National Health Mission

an overview

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Key conceptual premises underlying NRHM

Context

- Low public health expenditure on health, rising costs of private health care.
- Low fund absorption and poor efficiency in use of funds by the public health system.
- Infrastructure largely conforms to population norms but access, coverage and quality unsatisfactory.
- Fragmented vertical programmes
- Crisis in human resources
- Failure to involve communities and local government, to address social and environmental determinants of health care and poor inter-sectoral coordination
- Lack of access to community based health care; delays in care seeking

Response

- Increase public health expenditure: state and central share; flexible funding pools
- Institutional structures for improved governance and management – State and district societies, Facility and village committees
- Institute Indian Public Health Standards: Ensure Minimum package and quality of health services.
- Integrate vertical programs through robust health systems
- Address HR gaps: Multitasking, second ANM, contractual appointments, walk in interviews, incentives, including AYUSH practitioners
- Strengthen care seeking, facilitate behaviour change, Create decentralised health systems: empowering District health societies and financing district health plans
- Provide level care through ASHA, strengthened outreach; VHSNC/MAS

Key Objectives

Main objective is to support the States/UTs towards the provision of universal access to Equitable, Affordable and Quality healthcare services, accountable and responsive to people's needs, with effective inter-sectoral convergent action to address the wider social determinants of health.

To provide technical and financial support to States to strengthen health systems

To bring sharper focus on high focus States and rural population, particularly marginalized and vulnerable population

Architectural correction through integration of vertical programmes, decentralization and communitization

NHM Objectives and goals are aligned with National Health Policy (NHM) and Sustainable Development Goals (SDG)

NRHM PARADIGM – 5 MAIN APPROACHES

COMMUNITIZE

1. Decentralized planning,

District, Block and Village Level

2.Hospital Management Committee/ PRIs at all levels.

3. ASHA &village health committees

4. Untied grants to Village committees.

5. Increased NGO participation

6. Community Monitoring

IMPROVED MANAGEMENT THROUGH CAPACITY

1. Block & District Health
Office with management skills

2. NGOs in capacity building

3. Strengthening SIHFW/NIHFW

4.NHSRC / SHSRC / DRG / BRG

5.Continuous skill development Support

FLEXIBLE FINANCING

1. Untied grants to institutions/RKS

2. Easy Approval of new components

3.Sanctions made on basis
of centre and state plans

4.Demand side financing– money follows patient

5. More resources for more reforms

INNOVATION IN HUMAN RESOURCE MANAGEMENT

1. More Nurses at all levels– local Resident criteria

2. Multi-skilling male paramedicals and rationalisation of workforce.

3.Full utilisation of AYUSH potential

4. Creating specialists skill sets

MONITOR, PROGRESS AGAINST STANDARDS

1. Setting IPHS Standards

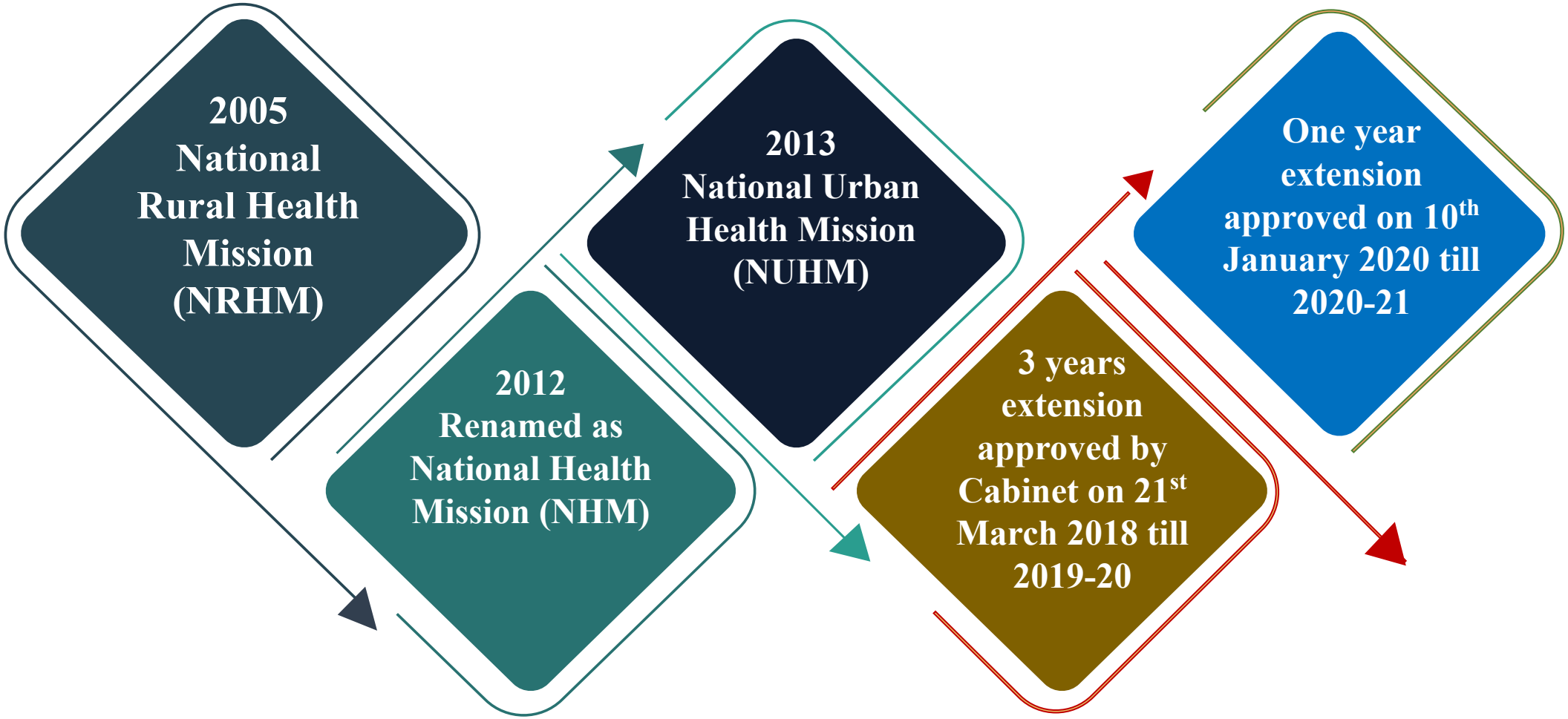
2. Facility Surveys

3. Quality Assurance Mechanisms

4. Resource support to reach standards

5. Independent Monitoring Committees at Block, District & State
Levels

NHM over the years…



Pools under National Health Mission (NHM)

NRHM & NUHM- Health System Strengthening (HSS) Pool

- Ayushman Bharat- Health & Wellness Centre (AB-HWCs)
- Free Essential Drugs
- Free Essential Diagnostics
- National Ambulance Service (NAS) & Mobile Medical Units (MMUs)
- Quality Assurance
- Untied Fund
- Human Resource for Health

⇔ Infrastructure Maintenance Pool

RCH Flexi-pool

- Reproductive Maternal Newborn Child Adolescent Health & Nutrition (RMNCAH+N)
- Intensified Pulse Polio Programme Immunization (IPPI) & Routine Immunization (RI)
- Rashtriya Bal Swasthya Karyakram (RBSK)
- Rashtriya Kishor Swasthya Karyakram (RKSK)

Communicable Disease (CD) Programme Pool

- TB Elimination Programme
- Vector Borne Disease Control Prog.
- Leprosy Elimination Prog.
- Integrated Disease Surveillance Programme
- Viral Hepatitis Control Programme

Non Communicable Disease (NCDs) programmes Pool

- Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke
- Control of Blindness and Deafness
- Mental Health Programme
- Oral Health Programme
- Programme for Prevention and Control of Fluorosis (NPPCF)
- Tobacco Control
- Care of Elderly and Palliative Care
- Pradhan Mantri National Dialysis Programme

Why is Health so Important ???

