Summer Internship Report

At

World Bank Group

(20th April 22 to 31st May 2022)

A Report on **"Systems Reform Endeavours for Transformed Health Achievements"** in Gujarat (SRESTHA-G).

By

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2021 – 2023

International Institute Of Health Management Research, New Delhi

CERTIFICATE OF APPROVAL

The following internship project report titled **"Systems Reform Endeavours for Transformed Health Achievements"** in Gujarat (SRESTHA-G) submitted by Col Aditya Chopra who interned to assist the World Bank Group Team in institutionalise and in initial preparations at Navsari, Gujarat for their mission SRESTHA-G, is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for award of Post Graduate Diploma in Health and Hospital Management for which it has been submitted. It is understood that by this approval, the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the report only for the purpose it is submitted.

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ACKNOWLEDGEMENTS

At this moment of accomplishment, I would like to express our deep and sincere gratitude to my mentor, Dr. Vinay Tripathi, Professor, IIHMR Delhi, who provided constant guidance and support during the internship period.

I would like to express our sincere gratitude to Mr. Rahul Pandey (Operations Officer, Health,Nutrition and Population, World Bank Group) and Dr. Elina Pradhan (Senior Health Specialist, World Bank Group and Team Member) for their continuous guidance; despite being busy with their duties, taking time to hear and guide me, and giving advice. This work would not have been possible without their constant support.

Chopra

Col Aditya Chopra

Roll No 005

TO WHOM SO EVER IT MAY CONCERN

It is certified that Col Aditya Chopra completed his internship with the World Bank Group with effect from 20th April 2022 to 31st May 2022 for a total of 200 hours and his performance over the internship period was exemplary.

Team SRESTHA-G wishes good luck to Col Aditya Chopra

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Table of Contents

Acronyms/ Abbreviations

1. SRESTHA-G– Systems Reform Endeavours for Transformed Health Achievements
2. MoHFW – Ministry of Health And Family Welfare
3. SOP – Standard Operating Procedure
4. ASHA – Accredited Social Health Activist
5. RBSK – Rashtriya Bal Swasthya Karaykram
6. HFWD- Health and Family Welfare Department
7. NFHS-National Family and Health Survey
8. AB-HWCs-Ayushman Bharat- Health and Wellness Centres
9. ULB-Urban Local Bodies
10. PRI-Panchayati Raj Institutions

Introduction

1. Gujarat is one of India's most urbanised states in India, with 43 percent of the population living in urban areas, according to the State government. The state is home to more than 60 million people (5 percent of the population of India as per the population census of India, 2011). But, according to the recently released report – National Family and Health Survey (NFHS-5), Gujarat is also known as one of the states facing huge challenges in dealing with malnutrition and anaemia. As per the report, malnutrition parameters such as stunting (that refers to low height for age) and wasting (that refers to low weight for age) have shown a spike when compared to the earlier edition of the NFHS report from 2015-16. Along with malnutrition trend, as per the latest report, the state is also tagged as one of the poor performing state in the country when it comes to anaemia in children under five years age.

2. Gujarat Chief Minister Bhupendra Patel approved the SRESTHA-G project, after which the proposal was forwarded to the Union Finance Ministry. The Gujarat government will implement the programme through the Health and Family Welfare Department (HFWD). The Program Development Objective is to improve service delivery in Gujarat by improving primary health care quality, equity, and comprehensiveness, improving service delivery models for adolescent girls, and increasing disease surveillance system capacity.

Overview of Gujarat health and nutrition status from NFHS-5 report:

Malnutrition: Gains Made In NFHS-4 Reversed In NHFS-5

3. According to the report, the proportion of the children under five years of age, among those surveyed, who are malnourished increased in Gujarat in 2019-20 as compared to 2015-16 data. NFHS-4 had reported an improvement in the proportion of children who were stunted or had low-height-for-age as it declined by 12.6 per cent from 51.1 in NFHS-3 (2005-06) to 38.5 per cent. However, in 2019-20, stunting, which has prolonged adverse effect on child health affecting physical and cognitive development has seen a marginal increase of 0.5 per cent in children under 5 years – from 38.5 per cent in 2015-16 to 39 per cent in 2019-20.

4. Child severe wasting reflects acute undernutrition and refers to children who have low weight for their height. This parameter has also shown an increasing trend in the state. The proportion of severely wasted children has increased by 1.1 per cent – from 9.5 per cent in 2015-16 to 10.6 per cent in 2019-20.

5. When it comes to the proportion of underweight & overweight children, Gujarat has again seen an increase. While about 39.3 per cent of the children surveyed were underweight in 2015-16 which was an improvement from the NFHS-3 figure of 44.2 per cents, the proportion increased to 39.7 per cent in 2019-20, showing an increase of 0.4 per cent in five years. Obesity among children has also doubled from 1.9 per cent in 2015-16 to 3.9 per cent in 2019-20, according to NFHS 5.

6. Apart from the schemes and programmes aimed at tackling malnutrition, the government earlier this year had also decided to include toor dal (Pigeon Pea), a source of protein and other nutrients in the list of groceries that are sold at subsidised rates through the Public Distribution System (PDS) under the National Food Security Act, 2013.

High Prevalence Of Anaemia Among Women And Children

7. Gujarat is the poor performing state in the country when it comes to anaemia in children under five years old as compared to NHFS 4 (2015-16). Anaemia among children aged 6-59 months increased to 79.7 per cent from 62.6, an increase of 17.1 per cent in five years. Whereas, anaemia in non-pregnant women increased to 65.1 per cent from 55.1 per cent and in expecting women it increased to 62.6 per cent from 51.3 per cent.

8. As far as men are concerned, in the age of 15-49 years Anaemia increased to 26.6 per cent from 21.6 per cent and in 15-19 years category, it increased to 36 from 31.9.

9. This is not the first time, Gujarat has seen such a trend. Back in 2015-16, according to the Nutrition Atlas which has been prepared by the Hyderabad-based National Institute of Nutrition, Gujarat was among the top 15 Anaemic states of India, with a higher percentage of anaemic women than the national average of 53.1 per cent.

Women In Gujarat Are Adopting Hygienic Method During Menstruation

10. NFHS-5 has revealed some increase in menstrual hygiene among women between 15 to 24 years of age in 2019-20, compared to NFHS-4. The state saw a jump of 5.5 per cent in this area as 65.8 per cent of the women surveyed in the said age group were using hygienic methods of menstrual management as compared to 60.3 per cent in NFHS-4.

Infant And Child Mortality Rate Shows A Decline

11. The NFHS-5 data shows a declining trend in Infant Mortality Rate (IMR), which is the number of babies less than one year of age dying per 1,000 live births, and Under Five Mortality Rate (U5MR), which refers to the number of children dying before reaching the age of five years per 1,000 live births.

12. According to the NFHS-5, infant mortality rate (IMR), saw a decline by 8.7 per cent from 2015-16 to 2019-20 – from 34.2 deaths per 1,000 live births in 2015-16 to 31.2 deaths per 1,000 live births in 2019-20. However, in the context of rural areas, the state was still among the bottom seven states with 33 IMR. According to NFHS-5, Gujarat's under-five mortality rate (U5MR) is at 37.6 deaths per 1000 lives in 2019-20, down from 43.5 deaths per 1,000 live births in 2015-2016.

