THE ROLE OF ASHA WORKERS IN PROMOTION OF RURAL HEALTH PROGRAMMES IN INDIA

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Abstract

It is the obligation of the state to provide free and universal access to quality health-care services to its citizens. India continues to be among the countries of the world that have a high burden of diseases. The various health programme and policies in the past have not been able to achieve the desired goals and objectives. 65th World Health Assembly in Geneva identified universal health coverage (UHC) as the key imperative for all countries to consolidate the public health advances. Accordingly, Planning Commission of India constituted a high level expert group (HLEG) on UHC in October 2010. HLEG submitted its report in Nov 2011 to Planning Commission on UHC for India by 2022. The recommendations for the provision of UHC pertain to the critical areas such as health financing, health infrastructure, health services norms, skilled human resource, access to medicines and vaccines, management and institutional reforms, and community participation. India faces enormous challenges to achieve UHC by 2022 such as high disease prevalence, issues of gender equality, unregulated and fragmented health-care delivery system, non-availability of adequate skilled human resource, vast social determinants of health, inadequate finances, lack of inter-sectoral co-ordination and various political pull and push of different forces, and interests. These challenges can be met by a paradigm shift in health policies and programs in favour of vulnerable population groups, restructuring of public health cadres, reorientation of undergraduate medical education, more emphasis on public health research, and extensive education campaigns. There are still areas of concern in fulfilling the objectives of achieving UHC by 2022 regarding financing model for health-care delivery, entitlement package, cost of health-care interventions and declining state budgets. However, the Government's commitment to provide adequate finances, recent bold social policy initiatives and enactments such as food security bill, enhanced participation by civil society in all health matters, major initiative by some states such as Tamil Nadu to improve health, water, and sanitation services are good enough reasons for hope that UHC can be achieved by 2022. However, in the absence of sustained financial support, strong political will and leadership, dedicated involvement of all stakeholders and community participation, attainment of UHC by 2022 will remain a Utopia.

Keywords: health-care, universal health coverage, human resource, stakeholders

1. Introduction

It is rightly said that, '*health is wealth*'. Every human being needs proper health to survive in the society and to achieve his desired goals to the fullest extent. If no proper health condition it leads to depression in his/her life. The State duty is to ensure better health programmes in this regard to venture the diseases which may result into ill health in the society. India being a welfare state to guarantee Universal Health Programmes to eradicate dangerous diseases which result into the death of poor and wreaker sections of the society.

Government of India and the State Governments have the general obligation to provide free and universal access to the health-care services and ensure that there shall not be any denial of health-care directly or indirectly to anyone, by any health-care service provider, public or private, by laying down minimum standards and appropriate regulatory mechanism. The 11thPlan health outcome indicators set as time-bound goals for lowering maternal and infant mortality, malnutrition among children, anemia among women and girls, fertility, and raising the child sex ratio have not been fully met. India trails in health outcomes behind Sri Lanka and Bangladesh. The health-care system in the country suffers from inadequate funding, lack of integration between disease control and other social sector programs, suboptimal use of traditional systems of medicines, weak regulatory mechanisms and poor capacity in health management. There are wide interstate disparity and differences between rural and urban indicators of health.

The twelfth plan seeks to provide a safe and healthy environment to communities, delivering universal access to basic health services, and to medicines, and regularly evaluating the health system. It also seeks to make the communities more health conscious by using the techniques of communication, behavior change, and participatory governance.

The 65th World Health Assembly meeting in Geneva identified universal health coverage (UHC) as a key imperative for all countries to consolidate the public health advances. Several countries have been working to reform their health systems during the last few decades. The high level expert group (HLEG) on UHC was constituted by the planning Commission of India in October 2010, with the mandate of developing a frame-work for providing easily accessible and affordable health-care to all Indians. HLEG submitted its report to the planning commission in November 2011. Keeping in view the outcomes of recommendations of previous many other committees, National health policies and programs, whether the recommendations of HLEG will have desired outcomes or remain a Utopia is the moot question to ponder over.