"Sarve bhavantu sukhinah, sarve santu niramaya"

Health – not only a Goal in itself, but also vital for improved developmental outcomes

- **Better Health Improves productivity**
- **Reduces Losses due to premature death, prolonged disability & early retirement**
- **Health and nutrition directly impact the scholastic achievements- bearing on productivity and income.**

Why public investment in Health?

- **Benefit to cost ratio for key healthcare interventions is 10:1**
- **Health Outcomes and financial protection depend on public spending on health - India ranks low on Life expectancy (125/183), Over 7% slip below poverty every year**
- **One extra year of population life expectancy raises GDP per capita by 4%**
- **Creates millions of jobs, largely for women, through the much needed expansion of the health workforce. The UN High Level Commission – "investment in job creation in the health and social sectors will make a critical positive contribution to inclusive economic growth", least likely to be affected by automation**

Why public investment in Health?

- **Issues of (i) information asymmetry e.g. food/drug regulation, and (ii) significant externalities e.g. TB, vaccination, (iii) prevention, health promotion & public health- not addressed by market forces- require government intervention**

- **Reduces inequity of healthcare delivery, markets don't address equity**

National Health Policy, 2017

Our Goal "The attainment of the highest possible level of health and well-being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence."

- India's journey towards Universal Health Coverage or Health for All is rooted in our commitments to several global initiatives including the Alma Ata declaration, the Millennium Development Goals, the Sustainable Development Goals and most recently the Astana Declaration.

- UHC, a key target of the 2030 Agenda for Sustainable Development Goals is an objective of India's National Health Policy, 2017
- **National Health Policy, 2017, is committed to raising public investments in health care to 2.5% of the GDP and two-thirds of the budget to primary health care.**

- **These investments, especially in primary care, will lead to improved health and developmental outcomes at a much lower cost, and in achieving UHC.**

Focus on Primary Health Care

Why Comprehensive Primary Health Care?

- Remarkable successes:- polio elimination, reduced IMR, MMR, TFR.
- Significant failures: Malaria, malnutrition, High OOPE, no attention to NCD at primary care level.
- Limited progress in making basic health care widely available
- Selective PHC: limited to RCH and communicable diseases- addresses about 20% of health care needs
- Epidemiologic Transition: chronic disease mortality accounts for nearly 60% of all mortality
- Health care is fragmented and expensive
- Low use of peripheral facilities
- Inflated costs due to fragmented care and poor clinical outcomes from lack of continuity in care.
- Cost containment is critical as is reducing the load on secondary and tertiary facilities to reduce patient loads and improve quality

What do investments in PHC entail

- Strengthening peripheral facilities to be transformed as Health and Wellness Centres – emphasis on close to community services
- Adding a new level of worker- the Community Health Officer
- A paradigm shift from individual worker driven to a PHC team- to deliver preventive, promotive, curative, rehabilitative and palliative care functions
- Cover all population sub-groups – new-borns to elderly
- Focus on health promotion and prevention- need for multi sectoral action- synergize with water, sanitation, and hygiene; indoor air pollution; and food safety.

Key Milestones

Budget announcement

Feb 2018

Inauguration of 1st HWC and NCD Application at Jaangla, Bijapur

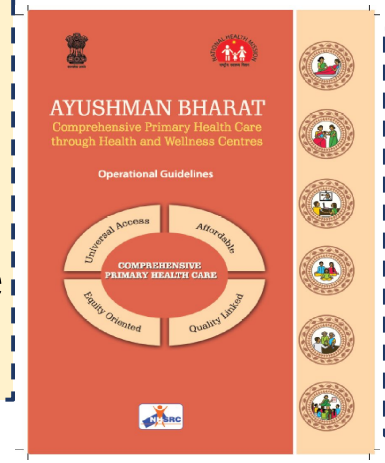
14th April, 2018

National Consultation on Comprehensive Primary Health Care

May 2018

Operational Guidelines on Comprehensive Primary Health Care finalized

July 2018



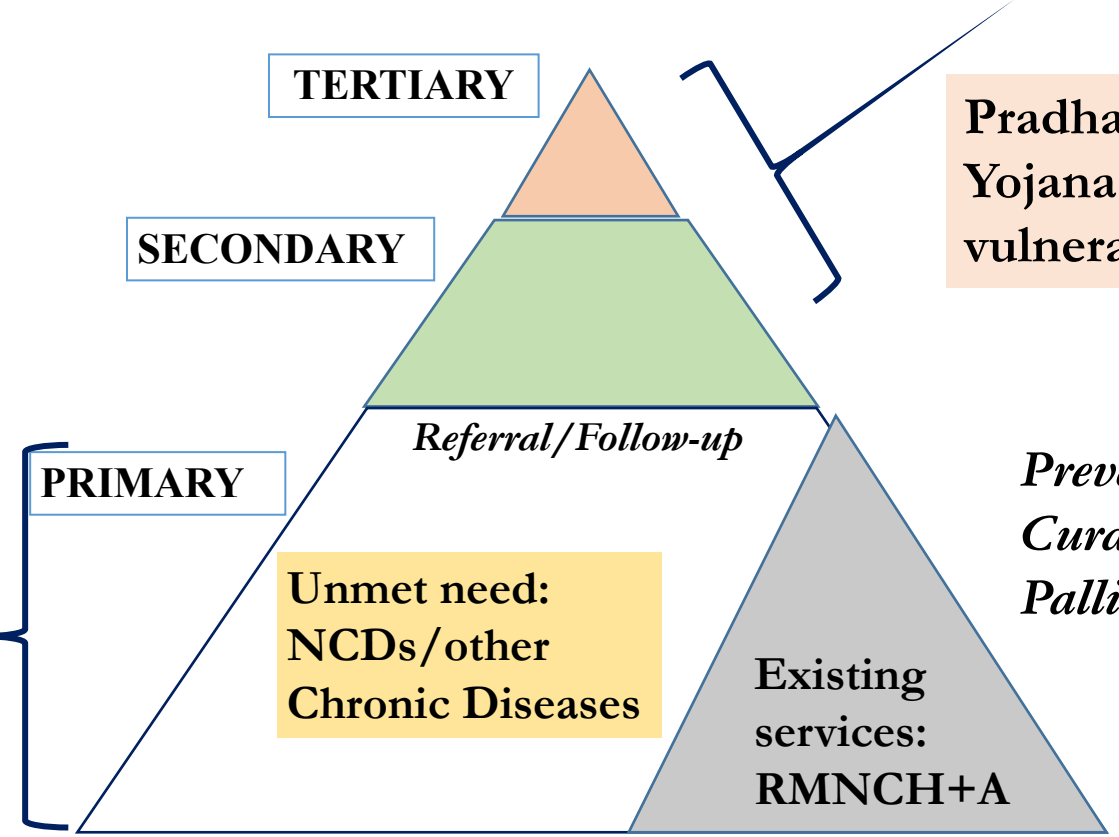
Operationalization of over 77,000 Health & Wellness Centres

July 2021

Operationalization of 1.5 Lakh Health & Wellness Centres

2022

Ayushman Bharat



Pradhan Mantri Jan Arogya Yojana – covers 40% of vulnerable population

Comprehensive Primary Health Care through HWCs

Preventive, Promotive, Curative, Rehabilitative & Palliative Care

CONTINUUM OF CARE – CPHC & PMJAY

NHM’s Institutional Mechanisms

National level Structures under NHM

Mission Steering Group – chaired by Union Minister of H&FW

- Provides broad policy direction
- Union Ministers, VC, NITI Aayog, CEO, NITI Aayog, GoI Secretaries, DGHS, 4 secretaries (High-Focus States), 9 PH professionals, etc.

