Speed Post

भारत सरकार
स्वास्थ्य एवं परिवार कल्याण मंत्रालय
निर्माण भवन, नई दिल्ली – 110011
Government of India
Ministry of Health & Family Welfare
Nirman Bhavan, New Delhi - 110011

सत्यमेव जयते

Manoj Jhalani, IAS
Joint Secretary
Telefax : 23063687
E-mail : manoj.jhalani@nic.in

Pic. Issue 12/2/2015

72 letters.

स्वास्थ्य एवं परिवार कल्याण मंत्रालय जारी किया 12 FEB 2015 ISSUED MINISTRY OF HEALTH & F.W.

D.O. Z-15015/11/2015-NRHM-I
Dated the 11th February, 2015

Dear Colleague,

You are aware that moving towards Universal Health Coverage (UHC) is a key goal of 12th Plan and the country has already charted a path that depends largely on provision of affordable, quality health care by the public health system as its main form of social protection.

Provision of Comprehensive Primary Healthcare is an integral and pivotal part of UHC and there is a felt need of generating evidence to evolve innovative solutions for strengthening the Primary Healthcare. In this context, a concept note on piloting HWC to provide comprehensive primary health care is enclosed. You may like to prioritise this pilot intervention in your States/UTs and can propose for the same in PIP 2015-16. The detailed operational guidelines in this regard will be shared shortly.

With regards,

Yours sincerely

(Manoj Jhalani)

O/C

Principal Secretary,
Health and Family Welfare (All States/UTs)

Copy to: Mission Director, National Health Mission (All States/UTs)

Towards UHC: Piloting Health and Wellness Centres to provide Comprehensive Primary Health Care

Part A: Background

1. Comprehensive Primary Health care includes the delivery of a package of preventive, promotive, curative and rehabilitative services delivered close to communities by health care providers that are sensitive, have an understanding of local health needs, cultural traditions and socio economic realities, and are able to provide care for most common ailments, enable referral for doctor or specialist consultations and can undertake follow-up.

2. This objective of the pilot is to provide comprehensive primary health care through strengthening of existing sub centres and sector level primary health centers in a block to Health and Wellness Centres linked to a block PHC. The Health and Wellness centres would have as their first point of referral the block PHC, which would have HR on the lines of what is defined in the IPHS standards.

3. This will be done through incremental addition of human resources to deliver the set of services (listed below), corresponding increase in infrastructure, ensuring drugs and supplies, skill building, establishing effective information systems for monitoring progress (on three fronts: service use, health outcomes, and out of pocket expenses on health care), use of standard treatment guidelines, performance measurement, and a reliable referral mechanism to ensure continuum of care.

4. Several of the activities in the proposed pilot are linked to systems at district and state level including financing. After the experience of the first year the state should be able to put in place a form of financing that is responsive to caseloads and needs. (Details for designing a fund flow mechanism are provided in the section below). In order to ensure free drugs and diagnostics, the state will have to ensure a state level system for procurement, distribution, logistics and quality assurance- that allows supply chain management to be responsive to changing and diverse patterns of consumption of consumables across facilities.

5. Since this is a pilot intended to scale up it is important to study the model, processes and outcomes as well as contextual variations seen during the

implementation phase. Technical assistance will be needed and the state could use eminent research organizations (anchored in the SHSRC, where SHSRCs exist), development partners, eminent NGOs and NHSRC. NHSRC would further provide technical support in terms of documenting process, sharing guidelines and support in operationalizing the pilot Health and Wellness Centres, based on the National Task Force recommendations to strengthen primary health care.

Part B: Key components of the pilot

1. Objective: The main objective of the pilot intervention is to assess the work processes, human resources and other associated requirements of converting existing sub centres to Health and Wellness centres as part to provide comprehensive primary health care through outreach and outpatient services, in preparation for scale up as a step towards achieving Universal Health Coverage.

2. Activities:

2.1 Strengthen the sub health center as a Health and Wellness centre to deliver a package of comprehensive primary health care services listed below. The first point of referral for such a centre would be a 24/7 block PHC. The block PHC and the Health and Wellness Centres should provide the package of comprehensive primary health care for the population and have effective linkages to the CHC and District Hospital for speciality consultation. .

(i) Comprehensive maternal health care services- delivery services to be provided in those sites equipped to serve as "delivery points"
(ii) Comprehensive neonatal and infant health care services
(iii) Comprehensive childhood and adolescent health care services
(iv) Comprehensive contraceptive services
(v) Comprehensive reproductive health care services
(vi) Comprehensive management of communicable diseases-
(vii) Comprehensive management of non-communicable diseases
(viii) Basic ophthalmic care services
(ix) Basic ENT care services
(x) Screening and basic management of mental health ailments

(xi) Basic dental health care

(xii) Basic geriatric health care services

The services listed from (i) through (v) are already being provided. Some aspects of these services would need to be strengthened. Care for Communicable diseases is being undertaken under vertical disease control programmes, although this will need coordination as to the services being provided at the sub centre and how it links to higher level facilities. NCD is one area which accounts for a major burden of disease and health care costs. The other services can be phased in gradually, prioritizing those which cause higher morbidity.