1.1. Health-care

Means testing, treatment, care, procedures, and any other service or intervention toward a therapeutic, nursing, rehabilitative, palliative, convalescent, preventive, diagnostic, research, and/or other health related or combinations thereof, including reproductive health-care and emergency medical treatment, in any system of medicine, and also includes any of these as a result of participation in a medical research program.

Ensuring equitable access for all Indian Citizens, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the Government being the guarantor and enabler, although not necessarily the only provider, of health and related services.

1.2. Health financing

There should be an increase in spending for public procurement of medicines from 0.1% to 0.5% of Gross Domestic Product (GDP). General taxation plus deductions for health-care from salaried individuals and tax-payers as the principal source of health-care financing should be used, and no fees of any kind be levied for the provision of health-care services under UHC. There should be flexibility in central financing to help meet diverse health requirements of states and at least 70% of all health-care spending should go to primary health-care. No

insurance companies or other agencies should be used to the purchase health-care services on behalf of the Government and all Government funded Insurance Schemes should be integrated with the UHC system. Government should an increase public expenditure on health from the current level of 1.2% GDP to at least 2.5% by the end of the 12th plan and to at least 3% of GDP by 2022.

1.3.Health services norms

National Health Package offering essential health services as part of citizen entitlement should be developed and a system of National Health Entitlement Cards to be introduced. Well defined service delivery partnership with Government. As purchaser and private sector as provider under strong regulation, accreditation and supervisory framework should be ensured. The district hospitals network to be strengthened and upgraded for health-care delivery and training. All health facilities to be licensed by 2017 to comply with the latest Indian Public Health Standards. In Urban areas, there is a need to rationalize services and focus on health needs of the poor. It should be ensured that all citizens have an entitlement to the same level of essential health-care strictly adhering to the quality assurance standards.

The empowerment of the rural peoples in various fields lies in the hands of the welfare state. The protection of health of the rural masses is another primordial duty casted upon the government since from its independence. The Constitution of India in its preamble states to secure justice to all citizens irrespective of caste, race, sex, community, religion etc. Justice is not to be denied to any person merely on the grounds of economic incapacity. The rural inhabitants are illiterate and unaware about the health measures to protect them from dangerous diseases. Hence the Government is playing the predominant role in promotion of the rural health programmes to be reached to the door steps of the rural households.

The incidence of maternal mortality rate (MMR) in India highlights the number of mothers dying per 100,000 live births, may be on a decline, still about five women die every hour in India from complications developed during childbirth. According to World Bank data the MMR in India reported in 2015 at 174 per 100,000 live births which is a significant decline from the 215 figure that was reported in 2010.In absolute numbers, nearly 45,000 mothers die due to causes related to childbirth every year that accounts for 17% of such deaths globally.

II.UNIVERSAL HEALTH COVERAGE

The main objective of Universal Health Coverage (UHC) is to provide citizens access to health services without them incurring any financial hardships and being pushed into poverty. Significantly, 70 per cent of healthcare is provided by the private sector in India. Challenges of health coverage in India

The WHO (World Health Organization) theme for the World Health Day (April 7) is "Universal health coverage: everyone, everywhere". The main objective of Universal Health Coverage (UHC) is to provide citizens access to health services without them incurring any financial hardships and being pushed into poverty. WHO and World Bank statistics are it is disheartening. According to their figures, approximately half of the world's 7.3 billion people are not able to obtain the health services they need and they still lack full coverage with essential health services. Every year, countless households are pushed into extreme poverty as a result of expenditure out of an individual's pocket on his health.

Though UHC is one of the 17 Sustainable Development Goals (SDGs) adopted by the United Nations for eliminating poverty, the grassroot scenario in India is bleak. Significantly, 70 per cent of healthcare is provided by the private sector in India. There is a large health disparity between social classes, urban and rural populations and geographical locations. Though India boasts of being the hub of medical tourism in the world, is it able to provide even basic healthcare to the marginalised and vulnerable communities of the country?

The silver lining in this scenario is the contribution of the National Rural Health Mission (NRHM), launched in 2005, in providing accessible, affordable and quality healthcare to the rural population in terms of Reproductive

and Child Health Services. It has, hence, contributed significantly in reducing the Maternal Mortality Rate and Infant Mortality Rate in India.