Empowered Programme Committee – chaired by Secretary (H&FW)

- Executive Committee
- GoI Secretaries, DGHS, 2 PH professionals, etc.
- All the Proposals brought before the MSG are first placed before EPC for examination by EPC.

NPCC –chaired by AS & MD (NHM)

- Under AS&MD, NHM
- Recommends PIPs for approval to Secretary

Exercise of the powers by MSG and EPC are subject to the condition that a progress report on NHM, along with deviation in financial norms, modifications in ongoing schemes and details of new schemes are placed before the Cabinet for information on an annual basis.

State level Structures under NHM

State Health Mission – chaired by State Chief Minister

- Provides broad policy direction
- State Ministers, MPs, MLAs, Chairpersons of ULBs and ZPs, CS, Secretaries, DHS, PH experts, NGOs, DPs, etc.

State Health Society

- **Governing Body- chaired by Chief Secretary**
- Secretaries from related ministries, DHS, AYUSH Director, PH Professionals, NGOs, DPs & Regional Directors
- Endorsement of Annual state action plan and inter-sectoral coordination

- **Executive Committee- chaired by State Principal Secretary, Health** with MD, NHM as Convener
- DHS, AYUSH Director, Regional Directors and Technical Officers from related departments
- Execution of approved State Action Plan and Follow up action on decisions of the Governing Body

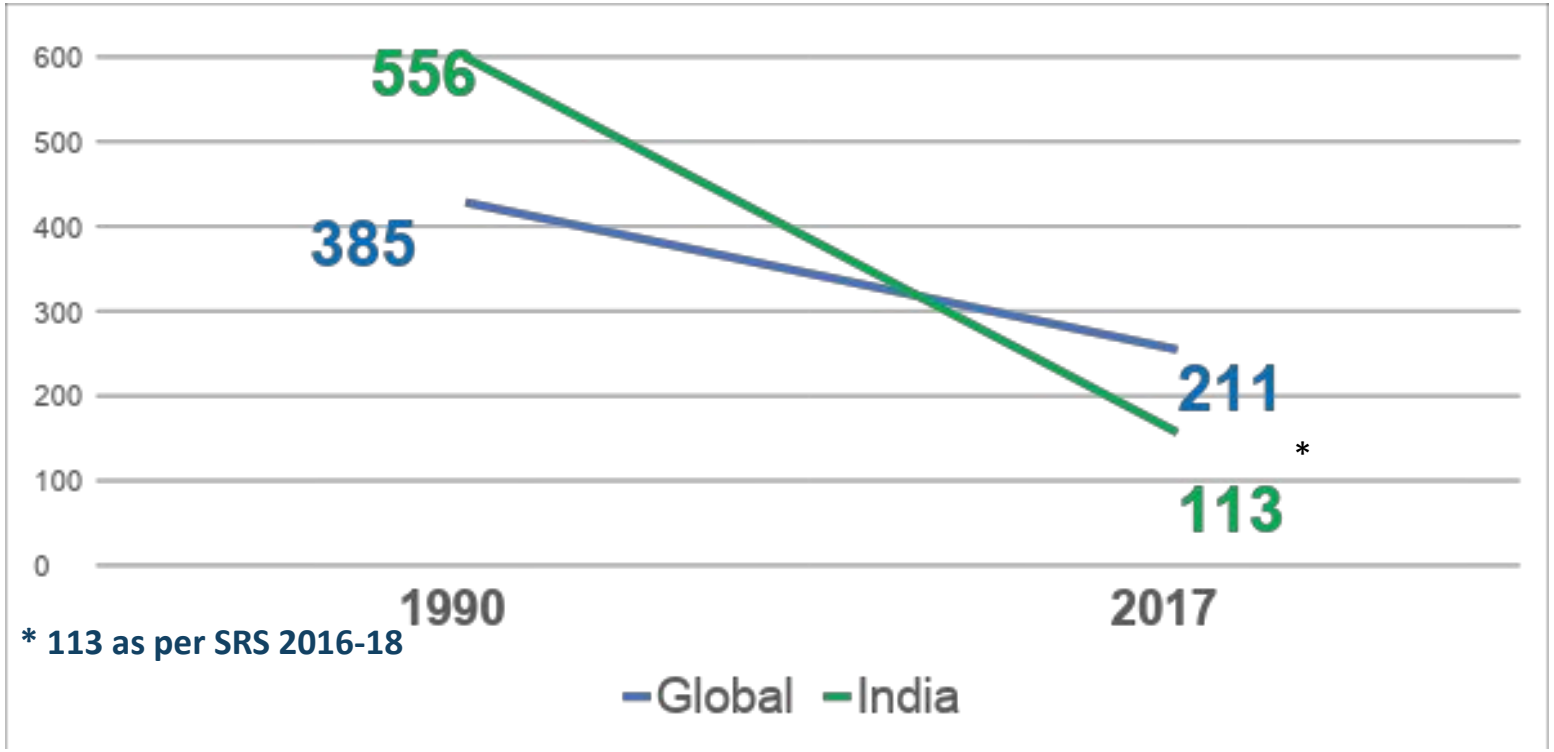
Similar structure of District Health Mission, District Health Society, City Urban Health Mission and Society are functional at District level and Urban Local Bodies level.