13. The NFHS-5 data also shows that institutional deliveries increased in the state from 88.5 per cent in 2015-16 to 94.3 per cent in 2019-20.

Increased Immunisation

14. According to the survey, there has been an improvement of 25.9 per cent in full vaccination coverage among children aged 12-23 months, among those surveyed in Gujarat in 2019-20 as compared to 2015-16. It has increased from 50.4 per cent in NFHS-4 to 76.3 per cent in NFHS-5. According to the Ministry of Health and Family Welfare, full immunisation implies vaccinating children with BCG (Bacilli Calmette-Guerin) which is a vaccine for tuberculosis (TB), vaccines to prevent measles – MMR (measles, mumps,

and rubella) and three doses each of polio (excluding polio vaccine given at birth) and DPT (diphtheria, pertussis, and tetanus).

Infant And Child Feeding Practices Shows A Reverse Trend

15. For the state Gujarat, another reverse trend has been seen in infant and child feeding practices when compared to the data recorded under the NFHS-4. Among the children surveyed, about 37.8 per cent of the children were breastfed within one hour of the birth in 2019-20 as compared to 49.9 per cent in 2015-16. However, there has been an increase of about 9.2 per cent in the proportion of children being exclusively breastfed in 2019-20 (65 per cent) as compared to 2015-16 (55.8 per cent).

16. Along with this, there has been a marginal gain in the proportion of children in the age group 6-23 months receiving an adequate diet from 5.8 per cent in NFHS-4 to 5.9 per cent in NFHS-5. But, the percentage of children receiving the adequate diet is still very low as compared to other states.

Improved Access To Drinking Water And Sanitation

17. According to NFHS-5, about 97.2 per cent of the sample population has access to drinking water in Gujarat as compared to NFHS-4 (95.9 per cent). According to the Union Health Ministry, the sources of drinking water include piped water in the residence or piped to the neighbour, public taps, tube-wells, dug-wells, rainwater tanks, community RO plants among others.

18. The survey also revealed an increase in per cent of the population surveyed with access to an improved sanitation facility. There has been an increase of 10.4 per cent when compared to the population having access to toilets in NFHS-4 which was 63.6 per cent.

Mission : Systems Reform Endeavours for Transformed Health Achievement in Gujarat (SRESTHA-G)

19. World Bank approved USD 350 million as financial aid for the Systems Reform Endeavours for Transformed Health Achievement in Gujarat (SRESTHA-G) project. The SRESTHA-G project will be worth USD 500 million, with the World Bank contributing USD 350 million. This project aims on transforming key health delivery systems in Gujarat. This programme will also be focusing on the key areas of improving equity, quality, and inclusiveness of primary healthcare services for all adolescent girls in the state. It will also focus on the disease surveillance systems' capacity. The project will also be aiming to increase the state's quality of psychiatric and non-communicable disease services, and the quality of nutrition services for children and mothers. This project will be implemented by the state government of Gujarat through the Health and Family Welfare Department of the state.

20. Under this project, the state government will be undertaking several initiatives to improve the state's health system quality by expanding the health services to the urban as well as the rural population of the state. The government is also looking to strengthen the state's epidemic prevention system.

Objective

21. The objective of internship was to support and assist the World Bank Group Team in its preparation, process for institutionalising and setting up of Mission SRESTHA-G, with a f**ocus on the health and nutrition component of the programme that aimed to improve service delivery interventions for adolescent girls in Gujarat.**

Tasks carried out during the Internship period

22. **Task 1. Go through the Qualification Pack (QP) and model curriculum for the 35 National Occupational Standards (colloquially known as job roles) outlined by the Health Sector Council for India., analyse and determine which job roles might be best suited for adolescent girls/young women (16-19yrs).**

23. **Time Allotted**. 56 hours

24. **Expected Outcome**. This task will be extremely useful in developing the urban zone-level skilling pilots being proposed under SRESTHA-Gujarat.

25. **Action**. The required analysis was been carried out after going through the above-mentioned literature and other related articles on the subject available on the net. Studies of World Bank Group on Adolescent Girls Initiative in various countries since 2015 was also studied.

26. The following was put forth for consideration of the World Group Team:

a. Skills that align with the market needs should be stressed upon.

b. Teach market relevant skills that the employers want, which apart from cognitive and technical skills may lay more stress on other soft skills like verbal communication, problem solving, team work etc. Focus may be on a comprehensive personality and skill development.

c. Skills imparted are scalable and are impactful interventions and not with short term employability goals.

d. Skills should be transferable and transcend into multiple sectors thus preparing an adolescent to be employable in diverse work settings.

e. An ecosystem approach where the curriculum is framed such to equip the girls with skills that the local employers are looking for and that vocational training matches with local market requirements. Factoring in the displacement of a girl from her local setting to take up a job somewhere else has to be thought of.

g. Cultural and social perceptions dictate the kind of job opted for by the adolescent. Long term tailored made skills which provide empowerment and employability options with decent renumeration without impinging on the self-esteem of the individual should be planned.

h. Attitude and aptitude govern the success of the training for the skill to be imparted. Prior psychometric tests/screening/interviews may be carried out to draw out suitable candidates for the requisite training.

27. **Detailed Analysis attached as Annexure I.**

28. **Task No 2.** **Review and suggest if certain questions can be further simplified from the respondent's perspective with respect to RKSK programme being implemented in Navsari District. Review of the questionnaire was also to be carried out from a sequencing perspective.**

29. **Time Allotted**. 40 Hours

30. **Expected Outcome**. World Bank Group intended to share the checklist with the government for responses from select block offices. The intent was to understand the implementation structures for RKSK at the block-level and identify gaps (and opportunities) to enhance block-level programming (capacities, resource allocation and outcome orientation) for AGs.

31. **Action.** The entire questionnaire as framed by World Bank team was reviewed and a fresh questionnaire was framed and forwarded to the team with the following comments on the checklist/questionnaire made by the World Bank team.

a. **Cover page**. Confidentiality clause should form part of the cover page. For example, Information shared will be completely confidential between the parties and shall not be disclosed to anybody else and will be used for the programmatic interventions only.

b. **Block official and Officer responsible for RKSK programme.** Since the information of official incharge is available in public domain the Govt officials may refrain from divulging name of other officers/ persons concerned.

c. At places in the questionnaire it is mentioned Block and at some places its Taluka. Block and Talukas (bilingual) may be mentioned to aid in better understanding. We have 252 Talukas /blocks in 27 districts of Gujarat.

d. Most of the quantitative data sought is available in various documents like MoHFW website, their statistical reports on the net. An update on the quantitative data can also be obtained from a District Medical Officer's office or any recent briefings in DoHFW office. Moreso, all respondents may not have correct information of data being asked for ,due to reasons of confidentiality.

e. Many questions are open ended. Open ended questions may not find answers from a respondent for it requires the respondent to think and describe his thoughts and opinions. May not find many responses. If, however, kept in the questionnaire should not be mandatory to answer.

f. Total 35 questions have been asked in the questionnaire. Recommended to be 20 questions maximum excluding introductory questions.

g. Fresh questionnaire has been framed under the following heads: -

i. Governance (Six questions)

ii. Implementation (Thirteen Questions)

iii. Monitoring and Evaluation (One questions)

iv. Linkages and Convergence. (Two Questions)

v. Introduction. (Three Questions)

32. **Questionnaire as forwarded to World Bank after review is attached as Annexure II**

33. **Task No 3**. **To carry out the study of health care systems of the world and organise an online familiarisation interactive session for the SRESTHA-G team.**

34. **Time Allotted**. 48 hours

35. **Expected Outcome**. To acquaint all the members (newly joined interns and consultants) about the prevalent health care structures in the world in comparison to India.