But this project also brings an array of new challenges.

1. The first challenge (even after 13 years of the launch of the NRHM and subsequent National Health Mission) is the wide disparity in the quality of healthcare services in the public and private sector as regulatory standards are neither established nor enforced properly by the Government of India. Unless strict laws are formulated by the Ministry of Health and Family Welfare (MOHFW) and the Indian Council of Medical Research, the country cannot attain success.

2. Secondly, the issue of quacks and traditional healers treating patients at the grassroot level is a serious concern. This is connected to the poor availability of healthcare services and service providers in rural areas. The government has not formulated any Bill to curb these malpractices. The extent of harm, morbidity and mortality resulting from such treatments is devastating.

3. Thirdly, the non-affordability of healthcare services is a major problem with the vast majority of our people. As a result, they are impoverished because of high out-of-pocket healthcare expenditures. They also suffer the adverse consequences of the poor quality of care. Cases of medical negligence are on the rise; and unethical medical and nursing practices are also resorted to. The recent case of medical negligence of a private hospital in the capital shook the conscience of the nation and is testimony to the fact that even the corporate hospitals too are falliable.

As per the Seventh Schedule of the Constitution, health has been assigned to the state governments. Hence, there is no single model for the country. The MOHFW envisages the basic right to providing universal health coverage for all citizens. It must initiate a massive, propulsive and compulsive propaganda. It should aim to regulate wasteful and preventable healthcare expenditure by developing a system of financing health services, and ensure access to essential medicines and technologies and a galaxy of well-trained and dedicated health workers.

It also encompasses formulating draft guidelines and a healthcare law for medical negligence and patient safety, strict training of medical and nursing graduates with an exit exam or licensing exam (after completion of formal medical and nursing programmes) like in the USA and European countries. All this would help achieve high-quality clinical governance, regulation, safety, and quality benchmarks and most vitally focus on financial cover for health maintenance and establishing community mental health services in a diligent and proactive manner.

III. Indian Constitutional Provisions

The Constitution of India under Part- IV obligates the state to take positive action in certain directions in order to promote the welfare of the people. In one of the case[2] the Supreme Court of India observed that,' the Constitution envisages the establishment of a welfare state at the federal level as well as the state level. In a welfare state the primary duty of the Government is to secure the welfare of the people'.

Article 38(1)[3] directs the state to strive to promote the welfare of the people by securing and protecting as effectively as it may a social order in which justice, social, economic and political, shall inform all the institutions of national life. Article 39[4] imposes obligation on the state to provide and make provision for;

a) adequate means of livelihood,
b) ownership and control of the material resources to be distributed as best to sub serve the common good,

[2] In *Paschim Banga Khet Mazdoor Samity v. State of West Bengal*, AIR 1996, SC 2426
[3] *Article 38* states about Social order based on justice
[4] *Article 39* states that, certain principles of policy to be followed by the state.

c) it does not result in concentration of wealth and means of production to the common detriment.
d) Equal pay for equal work
e) Health and strength of workers, tender age of the children not to be abused
f) Children are given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and childhood and youths are protected against exploitation, against moral and material abandonment.

Article 41 of the Constitution provides for the right to work, education and public assistance in cases of unemployment, old age, sickness and disablement. Duty of the State to raise the level of nutrition and the standard of living and to improve public health The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavour to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health.[5]

IV. Role of rural local bodies in promotion of health

The Tenth Five –Year Plan highlighted the importance of governance for tackling the problems of poverty, backwardness and low human development and pointed out the importance of embarking on a comprehensive governance-related reforms agenda. A multifaceted approach was adopted, with particular emphasis being laid on the implementation of the 73[rd6] and 74[th7] Constitutional amendment Act, 1992, which gave constitutional status to Panchayat Raj Institutions. New Part-IX inserted to the Constitution from articles 243-A-O deals with organisation of Panchayats. Part-IX-A has been introduced from articles 243-P-ZG deals with the constitution of Municipalities.