Key outcomes & Contributions

NHM performance is linked directly to 24 out of the 34 SDG-3 indicators

Maternal Mortality Ratio (MMR):

No. of Maternal Deaths per 1 lakh live birth



* 113 as per SRS 2016-18

Between 1990 and 2017

India MMR Decline	Global MMR Decline
80%	45%

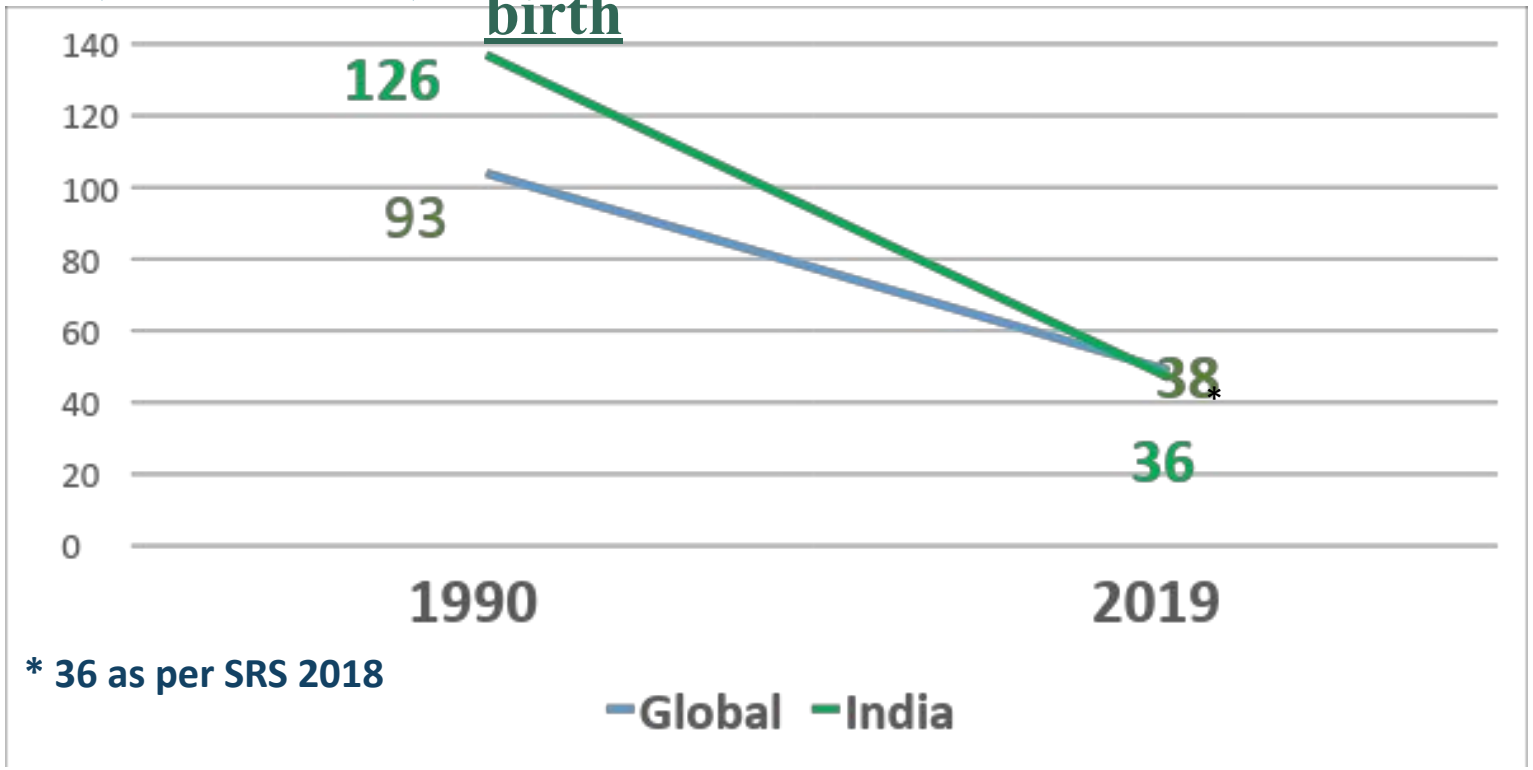
Data Source: SRS India and Trends of Maternal Mortality 2000-2017, UN MMEIG

SDG Target: 70 by 2030

As per SRS 2016-18, **five States have already attained SDG target: Kerala (43), Maharashtra (46), Tamil Nadu (60), Telengana (63) & Andhra Pradesh (65)**

Under 5 Mortality Rate (U5MR)

No. of Child (under 5) death per 1 thousand live birth



* 36 as per SRS 2018

Between 1990 and 2019

India U5MR Decline	Global U5MR Decline
71%	59%

Data Source: SRS, India and Levels & Trends in Child Mortality Report 2020 , Estimates developed by the UN Inter-agency Group for Child Mortality Estimation

SDG Target: 25 by 2030

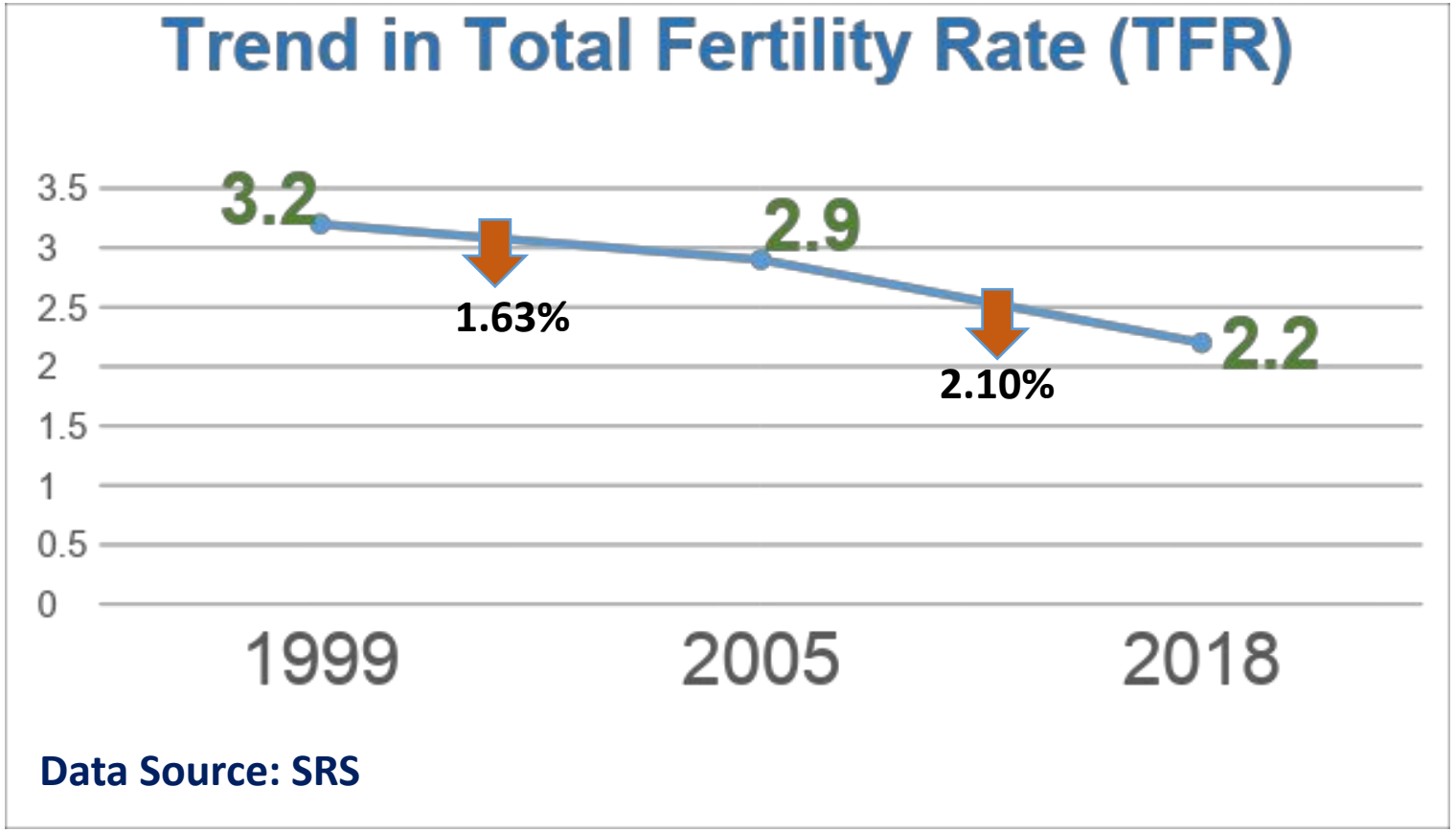
As per SRS 2018, **seven States have already attained** SDGs target : Kerala (10), Tamil Nadu (17), Delhi (19), Maharashtra (22), J&K (23), Punjab (23) & Himachal Pradesh (23)