36. **Action**. A power point presentation was made and 10 interns/consultants were briefed. PowerPoint presentation is attached separately to the report.

37. **Detailed analysis of health care systems of the worlds is attached as Annexure III**

38. **Task No 4. Carry out detailed study of service delivery interventions rendered by Health and Wellness Centres across the country under Ayushman Bharat Mission and suggest solutions as to how to operationalise the expanded services in all HWCs.**

39. **Time Allotted.** 64 hours

40. **Expected Outcome.** This as a ground work will be used as few suggestions to be given to the MoHFW for operationalising the expanded range of services across the country.

41. **Action**. A detailed literature review was carried out for all available guidelines on MoHFW website, National Health Portal. Students who had come for NHM internship to Haryana were also spoken too and discussed in detail about the ground realities. A presentation was forwarded to Mr Rahul Pandey for his records and perusal.

42. **Detailed note on the operationalising of HWCs across the country is attached as Annexure IV.**

Conclusion

43. Girls are stalled between school and productive work: more than a third—34%—of young women in developing countries are jobless—out of the labour force and not in school. Although the gender gap in school enrolment has been closing, the gender gap in labour force participation is on the rise.

44. Reaching girls during adolescence is critical—decisions made and behaviours established during this period affect their horizons later in life. Adolescence for boys typically ushers increased mobility and autonomy, but for girls it often comes with increased restrictions —fewer opportunities and less freedom to exercise choice. During this formative period in their lives it is important to provide adolescent girls with the tools they need to become economically empowered young women. As part of SHRESTHA which has its prime focus on Adolescent Girls, the landscape of health and nutrition status in adolescent girls of Gujarat will likely see a change in years to come.

45. While we believe that the newly designed HWCs initiative has several novel features that have the potential to vastly benefit the rural populations, at the same time it is critical to keep in mind the following broad issues if the HWCs have to succeed on scale: a) a much higher level of public health spending in general and much higher outlays for HWCs in particular; b) proper recruitment, comprehensive training, effective control and oversight and timely and adequate payments for the various health functionaries; c) an effective and efficient management structure for the HWCs; and d) commensurate physical infrastructure and human resources in the sub-centers and the Primary Health Centers converted into the HWCs with the growing needs of the regions.

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Annexure I
(Refer to para 27 of the internship report)

Analysis of the job roles best suited for adolescent girls/young women (16-19 yrs)

Sub Sector	Occupation	QP Name	NSQF Level	Job Description and Attributes	Expository
Allied Health and Paramedics	Diagnostic	Phlebotomist_v2	4	Draws blood samples from patients, guides patients in collection of other types of samples. Requires good communication and time management skills, ability to work in a multidisciplinary environment. Science with class XII	Job requires a well developed skill, with clarity of procedures. Trainee required to demonstrate practical skill in familiar, predictable, routine situation. Basic nursing skill ,widely used for diagnostic purpose, therefore relevant for training. Highly Recommended
Allied Health and Paramedics	Diagnostic	COVID Frontline Worker (Sample Collection Support)_v1.0	4	Draw samples including oral/nasal swabs from patients. Responsibilities mapped to the competencies required by a phlebotomist. Science with class XII. Crash Course. After completion of the course the individual will not be equivalent to a certified Phlebotomist	Situational demand-based job role. Presently useful, may become redundant with the decline in COVID cases. However, the skills attained in this crash course may be certified to the level of a Phlebotomist in due course. May be considered
Allied Health and Paramedics	Emergency Medical Technician - Basic	Emergency Medical Technician(EMT) - Basic	4	Provide emergency medical support and care to individuals and transport them to medical facility in time. Able to lift between 45-99 kgs of weight with a partner. Work under extremely stressful conditions. Class XII	There will always be a requirement for an EMT in all types of health care centres. With requisite basic training the person is employable in rural and urban set up. Provides crucial medical support staff with scope for progressive career profile. Training investments are high and limited scope with specific types of machines which face redundancy in quick times. Recommended

Allied Health and Paramedics	Emergency Services	COVID Frontline Worker (Emergency Care Support)_V1	4	Provide emergency medical support and care to individuals and transport them to medical facility in time. Ability to work with basic equipment like Oxygen Concentrator ,Cylinder, Nebuliser etc. Must be able to lift between 45-99 kgs of weight with a partner. Work under extremely stressful conditions. Class XII. Crash Course during Covid pandemic	A stop gap arrangement as per situation and demand. May become redundant with the decline in COVID cases however may be certified to cater to other emergency service requirements. May be considered
Allied Health and Paramedics	Curative services	Dresser (Medical)	3	Performs dressing of patients and related activities. 10th class.	May act as first responders in a health care facility. Low QR and better reach among women folk requiring basic first aid. May function as support staff. Highly recommended.
Allied Health and Paramedics	Non Direct Care	Geriatric Care Aide	3	Provides routine individualised care to geriatrics and assist other health care providers in old age homes etc. Support patients by undertaking non-clinical tasks. 10th class.	Low QR and high demand for geriatric care at home/ rehab centres, post-surgery/chronic illness. Job profile is non clinical and more of a care giver in nature. Broad spectrum of employability. Recommended.
Ayush	Ayurveda Therapy	Panchkarma Technician_v1	4	Provides panchakarma therapy as per prescription by creating appropriate and conducive ambience and ensuring availability of required materials, herbs and related formulations. Class XII.	Empowering job role. Training can be administered to aspiring and self-motivated trainees. However employment opportunities are limited. May be considered
Ayush	Ayurveda Therapy	Kshara Karma Technician	4	Assists Ayurvedic surgeon with the Kshara Karma procedure as well as arrange for the pre and post requirements of Ayurvedic surgical procedures. Class XII	As per the aptitude for the job, certain trainees may be trained for the task, however job avenues would depend on the demand for Ayurvedic surgery in the future. May be considered.
Ayush	Ayurveda Diet	Ayurveda Ahara and Poshan Sahayak	4	Works under the supervision of a Ayurveda Dietician and coordinates with the Ayurveda cook for food preparation as per Ayurvedic principles. Class 10th.	Routine activities of the kitchen. To act as a medium helping patient to follow Ayurveda diet plan.Productive training for aiding holistic health.Recommended.