2.2 Put in place a team of mid-level provider (e.g AYUSH), one ANM, one male multipurpose worker and ASHAs belonging to the villages of the sub centre area. Develop a plan for the organization of services and a corresponding to this a skill development plan to enable the team to deliver the services as listed in 2.1. States can recruit the additional staff as per national guidelines.

2.3 Put in place an IT platform that enables the team to record the services provided, to provide continuity of care across time and across levels, to perform population based analytics and to enable monitoring. The actual burden of recording and register work for the expanded basket of services should be measurably less than for the current package of services by ensuring that register work is not an added on layer but integrated into the work process itself. GOI will facilitate the process.

2.4 In terms of geographical access, health and wellness centres should be within reach of the population –for e.g, within a thirty minute walking distance.

2.5 Financing: The detailed indicative budget is at Annexure 1.
The incremental support needed to provide the additional services in the package is budgeted at Rs. 14, 69,284. Other existing costs [HR: Rs. 8, 16,000 and untied fund of Rs. 20,000 (As per guidelines)] would remain the same. In addition a 20% overhead to the budget (Rs.4,61,056) could be added to support TA and baseline studies. This would bring it to a total of Rs. 2766340 per sub centre. This does not include expenditure on drugs and supplies, (including) diagnostics and on emergency transport to be allocated from district level, based on existing needs (will need real time data).

2.6 Enable family folders and an individual health card through the ASHA who also informs the family of what services the centre offers and who the members of the primary care team is. The Health and Wellness Centre team will have a record of the family health cards. A digital format would be implemented depending on the state of readiness so as to facilitate referrals and enable a continuum of care.

2.7 For conditions that require long term treatment, drug supplies must be available at the centres so that patients do not have to travel far from their homes for prescription refills, and the Primary care team can also monitor compliance and provide follow up check-ups and counselling.

2.8 Develop a system for referral and patient transport for secondary care hospitalization using the golden hour thumb rule.

2.9 Develop a strategy for counselling and interpersonal communication at community and facility levels that emphasizes action on social determinants as well as addresses modifiable risk factors. This is a role that will need to engage the VHSNC, ASHA and ANM.

2.10 Undertake a baseline survey to assess morbidity burden and out of pocket expenses.

State may implement such a pilot in a few blocks or districts.

Annexure I

Indicative Activities and Costs per Sub Centres			
S.No	Activity	Indicative Costs (Per annum) in Rs	Remarks
A	**HWC - at Sub centres**		
	Total team/skill mix needed for a population of 5000: one mid-level provider; one ANM; one MPW, 5 ASHA, ANM and MPW will be skilled for basic lab investigations; and mid-level provider can dispense		
1	**Salaries:**		
1.1	One Mid-level Service provider	4,20,000.00	Rs. 20,000/month and Rs. 15,000 /month as performance incentive
1.2	One MPW	1,80,000.00	Rs.15000/month
1.3	Additional Salary For Existing ANM (For additional task envisaged)	43,200.00	20% of salary assuming Rs. 18000/month: 3600
1.4	ASHA Incentive	60,000.00	Five ASHA at addl. Rs. 1000/month
1.5	Team based incentives	85,920.00	At 10% of all salaries. Approximately 40% of salary of contractual staff should be linked to performance; regular staff should not get more than 10% of the team incentive as incentive.
2	**Training**		
2.1	Bridge course/ Training on the Standard Treatment Protocols	80,000.00	
2.2	Multiskilling	20,000.00	

Indicative Activities and Costs per Sub Centres			
S.No	Activity	Indicative Costs (Per annum) in Rs	Remarks
3	**Screening for NCD**	25,000.00	Additional tests for diabetes, Cancer cervix, Oral cancer, etc. calculation: Rs. 10@ 50% of the population (one time mas screening and then follow up for those with the conditions
4	**IEC**	25,000.00	Rs. 5 per capita
5	**Infrastructure Strengthening of SC to HWC**	5,00,000.00	Rs.5 lakhs for an additional room for mid-level service provider.
	Sub total	14,39,120.00	
6	**Independent monitoring costs for performance assessment at 2%**	30,164.80	
	TOTAL	14,69,284.80	

Note: All the above costs are estimates only. State to budget for activities as per their context.