Total Fertility Rate (TFR):

Average no. of children that would be born to a woman over her lifetime

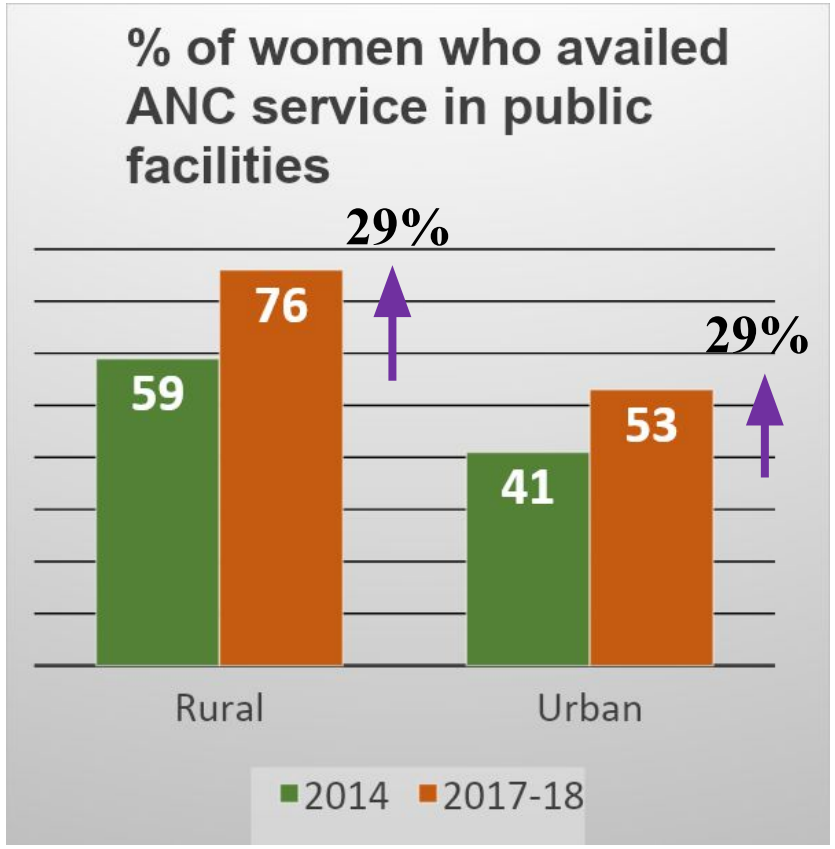
India has seen a considerable decline in TFR over the last few decades;

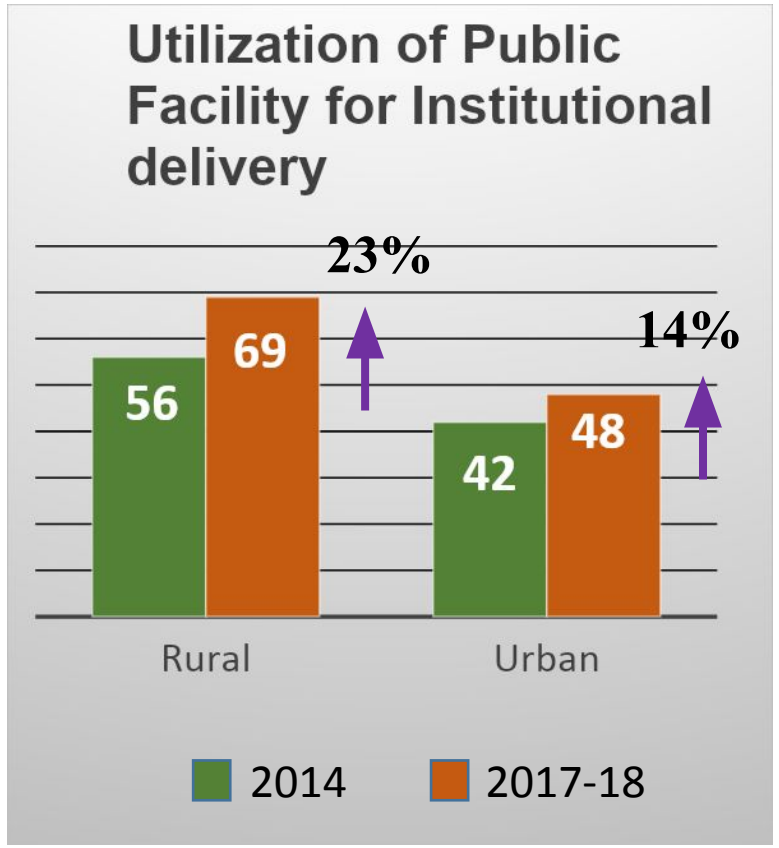
From 3.2 in 1999 to 2.2 in 2018

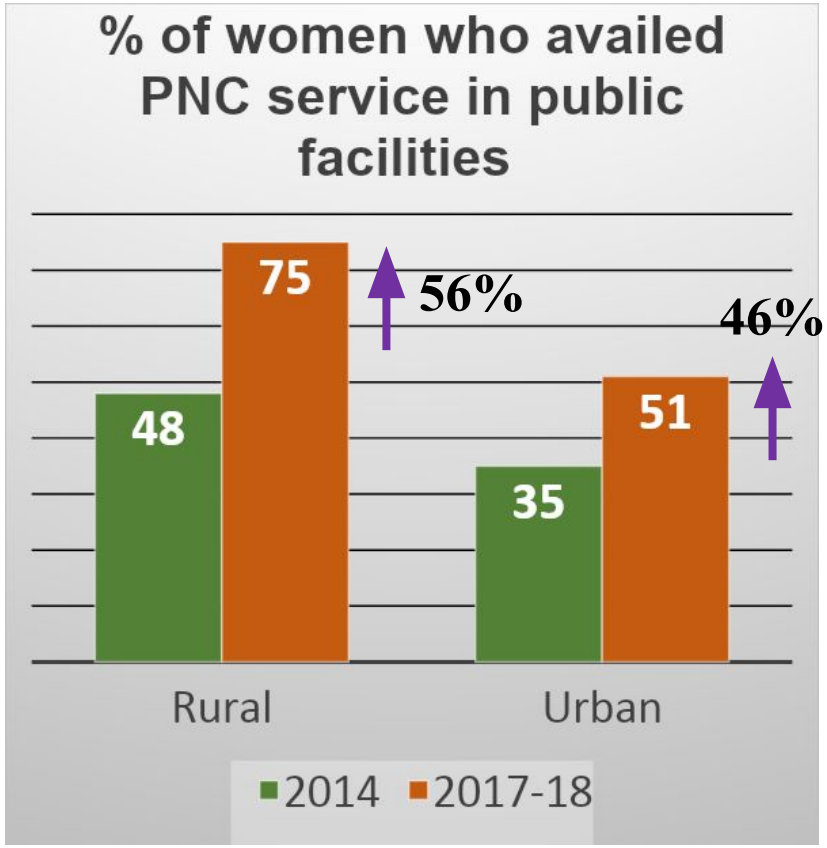


Currently 28 States/ UTs out of 36 have achieved desired replacement level of fertility (2.1)