Ayush	Ayurveda Diet	Ayurveda Dietician	5	Prepares a diet plan. Primary role is to assess nutritional needs and prescribe an ayurvedic diet plan for a healthy as well as a diseased individual. Advisory and supervisory role in preparation of therapeutic diets in hospitals and other establishments. Medical Graduate with BAMS degree. Minimum job entry age is 23 yrs.	Requires a formal Under Graduate Degree in Ayurvedic Sciences, with minimum entry age of 23 yrs. Does not correspond to the age group being considered (16-19 yrs).
Ayush	Yoga	Yoga Therapy Assistant(Options : Diabetes/Palliative Care)	4	Health care professionals who demonstrate and assist to provide yoga therapies to the individuals. Class XII.	Always in demand. Independent Role. Can be scaled up to provide patient specific needs for diabetes and palliative therapies. Highly recommended.
Ayush	Yoga	Assistant Yoga Instructor	3	Under the guidance of Yoga Instructor demonstrate Yoga techniques. 8th Class, ASHA or AWW with two years experience	Basic entry level training of yoga. May be upskilled, depending on the aptitude of the individual. Recommended
Ayush	Yoga	Yoga Wellness Trainer	5	Teaches yoga for promotion of wellness in educational institutions,yoga studios, workplaces, PHCs etc. Also guide subordinates for relevant yoga demonstrations. Certificate(Yoga Instructor) with two years experience, I.T.I (Certificate in Cosmetology), Class XII th with one year experience. Minimum age 18 years.	Proponent of Yoga as a means to achieve holistic wellness. Demand in urban areas as well. Can work as free lancers/entrepreneurs/personal trainers.Highly Recommended.
Ayush	Unani	Cupping Therapy Assistant	4	Assists Ayurvedic practitioner in carrying out dry and wet cpping therapy which is creating suction by placing heated cups on the skin by the hand. Class X.	Support Role. Job avenues would depend on the demand for such procedures in the future.May be considered.
Allied Health and Paramedics	Non Direct Care	General Duty Assistant_v2	4	Provides patient care and assist in preparing patients unit. Personal care ,comfort and assistance in fulfilling the basic needs of the patient.10th Class	Aptitude is paramount for such job- an empathetic , compassionate and nurturing attitude is the only pre requisite for the job. Likely to be in demand always. Recommended.

Allied Health and Paramedics	Non Direct Care	Home Health Aide_v2	3	Provides assistance to patients with diverse needs in carrying out their daily living activities. Personal care, comfort and assistance while the patients are coping up with their health conditions. Should possess cooking, driving and housekeeping skills preferably. 10th Class	Personal care especially for elderly and paralysed patients in home settings. There is a continuous demand for this kind of entry level health care job with basic housekeeping skills. On the job training. Recommended.
Allied Health and Paramedics	Non Direct Care	General Duty Assistant Advanced	4	Individual provides patient care. Monitor or report changes in the health status of a patient. Works in collaboration with doctors and nurses and deliver health care services as suggested by them. 10th Class	Progression pathways in terms of specialisation in advanced procedures or Supervisory role in health care setting in future possible. Diversification of profile is possible. Recommended.
Allied Health and Paramedics	Patient Care Services	COVID Frontline Worker (Basic Care Support)_V1	4	Provide basic care and support to the COVID patients. Ability to work with basic equipment like Oxygen Concentrator ,Cylinder, Nebuliser etc. Key responsibilities are mapped to the competencies required by a General Duty Assistant. Class X. Crash Course during Covid pandemic	Demand is Situation based. Lessons learnt over the last two years, basic care duties have massive demand and can reduce burden on the other trained staff. Recommended.
Allied Health and Paramedics	Patient Care Services	COVID Frontline Worker (Home Care Support)_V1	3	Provides assistance to COVID patients with diverse needs in carrying out their daily living activities. Ability to work with basic equipment like Oxygen Concentrator ,Cylinder, Nebuliser etc. Key responsibilities are mapped to the competencies required by a Home Health Aide. Class X. Crash Course during Covid pandemic Should possess cooking, driving and house keeping skills preferably.	Specialised care will always be required in any pandemic which invariably paralyses the entire health care system and puts tremendous pressure on the health care facilities. Demand is situation based. May be considered
Allied Health and Paramedics	Non Direct Care	Dietetic Aide_v2	3	Works under the supervision of a registered Dietician. Prepares and serves meals to patients with specific dietary regulations and food handling practices. Class	Excellent cooking abilities and ability to operate kitchen equipment. Enhances the employability at places where special meals are required to be delivered. Recommended

				10th.	
Allied Health and Paramedics	Non Direct Care	Medical Records Assistant_v2	4	Compiles, process and maintains medical records of the patients in a manner which meets the medical, administrative, ethical , legal and regulatory requirements of the health care system following the latest coding systems and standards. Class XII(Science)	Responsible and dignified job role. IT skills, being conversant with filing and standards of the industry requires one to keep abreast with the latest technology and applications. Requires constant upskilling due to evolving technology. Highly Recommended.
Allied Health and Paramedics	Non-Direct Care	Medical Equipment Technology Assistant	4	Commonly referred to as Medical Equipment repairers in the health care industry. Also known as biomedical equipment assistants. They adjust and repair machines by using tools and computer applications.Class X and I.T.I diploma with three years experience or any other diploma in technical/electonic repairs	Aptitude based. Demanding job both physically and mentally. Training investments are more and limited scope with specific types of machines which face redundancy in quick times .May be considered.
Allied Health and Paramedics	Non-Direct Care	Diabetes Educator	5	A health professional who educates and supports people affected by diabetes to understand and manage the condition. They promote self management to achieve individualised behaviour and treatment goals. Graduate in Public Health, Nutrition, Pharmacology, Occupational Therapy etc.	Job role with demand in urban areas, the training and education required would continue even beyond 19 years of age to make the trainee employable for the job.Recommended.

Allied Health and Paramedics	Non Direct Care	COVID Frontline Worker (Medical Equipment Support)_V1	4	Individuals on this job require to use various medical equipment needed during COVID management such as ventilators, BIPAP and CPAP, Oxygen Equipment, Digital thermometer, Flowmeter, Humidifier, BP Equipment etc. They are responsible for repair and maintenance of machines by using tools and computer applications. Class X and I.T.I diploma with three years experience or any other diploma in technical/electronic repairs. Crash Course.	Though it remains a situational and circumstance based course, skills attained to use basic medical equipment may be utilised for later support functions by imparting a certified course on Medical Equipment Technology. May be considered
Allied Health and Paramedics	Non Direct Care	COVID Frontline Worker (Advanced Care Support)_V1	4	Responsible for providing assistance in implementation of nursing care plan as per COVID protocols. Ability to work with basic equipment like Oxygen Concentrator ,Cylinder, Nebuliser etc. Key responsibilities are mapped to the competencies required by a General Duty Assistant-Advanced. Crash Course	Same as above. May be considered
Allied Health and Paramedics	Non direct Care	Geriatric Care Assistant	4	Provides routine individualised care to geriatrics and assist other health care providers in old age homes etc. Cooking, driving and housekeeping skills preferable. English speaking with soft skills preferable. Class XII preferably Biology, or ANM certificate, or certificate -NSQF(Home Health Aide or General Duty Assistant with one to two years' experience	With a growing percentage of old population and emergence of nuclear families, geriatric care will see a surge- be at home or any other health care facility. A useful and recommended training with wide avenues for employment. Highly Recommended

