them to deliver in government health institutes. Under the scheme cash assistance is provided to eligible pregnant women for giving birth of a child in a government hospital. This scheme has brought remarkable changes in the mindset of people and large scale of pregnant ladies started to give birth of their child in government hospitals.

d) **National Mobile Medical Units (NMMUs):** National Mobile Medical Units aims to provide outreach services in rural and remote areas. It comprises two or three vehicles varying state wise one with medical and paramedical personnel another for carrying equipment and basic laboratory facilities and another for diagnostic equipment

such as X ray, ultrasound ECG machine and generator. Many un-served areas have been covered through National Mobile Medical Units (NMMUs). (Operational Guideline for mobile medical unit).

e) **Free Drugs and Free Diagnostic Service:** A new initiative is launched under the National Health Mission to provide Free Drugs Service and Free Diagnostic Service with a motive to lower the out of pocket expenditure on health.

f) **National Ambulance Services:** Free ambulance services are now provided in every nook and corner of the country connected with a toll free number which is supposed to reach within 30 minutes of the call.

g) **Janani Shishu Suraksha Karyakarm (JSSK):** This health related project was introduced to provide free transport, free drugs, free diagnostic, free blood, and free diet to pregnant women who come for delivery in public health institutions and sick infants up to one year.

h) **Rashtriya Bal Swasthya Karyakram (RBSK):** A Child Health Screening and Early intervention Services has been launched in February 2013 to screen diseases specific to childhood, developmental delays, disabilities, birth defects and deficiencies. The initiative will cover about 27 crore children between 0–18 years of

age and also provide free treatment including surgery for health problems diagnosed under this initiative.

i) **Mother and Child Health Wings (MCH Wings):** With a focus to reduce maternal and child mortality, dedicated Mother and Child Health Wings with 100/50/30 bed capacity have been sanctioned in high case load district hospitals with huge number of patients and CHCs which would create additional beds for mothers and children.

j) **District Hospital and Knowledge Center (DHKC):** As a new initiative District Hospitals are being strengthened to provide Multi-specialty health care including dialysis care, intensive cardiac care, cancer treatment, mental illness, emergency medical and trauma care etc. These hospitals would act as the knowledge support for clinical care in facilities below it through a tele-medicine center located in the district headquarters and also developed as centers for training of para-medician and nurses.

k) **National Iron+ Initiative:** The National Iron+ Initiative is an attempt to look at Iron Deficiency Anemia in which beneficiaries will receive iron and folic acid supplementation irrespective of their Iron/Hb status. This initiative will bring together existing programmes (IFA supplementation for: pregnant and lactating women and; children in the age group of 6–60 months) and introduce new age groups.

l) **Tribal TB Eradication Project:** The various health programme launched by the government has influential effect in the life of its people on 20th January 2017. These policies and programmes are generally aimed to ease the sufferings of people in health related issues and made utmost effort to make the benefits of these polices and programme available to all so that the Government vision "Health for All", can be achieved.