Improved ANC-Institutional Deliveries-PNC Services

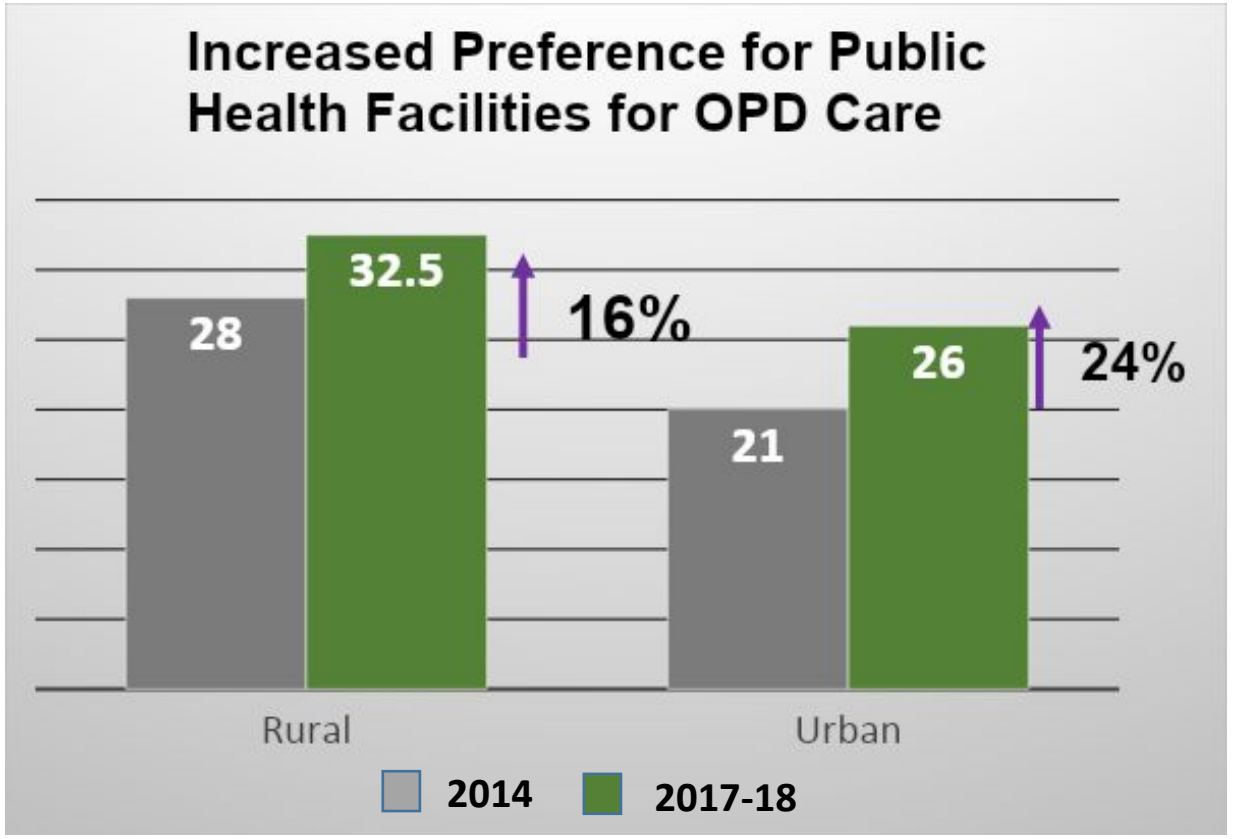


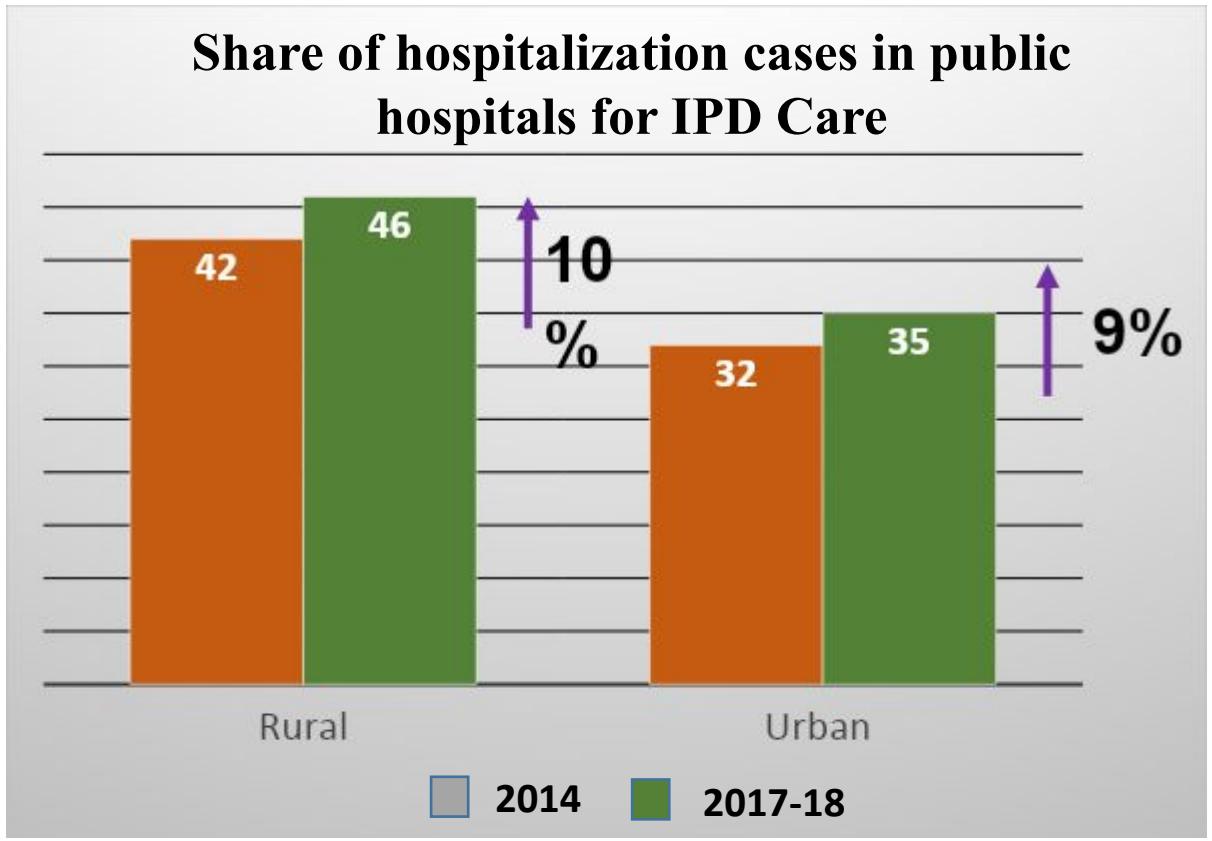




Data Source: NSSO Survey

Increased public healthcare utilization





Considerable increase in utilization of public health facilities as per NSSO Survey