Allied Health and Paramedics	Non Direct Care	Hospital Front Desk Coordinator	4	Are the first contact point in healthcare organisations encountered by the patients and visitors. Assist in coordination at Front Desk at Healthcare facility. Class XII th. Good Communication skills and computer savvy.	Highly empowering job role with a wide scope of employability in various sectors other than health too like receptionists, call centre and CRM etc.Highly recommended.
Healthcare Management	Hospital Administration	Patient Relations Associate	5	Responsible for counselling, assisting and supporting patients and visitors as per their needs along with effectively managing front desk services in a healthcare set up without giving any opinions/ assurances on clinical matters. Good communication and inter personal skills. Graduate in any stream or Certificate - NSQF -Hospital Front Desk Coordinator	Only preliminary and basic training can be imparted as the job role requires a graduation degree. May function as patient companions in the initial period. Out of purview for the considered age group.
Allied Health and Paramedics	Non Direct Care	Assistant Duty Manager – Patient Relations Service	6	Supervises front desk activities. Implements the defined process laid down effective management of hospital front desk activities and guides and monitors concerned staff.Basic knowledge of computer system. Graduate in any stream with one to two years in administration role.	Initial training in computers and communication skills can be given in the age group of 16-19 yrs.However job profile requires higher qualification and experience for induction.Out of purview of age group being considered.
Allied Health and Paramedics	Non Direct Care	Duty Manager – Patient Relation services	7	Oversee and manage patient care services departments. Involved on planning,organising, directing and controlling related resources at front Desk. Acts individually to manage crisis, interpret policy and make timely decisions. Graduate with two to three years of experience	With preliminary and basic training ,the trainee may function as patient facilitator in the initial period.However,higher qualification and experience required for the job role which renders it out of purview for 16-19yrs age group.

Healthcare Management	Healthcare Administration	Pradhan Mantri Arogya Mitra _v2	3	Primary contact for the beneficiaries at every empanelled health care service centre. PMAM shall be responsible to operate the Beneficiary Identification System to identify and verify the beneficiary entitled under Ayushman Bharat. Good Communication skills in English/ Hindi and local language. Class XII with one year experience .Basic Computer knowledge.	Akin to a Desk Entry Operator involving work within defined limit. However,such skill set permits working in different office settings and can be employable in other sectors too. Highly recommended
Healthcare Management	Healthcare Administration	Healthcare Quality Assurance Manager	6	Ensures that healthcare organisation gets the right guidance to implement quality accreditations/ certification standards and healthcare personnel are quided to follow quality parameters at all times.Medical Graduate(MBBS/BAMS/BHMS/BUMS) with three to five yers of experience or Graduate9 BDS/Nursing/ Allied Health Professionals. Minimum 25 yrs.	Requires highly specialised knowledge, inter personal communication skills. Highly transferable skill sets. Out of the purview of the adolescent girls age group.
Allied Health and Paramedics	Non direct Care	Central Sterile Service Department (CSSD) Assistant	4	Responsible for functions of decontamination, assembly and sterile processing , sterile storage and distribution. Class XII with Science	Knowledge based job profile with requirement in all health care facilities. May be considered.
Social Work and Community Health	Environmental Health Services	Sanitary Health Aide	3	They manage health and sanitation aspects in a variety of organisations and in the community. Also implement evidence based public health practices across a number of establishments. Class X	A safai karamchari, menial in nature, would attract only certain section of the society. May find few takers. Not recommended.
Allied Health and Paramedics	Counselling	Diabetes Assistant	4	Works in direct coordinator with Diabetes Educator in developing a comprehensive ,cost effective Diabetes Self Management plan for individuals suffering form diabetes and diabetic symptoms. Impart understanding of the effects of healthy behaviour and lifestyle on	Wide spread disease, awareness and counselling in demand and impactful . Information education and communication is the most important aspect for the prevention and management of diabetes. Done personally may have better outcomes. Employability is high in health care facilities. Highly Recommended

				acute and chronic problems related to diabetes. 12th with Science or Home Science Minimum age 18 yrs well versed with English and IT skills	

Annexure II
(Refer to para 32 of the internship report)

QUESTIONNAIRE FOR THE BLOCK LEVEL OFFICERS

1	District under which posted?
2	Taluka Name
3	Taluka Number
4	Is there a Nodal Officer nominated for RKSK in your Taluka
5	Number of PHCs covered under the Taluka
6	No. of ASHAs reporting to the Taluka-office
7	No. of ANMs reporting to the Taluka-office
8	No of ANMs trained in FY
9	No of AFHCs functioning in the Taluka
10	Has the MO been trained on AFHS
11	No of adolescents who attended the clinic in last three months
12	No of Peer Educators trained in Taluka
13	No of AHD held in the FY in Taluka
14	No of AFC meetings held in FY in Taluka
15	Total Number of adolescents covered under WIFS(in and out of school)
16	Total Number of adolescents girls covered under MHS
17	How are sanitary napkins are procured for the adolescent girls ?
18	No of Schools implementing School Health Programme (SHP) Activities
19	Does the schools implementing SHP have Health and Wellness Ambassadors nominated?
20	No of DCAH meetings held in FY
21	Any convergence meetings between departments held? If yes, then mention department
22	Are you able to utilize entire budget allocation for the programme?
23	Are incentives to ASHAs being provided for their contributions?
24	Has any NGO being selected for the implementation of programme?
25	Any other remarks or suggestions

Annexure III
(Refer to para 37 of the internship report)

Health care Systems across the world

Healthcare in the USA

The USA does not have a universal, free healthcare program, unlike most other developed countries. Instead, in line with the free-market-virtue mindset, most Americans are served by a mix of publicly and privately funded programs and healthcare systems.

Most hospitals and clinics are privately owned, with about 60% being non-profits, and another fifth being for-profit facilities. Coverage by federal and state programs is partial, and most insured Americans have employment-based private insurance. Group plans funded by the employer cover about 150 million Americans.

Private insurance

These include health maintenance organizations (HMOs), which are networks of providers. Insured patients see a primary care physician (PCP), whose refers them to a specialist if necessary.

A more popular option is to use preferred provider organizations (PPOs), which allow patients to see external providers, choose their PCPs, and see a specialist without a PCP referral provided the former is willing. These are now used by over 55% of insured employees, compared to 25% in HMOs or point-of-service (POS) plans. With POS plans, patients must have a PCP in the provider network, but can go out of the network for a fee.

Federal insurance

The Indian Health Services and Veteran Health Administration provide care for Native Americans and military veterans, respectively. The Military Health System, operated by the Department of Defense, provides paid care to serving military personnel.

Publicly funded insurance

Public spending accounts for at least half of all healthcare expenditure, while third-party payers pay only 27%.

About a third of the population is covered by three publicly funded programs – Medicare, for people above 65 years and some disabled people, Medicaid, for those living in poverty. and the Children's Health Insurance programs, which cover children from families that are not eligible for Medicaid, at above 300 percent of the Federal Poverty Level (FPL).

The ACA act of 2010 ("Obamacare'), which was enacted in 2010, revamped health insurance. It created health insurance marketplaces, which cover about 17 million

Americans. However, these plans are often small, exclusive, and restricted in provider choice.

At the same time, the expansion of Medicaid under the ACA act has possibly saved many lives at less than $900,000 per life saved, vs $7.6 million under other public insurance plans.

The good and the bad

Among 11 high-income countries, the US healthcare system is the most expensive, with 17% of the GDP being spent on healthcare in 2018. Many American health indicators far surpass world standards.

Its rate of specialized scans (computerized tomography – CT – and MRI) – are among the highest in the world, at double the OECD average. So is its utilization of hip replacements, influenza vaccines, and breast cancer screenings.

However, among developed countries, the American system is among the least accessible, efficient and equitable. The number of physicians, and rate of physician visits, is among the lowest. Ethnic and disadvantaged social groups suffer massive inequalities.

About 14% of Americans (over 27 million) were uninsured against illness at the end of 2018, causing an estimated 60,000 avoidable deaths. High medical costs have led to bankruptcy for a fourth of senior citizens, says an earlier study.

Preventable and lifestyle conditions such as obesity, hypertension and diabetes are rampant: this indicates poor access to primary care and primary prevention of disease, compared to its peers.

Overall, the US healthcare system allows providers to inflate prices and expensive services, but poorly compensates essential services such as primary care and behavioural advice. It also draws healthcare services away from rural and poor communities.

Nonetheless, the US leads in medical innovation, boasting many of the world's leading hospitals. For those who can pay, it provides high-quality care.

UK healthcare system

The UK healthcare system covers the whole population via the National Health System (NHS), which is 79% publicly financed from taxes, and operated by the Department of Health. About 20% is paid for by national insurance, and private patients and co payments make up the rest.

NHS England supervises and funds local Clinical Commissioning Groups. These provide comprehensive care, including preventive screening programs and vaccinations, inpatient and outpatient care in hospitals, maternity care, mental health care and palliative care.

Like the USA, the UK has public, private profit and non-profit hospitals. The first type is operated as hospital trusts or foundation trusts, in three tiers: community hospitals, district hospitals, and regional-level hospitals. Dedicated hospitals offer specialized treatment.

General practitioners (GPs) offer primary care to locals through their practices. Many such practices are overtaxed: one alternative is registration-free walk-in centres. GPs refer patients as necessary for secondary care.

All residents of England, as well as anyone with a European Health Insurance Card, are entitled to NHS care: primary care is mostly free. Others receive emergency or infection-selective treatment.

Patients in the NHS can choose a hospital and specialist. Currently, 12% of the population also opts for private health insurance, mainly to avoid the waiting period for elective care, to have a choice of specialists, and better facilities.

Private hospitals typically offer specialized treatments, such as bariatric surgery, and do not offer trauma care, emergency services or intensive care.

The UK spends about a tenth of its GDP on healthcare, with almost 80% being spent on the NHS. Unlike the American healthcare system, the NHS's administrative spending is only 16% of healthcare costs.

The good and the bad

Universal free healthcare is widely considered to be good for the country, health-wise as well as economically.

The UK NHS provides free healthcare for all and higher life expectancy than in the USA, at half the cost. Patient satisfaction is relatively high, at 61%, compared to 29% in the US.

Taxes for healthcare may appear higher but are actually equivalent to the total medical expenses in the US. Moreover, drugs are cheaper, and there are no surprise medical costs.

Austerity cuts have led to a reluctance to recruit staff and to upgrade equipment, which may eventually affect the quality of care. Waiting times for consultations and surgeries are long.

A third issue is health tourism, where non-residents exploit the NHS to get high-quality medical care at a lower cost than is available where they live, but without a corresponding contribution through taxes. Ethnic minorities and the poor face inequality in the healthcare system. Social care measures need to be implemented.

Healthcare in the European Union

Each country in the EU has its own healthcare system. However, EU members generally share the same goal as the UK model. All healthcare systems in Europe automatically

include all citizens irrespective of paying capacity. Secondly, all are mostly funded by taxes paid by the employer and by the public. Healthcare is free, except for some elective and specialist services.

Three models

There are fundamentally three models at work within the EU: single-payer, socialized, and privatized-regulated.

In a single-payer system, the government provides universal insurance or coverage, but the actual care is by private practices and hospitals.

Individuals may opt for additional private insurance to cover services that are not covered by public healthcare, but not for those already available. The payment for such providers may be fee-for-service, or capitation, based on the number of patients enrolled.

More recently, lump-sum payments have been adopted to cover all services per year per person enrolled. However, fee-for-service tends to encourage excessive use of manpower and capital resources.

Hospital funds are allocated as diagnosis-related groups (DRGs), per-diem, or as lump-sum payments for all services.

The socialized system is one where the government both provides insurance and runs the hospitals. It is thus the only health insurance provider. The NHS is a version of this model, which is also used in France, Italy, Norway and Sweden.

Patients may opt for supplemental private insurance, to get services not supplied within the public health service, or to see doctors not employed by this service.

France, cited by some as having among the best healthcare systems in the world, has a significant private healthcare system as well as statutory health insurance, offering a wide choice of coverage.

However, recent amendments to the law made it mandatory for employees to pay half of the insurance sponsored by their employers. This is especially so for dental and vision expenses, not covered by the state health insurance.

This system strongly resembles the American Medicare, Medicaid and Veteran Affairs schemes.

The privatized but regulated healthcare systems within the EU are exemplified by Germany. Here, though all citizens earning below a threshold must take health insurance, their unemployed spouses and dependents are also covered without any extra cost.

Above this threshold, employees may buy private insurance. However, other than self-employed and government servants, most people prefer not to.

In Switzerland and the Netherlands, health insurance is mandatory and provided exclusively by private providers. The government subsidizes the premiums through taxes, making it possible for even low-earning citizens to afford health insurance.

All insurers are legally required to accept any applicant. This costs the patient much less than it would in the US, the system is easier to navigate, and the coinsurance is capped at a reasonable ceiling.

Thus, European healthcare provides primary and some secondary medical care, with some places allowing private companies to sponsor more insurance for their employees.

Privatized programs allow for specialized care, cut down the waiting time for a procedure, or expand the patient's choices.

The EU average for healthcare expenditure is about 8% of the GDP, but Cyprus and Latvia are at 3.5%, with other East European nations at 5%. Public spending in this sector typically makes up about 15% of the total government budget.

The good and the bad

Most EU members enjoy the approval of the majority of their people for their healthcare systems, with less than 5% of people in four-fifths of European countries reporting unmet needs.