- **Free Drugs Service Initiative (FDSI)**
- **Free Diagnostics Initiative (FDI)**
- **Increased number of health facilities**
- **Specialists, Doctors, other HR and ASHAs**
- **Referral Transport Services**
- **National Health Programmes**

Considerable increase in Public Health Facilities (PHFs)

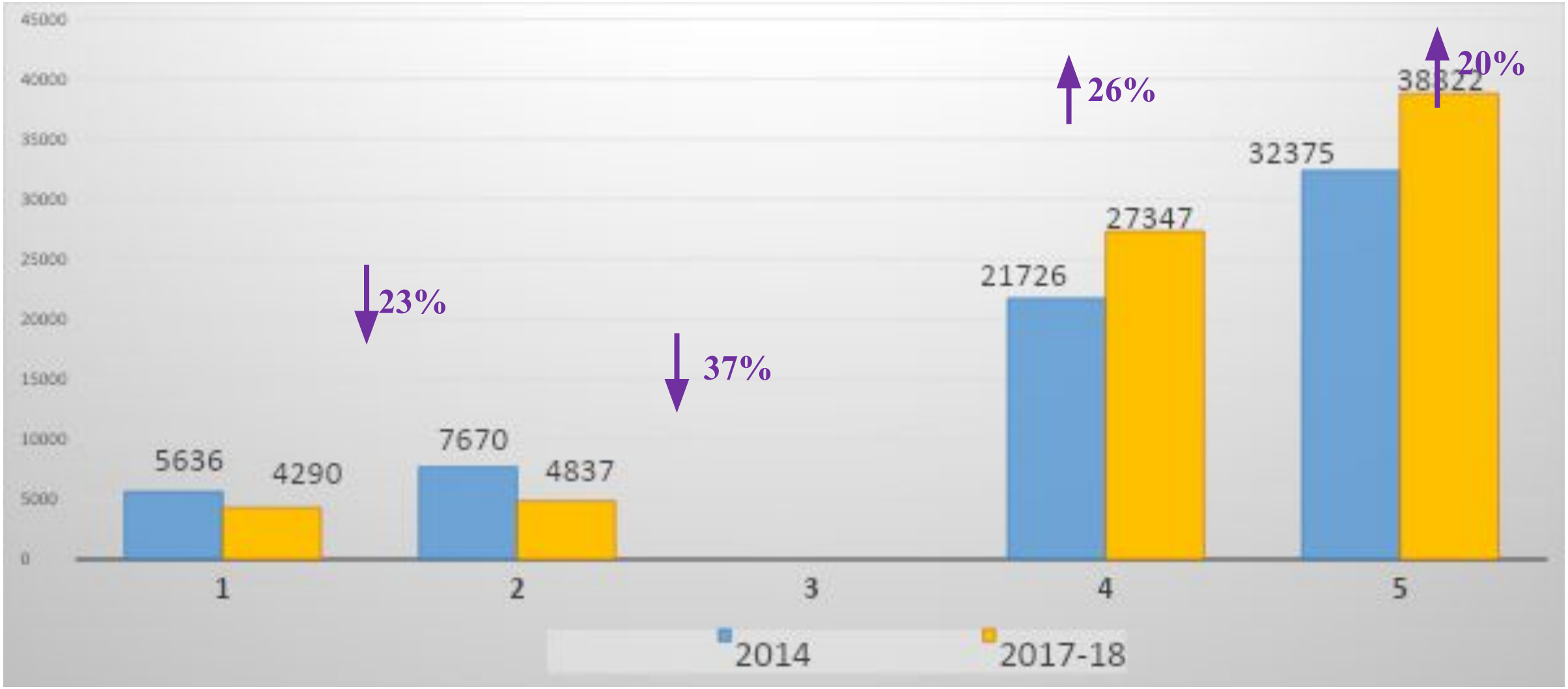
Facility	In position 2005	In position 2020	Requirement as per population norms	Gap in PHFs as per population norms
SHC	142655	157921	191461	33,540
PHC	23109	30813	31337	524
CHC	3222	5649	7820	2,241
SDH	NA	1193	NA	NA
DH		810	94*	94

*94 districts not having DHs

As on date, 77,623 Sub Health Centres and Primary Health Centres have been transformed as AB-HWCs

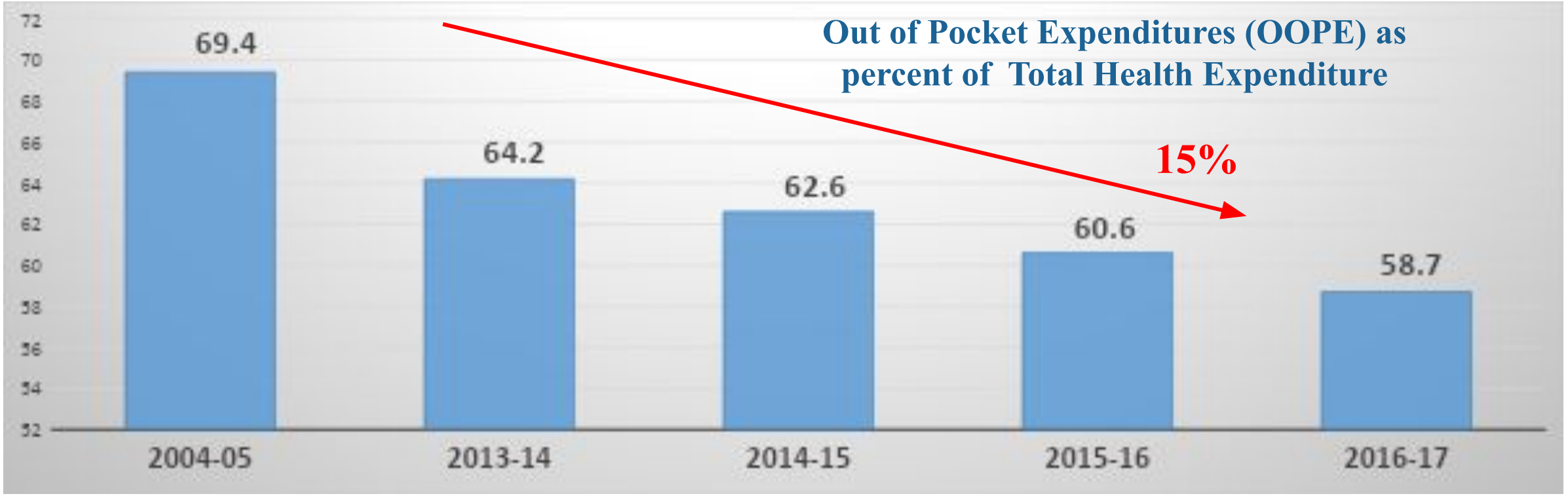
SHC: Sub Health Centre, **PHC:** Primary Health Centre, **CHC:** Community Health Centre,
SDH: Sub-Divisional Hospital, **DH:** District Hospital

Reduction in Average Medical Expenditure in Public Health Care facilities Vs Private Healthcare Facilities



Data Source: NSSO Survey (Amount in Rs)

Continuing Reduction of OOPE



Data Source: NHA estimates. As per provision estimate, the OOPE of 2017-18 is 48.8% of THE

Major interventions for considerable reduction in OOPE

- National Health Programmes
- Free Drugs Services Initiative (FDSI)
- Free Diagnostic Services Initiative
- Specialists, Doctors, other HR and ASHAs
- Referral Transport Services
- Support for Infrastructure

Reforms Effected through NHM

Reforms Effected through NHM

Governance Reforms

- Flexibility to States for de-centralised planning and financing
- Decentralized Management Units
- Output based budgeting
- Community ownership of healthcare facilities
- Jan Arogya Samitis (JAS) till PHC level and Rogi Kalyan Samitis (RKS) beyond PHC level
- Establishment of community collectives for accountability, such as Village Health Nutrition and Sanitation Committees (VHSNCs) and Mahila Arogya Samitis (MAS)

Equitable Distribution of Resources

- Equitable distribution of resources among States
- Allocation to Districts within the States/UTs prioritized HPDs, ADs, Tribal Districts and LWE Districts

Human Resources related Reforms

- Availability of specialist doctors in public health facilities
- Support to states for DNB and CPS courses in DHs
- Policy support on creation of specialist cadre
- Human Resource Information System (HRIS)

IT Reforms

- HMIS 2.0
- Integration with IHIP, RCH Portal, NIKSHAY, NCD App / Portal, eSanjeevani Tele-consultation
- Integration with NDHM Architecture

Financing Reforms

- **NHM progresses from input-based financing to performance-based financing.**
  - 20% of NHM programmatic flexi-pools resources (except IM& KG) earmarked
  - Release based on Conditionality Framework
  - Significant weightage of 50% from the NITI Aayog's State Health Index Report and the District Hospital Rankings
- **States pursued to increase their State Health Budget by at least 10% annually.**
- **NHM Financial Accounting and Management System (N-FAMS), an IT solution to effect just-in-time releases, is currently being piloted in Assam, Bihar, Haryana, Odisha and Tamil Nadu.**

Procurement and Logistic Reforms

- **Created the institutional mechanisms for effective procurement modalities**
  - Almost all the States/UTs have Medical services Corporations
  - DVDMS – real time Inventory management system for monitoring the stock outs
  - Ensuring last mile delivery and tracking
- **NHM supports states to improve supply chain and logistics management by supporting for Drug Ware houses**
- **NHM expands procurement capacity of the States including technical hand-holding**

Secondary Care

Strengthening Secondary Care

Strengthening secondary care facilities including specialist care, operative services, emergency and critical care, blood transfusion services etc.

Indian Public Health Standards

Defining population norms, based on services, infrastructure, human resource, drugs, diagnostics, etc. required at district level.

Comprehensive District Plan

DHAP, Disease Burden, OOPE

Knowledge Hub

DH as Knowledge Hub- teaching and training for medical, nursing and paramedical courses..

DNB Courses at District Hospital

DNB courses – both Post MBBS Diploma and degree course at district hospitals

Model Health Districts

Comprehensive Planning for delivery of services in the districts with ensuring assured linkages at all levels of health facilities.

Aspirational Districts

Focus on aspirational districts to strengthen health care delivery.

Sources of Knowledge and Evidence: Strengthening Implementation, Enabling Policy modifications

- Routine Health Management and Information Systems (HMIS) , Other Programmatic Information Systems- Nikshay, RCH Portal, NCD etc
- **Large Scale surveys:** NFHS, NSSO, SRS, National Health Accounts
- Specifically Commissioned Evaluations
- **Studies:** conducted by academic institutions, research agencies/Development partners
- **Global Data estimates**: Global Burden of Disease, WHO Observatory
- **Non traditional:** Annual Common Review Missions, Best Practice Workshops, Routine field visits

Convergence

Making Health a Social Movement – Jan Andolan

To address social determinants of Health and Build and strengthen institutional mechanisms, in collaboration with concerned Ministries / Departments

- **Fit India of MoYAS**
- **POSHAN Abiyaan of MoWCD**
- **YOGA of MoAYUSH**
- **Swachha Bharat Mission**
- **GPDP – Public Planning Campaign of MoPR**

- **Implementation of Targeted Interventions of NHM in collaboration with other Ministries / Departments**
  - **Rashtriya Bal Swasthya Karyakram (RBSK) with D/o School Education and ICDS (MoWCD),**
  - **Swachh Swasth Sarvatra initiative with the Ministry of Drinking Water and Sanitation**
  - **Mainstreaming of AYUSH services through PHCs, CHCs, SDHs and DHs with MoAYUSH to enhance choice of treatment services for citizens etc.**

Key Findings in the Evaluation of NHM by NITI Aayog

The report has recommended continuation of the NHM, with increased allocations

All the objectives are still relevant and expected to remain relevant in the next decades

The scheme has been successful in improving the health indicators, including prevention and control of CDs and NCDs

Strengthening of District Hospitals under National Health Mission is a major step towards focussing on NCD Burden

Introduction of Health and Wellness Centres has been a positive initiative towards Comprehensive Primary Health Care

XV Finance Commission

Total Grants Recommended by XV FC for the Health Sector-

- Grants aggregating to **Rs. 70,051 Crores** through **local governments**
- **sectoral grants** aggregating to **Rs. 31,755 Crores** to States.
- **State-specific grants** for health amounting to **Rs. 4,800 Crore**

The Union Government has accepted the grant of **Rs. 70,051 crores for local governments**. This grant is split into urban and rural components as follows-

Urban Health Grant	**Rs 26,123 Crores**	37% of total funds
Rural Health Grant	**Rs. 43,928 Crores**	63% of total funds

While making district wise allocations, State has to factor-in-
(i) Urban and rural population of the district;
(ii) preferential allocation to aspirational districts including tribal, hilly, hard to reach, insurgency affected areas.

NHM: Road ahead

- Enhanced focus on Quality of Health Care at PHFs; new Quality Guidelines are under preparation
- Output based monitoring
- Enable states to comply with revised Indian Public Health Standards (under revision)
- Institutionalize District Planning- by way of standardized templates, district wise resource allocation including PMASBY, 15th FC, ECRP grants besides, NHM.
- Intensify monitoring efforts : including IT enabled dashboards, geotagging of the facilities and infrastructure works
- Strengthen community actions to improve accountability – JASs, SHG & Local Bodies engagement
- Leverage Resources from various sources viz, District Mineral Funds, DoNER, MOTA, MoMA, CSR and private

Way Forward

PHFs complying Indian Public Health Standards (IPHS)

Efforts to make all public health facilities compliant to IPHS

Monitoring HRH through PRAGATI

Inclusion of HR index in PM-Pragati to ensure timely-filling up of critical Human Resources for Health

Saturating Tribal areas for PHFs as per population norms

Efforts to close gap in PHFs requirement in tribal areas

Public Health Management Cadre

Support to States to implement PHMC

Involving Local Bodies (RLBs and ULBs) and Community

Community owned and managed health delivery system


NATIONAL HEALTH MISSION
NATIONAL HEALTH MISSION
THE ADMINISTRATION OF UT OF LADAKH
LAHDC, LEH
AYUSHMAN BHARAT
HEALTH & WELLNESS CENTRE,PHC CHUSHUL

THANK YOU!