National health systems tend to control costs better. The introduction of internal markets may increase the healthcare economy and efficiency.

Nonetheless, funding pressures are likely to go up as patients expect more advanced treatments and as technology develops. The graying of Europe may impede fund flows to these programs, given that about 70% of the funding comes from the public sector in most countries.

At the same time, aging is associated with different patterns of disease, typically conditions that are both preventable and care-intensive. As age increases, however, social welfare tends to absorb more of the costs.Inequalities in health status and inequity in healthcare finance and delivery continue to plague the system in many EU nations.

Healthcare systems in Asia

Asian healthcare systems are a mélange of public and privately managed programs.

Singapore

Singapore uses the 3Ms system: a public statutory insurance system, MediShield Life for large hospital bills, and some high-end outpatient treatments as well, but not primary care, or specialist care at the outpatient level.

The premiums are subsidized to help even low-earning people to pay them, and working-age people pay more to allow older people to enjoy lower premiums.

A compulsory national health savings account called MediSave helps pay for hospital care and some outpatient treatments. MediFund is a social welfare program for poor citizens who cannot pay for out-of-pocket expenses even with MediSave.

Thus, the government, healthcare providers, and patients all share the responsibility for healthcare coverage – a multipayer financing system. While competition and market forces enhance the quality of healthcare, the government strictly regulates the costs when they begin to rise beyond affordable rates.

The Ministry of Health also plans for workforce strength, training and land allotment for healthcare facilities, along with preventive health interventions. The system's centralized nature keeps administrative costs low and simplifies procedures.

Singapore spends about 4.5% of its GDP on healthcare, about 40% by the government, with 30% being out-of-pocket expenses.

China

China has almost universal publicly funded medical insurance, with urban employees enrolled in employment-based programs. Others enroll voluntarily, for basic subsidized medical insurance. Comprehensive healthcare is covered, but deductibles and copayments apply. There is also a ceiling on reimbursement.

For-profit private insurance is also available for services not covered by public insurance. Patients share costs for physician visits, inpatient care and prescription drugs, which are uncapped.

China spends about 6.6% of its GDP on healthcare, with 28% being funded by central and local governments, 28% out-of-pocket, and 44% by public or private insurance, and social health donations. These form part of a medical assistance program for the poor.

Wide inequalities in public health services have been reported. Most residents feel that their insurance is as helpful, at least, as the basic public health services.

India

India provides universal free outpatient and inpatient care at government clinics and hospitals. States are in charge of organizing their healthcare services.

However, government facilities are notoriously understaffed and ill-equipped, so that most people pay out-of-pocket for private healthcare. The National Health Protection Scheme (Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana, or PM-JAY) was recently launched to attempt to address this: it supersedes the earlier under-performing National Health Insurance Program (Rashtriya Swasthya Bima Yojana, or RSBY).

The PM-JAY program is financed by taxes and enables free secondary and tertiary care at private hospitals. PM-JAY envisages grassroots Health and Wellness Centers while providing cashless hospital care for the 40% of people (approximately 100 million) who live below the poverty line.

Government workers and most formal employees have their own health insurance schemes. A few private health insurance providers also exist, with limited uptake. Less than 40% of Indians are insured.

The situation is worsened by the poor quality of public healthcare services and the shortage of doctors and equipment. Corruption, as in many developing countries, along with accessibility issues, exacerbates these drawbacks.

India spends less than 4% of its GDP on healthcare, with a quarter being funded by the public sector. Out-of-pocket payments at private hospitals make up 75% of the total expenditure, in stark contrast to other poor countries.

Healthcare systems in Australia

Australia has a tax-funded universal free public health insurance program, called Medicare. All citizens get free care for public and many physician services and drugs at public hospitals.

About 50% of Australian citizens also take out private insurance to pay for private hospital care or dental care. This is encouraged by the government, and high-income families pay a tax penalty for not buying private insurance.

The total expenditure on healthcare is about 10% of GDP, with 67% being from the public sector. It is jointly run by federal, state and territorial governments, and is among the best in the world.

Pros and cons

While free universal care is an undoubted advantage, funding may be challenging as the population ages, reducing tax inflow. Meanwhile, medical technology costs go up, making it difficult to keep up.

There is a disparity in access and care quality between the non-indigenous and the aboriginal population. Research is not well-aligned with national priorities. Urbanization continues to pose an obstacle to healthy living.mics of Healthcare Will

Healthcare systems in South America

While medical services tend to be cheaper here, they are also universal and publicly funded in countries like Chile and Columbia. As a result, medical tourism has boomed in these places.

Healthcare systems have progressed since the time when only employees in the formal labor market received public health insurance, to which employers, employees and government contributed.

The rest of the people relied on fragmentary services by the Ministry of Health, the church, and charitable or philanthropic organizations. The rich had private health care. The poor had almost nothing.

Colombia

Colombia is a success story in South American healthcare. It covers almost 97% of its population by mandatory universal health insurance. All citizens have access to the same healthcare services, with only 14% out-of-pocket spending. This is lower than that in many OECD countries.

The health system is financed through taxes and employment insurance and fully subsidizes the poor. Both public and private insurers are involved, and providers also belong to both public and private sectors, with a healthy competition between the two.

The FOSYGA; Solidarity and Guarantee Fund, is based on cross-subsidies between rich and poor, young and old, and healthy vs sick.

Participants may choose their provider within their network, and receive a package of primary care, some inpatient care, and emergency care, as well as inpatient care at tertiary level public hospitals. Eventually, the government hopes to eliminate supply-side subsidies and provide uniform coverage for all.

Performance management, accountability and efficiency need to be improved to build on these gains.

Chile

Chile has statutory health insurance for workers, with no employer or government contribution. The health funds are managed by ISAPREs (Social Security Health Institutions).

The rest of the population is covered by a public fund manager, the National Health Fund (FONASA). These cover healthcare payments.

Brazil

Brazil has a government-run universal comprehensive public health system, funded by taxes at federal, state and municipality level. While the federal contribution is about 43% of total public health expenditure, municipalities contribute almost a third.

The system covers all types of healthcare for all citizens and visitors. However, wait times are unreasonably long at all stages, leading to out-of-pocket spending for basic care, while the delays push up treatment costs.

Drug unavailability leads to out-of-pocket spending. About a quarter of people have private health insurance, typically as an employment benefit.

National health expenditure is about 9% of the GDP. Most hospitals are public.

Costa Rica

Costa Rica also has a successful healthcare system, under a single-payer model that combines social security with the medical services offered by the Ministry of Health. About 86% of the population has access to high-quality comprehensive care, which is delivered free. The rest are able to pay for care.

Argentina

Argentina has a healthcare system whereby insurance is provided and managed chiefly by workers' unions, while over a third of the population is uninsured and depend on public healthcare.

The good and the bad

South American healthcare systems suffer from poor resources, which are badly distributed to cover some areas. The capacity of the systems is low, and drug shortages are common. Corruption vitiates the process of official appointment and hampers reforms.

Healthcare systems in Africa

Sub-Saharan Africa has 13% of the world's population but carries a fourth of the world's disease burden. However, it spends only 1% of the global health expenditure.

Three out of four Africans have a per capita income of below $2 a day, and almost half spend less than $1 a day. Universal free healthcare is a right that is agreed to by all but is slow to become a reality.

Most Africans that are either low or middle-income turn to the public health system or to traditional healers. Only a few are able to afford high-quality private care, but nonetheless, out-of-pocket expenditures are bound to be high in this two-tier system.

Private spending accounts for 60% of all payments on healthcare. However, half of private healthcare expenditure is spent on private providers, and 40% of the lowest-income people in Africa pay for care from for-profit providers.

In Rwanda, national health insurance covers over 90% of the population, whereas less than 9% are covered in other countries.

Ghana has a National Health Insurance Scheme (NHIS), and built a public-private partnership network to reach areas without public health services. Funded through taxation, the NHIS covers most common diseases.

All residents must enrol and pay an annual premium, in return for free care. About a quarter lack any insurance, however. Almost 70% of those insured do not have to pay premiums, and underfunding challenges the working of the scheme.

In Kenya, a similar national health insurance program exists, for salaried employees, and for self-employed if they want to enrol. However, even this cost is inaccessible to most citizens.

So is the case with Tanzania, with its NHIF and CHF, for civil servants who pay 6% of their income, and for indigents and low-income people. In fact, most African countries share this situation, and national free healthcare accessible to those living in poverty is still a pipe dream.

Many countries spend only donor money on healthcare. Many times, international loans intended to improve the healthcare infrastructure had many strings attached. As a result, user fees were imposed on primary care. Drug pricing went up. Preventive and primary care was put out of reach of most low-income Africans.

Medicine became commercialized and privatized, and inequalities became more unequal. Infectious diseases like HIV emerged again. Government spending on health was cut due to required austerity measures.

Vacancies in the public sector increased, worsened by a freeze on recruitment and the flight of health professionals outside Africa. Most physicians went into private practice in urban areas, serving about 15% of the population. Drug shortages were endemic and intractable.

Cumbersome bureaucracy at all levels, inadequate coverage by insurance, low benefits for inpatient care, lack of transparency, and poor accountability, are the chief features of African health systems, in general.

This is worsened by the outflow of doctors to the US and other more lucrative and functional locations, and by ignoring the unique conditions of Africa in favour of western theories and policies. Poor sanitation and potable water facilities contribute greatly to this scenario.

Only six African countries spend 15% of their budgets on healthcare, and these are yet to achieve universal access to reasonable-quality healthcare.

The features that make for a good one include long-term investments in human resources and infrastructure, and in primary care (as in Israel). A Nordic focus on preventive care to improve population health and build capacity is important.

Public funding to allow the poorest to access healthcare and medication is an excellent model to follow, as in many Commonwealth and EU systems. Patient and community engagement, with an innovative streak, and a rapid response, is essential for maximizing coverage, like Rwanda and India.

Due investment in information technology and in research and development are key to making healthcare systems more accessible and improving health outcomes.

Lastly, attention to aged care, as in Japan, and to mental well-being, a mark of the Australian system, along with providing a choice of providers and services to the patient, seen in France, are fundamental to a healthcare system that follows best practices.

Annexure IV
(Refer to para 42 of the internship report)

AB-HWC- Expanded Range of Services

Introduction

1. Ayushman Bharat (AB) is an attempt to move from a selective approach to health care to deliver comprehensive range of services spanning preventive, promotive, curative, rehabilitative and palliative care. It has two components which are complementary to each other. Under its first component, 1,50,000 Health & Wellness Centres (HWCs) will be created to deliver Comprehensive Primary Health Care, that is universal and free to users, with a focus on wellness and the delivery of an expanded range of services closer to the community. The second component is the Pradhan Mantri Jan Arogya Yojana (PM-JAY) which provides health insurance cover of Rs. 5 lakhs per year to over 10 crore poor and vulnerable families for seeking secondary and tertiary care.

Expanded range of services

2. The expansion of services has been planned in incremental manner. As a first step, Screening, Prevention, Control and Management of Non-communicable Diseases and Chronic Communicable diseases like Tuberculosis and Leprosy has been introduced at HWCs.

a. Care in pregnancy and childbirth.
b. Neonatal and infant health care services
c. Childhood and adolescent health care services.
d. Family planning, Contraceptive services and Other Reproductive Health Care services
e. Management of Communicable diseases: National Health Programs
f. Management of Common Communicable Diseases and General Out-patient care for acute simple illnesses and minor ailments
g. Screening, Prevention, Control and Management of Non-Communicable diseases and chronic communicable disease like TB and Leprosy
h. Basic Oral health care
j. Care for Common Ophthalmic and ENT problems
k. Elderly and Palliative health care services
l. Emergency Medical Services
m. Screening and Basic management of Mental health ailment

3. Challenges

a. Inadequate health budget
b. Lack of the required human resources especially in rural areas
c. Recruitment of the required number of health workers
d. Upgrading of infrastructure.
e. Transforming a Sub centres to a HWC more challenging compared to transforming a PHC into a HWC.
f. Development and implementation of the IT system.
g. Pathways for follow-up treatment after primary care is delivered at the HWCs

4. **Opportunities**

a. Expansion of Primary Health Care to CPHC
b. Upgradation of Infrastructure
c. Employment Opportunities
d. Fostering Partnerships
e. Inter-Sectoral Convergence
f. Improved Knowledge and Awareness
g. Research Opportunities
h. Monetary Gains

5. **Recommendations for the roll out of the expanded package of services at all functional AB-HWCs**:

a. **Basic training to the CHOs –** to facilitate early detection and timely referral for mental health conditions and critical conditions of eye and ENT.

b. **Expand pool of trainers for each cadre- ASHA, ASHA Facilitator, MPW-F/M, CHO/Staff Nurse/MO**

c. **Revised Community Based Assessment Checklists** to be provided to the AB-HWCs- and team training

d. The **AB-HWCs App to be downloaded** by all CHOs for entering service delivery and wellness related activities. **Facilitate JAS formation -** Roll out training for the members; NHSRC to support training

d. Ensure that the **Citizens Charter at AB-HWCs is updated as services are added on**.

e. Display the list of essential medicines and diagnostics/Teleconsultation hours

f. Strengthen VHSNC and MAS- leverage resources from PRI/ULB

g. **Ensure Teleconsultation services at the AB-HWCs**

h. Ensure **Laptops/Desktops** with cameras and internet connectivity

j. Identification and **linkages** with the hubs, **defined calendar** for specialist consultations

k. **Train** CHO, Staff Nurse and MO in use and the necessity of follow up

l. Strengthen the HWC team at HWC- SHC to **generate awareness and facilitate** delivery of existing and newer packages (Specific focus on essential services)

m. Empower CHO to lead the HWC-SHC team – mentoring and support- PHC-MO, District level

n. Medical Officers of PHCs to be supported and mentored to take ownership of the population in their coverage area

o. Strengthen monitoring and support to HWC teams at both levels – leverage medical colleges, public health institutions, NGOs