The Government of Karnataka in pursuant to the 73[rd] and 74[th] Constitutional amendment has enacted the Karnataka Panchayat Raj Act, 1993. The Act enables the Pacnhayats to perform various functions in relation to the rural health as specified in schedules.[8] The protection of public health and family welfare is one of the powers of the panchayats in rural areas. Is is the duty of the Grama Panchayat to promote the health, safety, education, comfort, convenience, social or economic well being of the inhabitants.

The Karnataka Panchayat Raj Amendment Act of 2010 created the post of Panchayat Development Officer.[9]It is the duty of the PDO to take necessary steps to implement the welfare schemes as framed by the government from time to time, prevention and remedial measures against epidemics etc.[10]Taluk Panchayat is empowered for promotion of health and family welfare programmes, promotion of immunisation and vaccination programmes, health and sanitation at fairs and festivals.[11] The programmes relating to women and child development including the promotion of programmes relating to development of women and children, promotion of school health and nutrition programmes and promotion of participation of voluntary organisations in women and child development programmes is also the powers of the Taluk Panchayat under the Act.[12]

The key progress of a country lies in reducing its maternal and child mortality and morbidity. Over the years, the Government of India has taken many initiatives, and the improved health indicators are the result of such initiatives. After the launch of National Rural Health Mission(NHRM) in 2005 the significant improvements have taken place in building the health infrastructure in the country. The now called National Health Mission, is

[5] Article 47 of the Indian Constitution
[6] The 73[rd] Constitutional amendment 1992, states about the establishment of Panchayat Raj System
[7] The 74[th] Constitutional amendment 1992, deals with the municipalities.
[8] Schedule-I of the Karnataka Panchayat Raj Act, 1993 says about the powers of Grama Panchayat, Schedule-II says about the powers of Taluk Panchayat, Schedule –III says about the powers of Zilla Panchayat.
[9] Act No. 24 of 2010, section-2(28-A) inserted by the Act.
[10] Item No XIX of Schedule-I of Karnataka Panchayat Raj Act.
[11] Item no XIX of Schedule-II of the Karnataka Panchayat Raj Act,1993.
[12] Item No XX of Schedule –II of Act.

reflected in progress towards achieving targets for the reduction of Maternal Mortality Rate (MMR), Infant Mortality Rate(IMR), Total fertility Rate(TFR) and other indicators.

V. Roles and responsibilities of ASHA Workers

Accredited social health activists (ASHAs) is community health workers instituted by the government of India's Ministry of Health and Family Welfare (MoHFW) as part of the National Rural Health Mission (NRHM). The mission began in 2005; full implementation was targeted for 2012. Once fully implemented, there is to be "an ASHA in every village" in India, a target that translates into 250,000 ASHAs in 10 states. The grand total number of ASHAs in India was reported in July 2013 to be 870,089. There are 859,331 ASHAs in 32 states and union territories as per the data provided by the states in December 2014. This excludes data from the states of Himachal Pradesh, Goa, Puduchery and Chandigarh, since the selection of ASHA is under way in these states.

ASHAs are local women trained to act as health educators and promoters in their communities. Their tasks include motivating women to give birth in hospitals, bringing children to immunization clinics, encouraging family planning (e.g., surgical sterilization), treating basic illness and injury with first aid, keeping demographic records, and improving village sanitation. ASHAs are also meant to serve as a key communication mechanism between the healthcare system and rural populations.

4.1. Selection

ASHAs must primarily be female residents of the village that they have been selected to serve, who are likely to remain in that village for the foreseeable future. Married, widowed or divorced women are preferred over women who have yet to marry since Indian cultural norms dictate that upon marriage a woman leaves her village and migrates to that of her husband. ASHAs preference for selection is they must have qualified up to 10, preferably is between the ages of 25 and 45, and are selected by and accountable to the gram panchayat (local government). If there is no suitable literate candidate, a semi-literate woman with a formal education lower than eighth standard, may be selected.

4.2. Remuneration

Although ASHAs are considered volunteers, they receive outcome-based remuneration and financial compensation for training days. For example, if an ASHA facilitates an institutional delivery she receives 600 (US$9.30) and the mother receives 1,400 (US$22). ASHAs also receive 150 (US$2.30) for each child completing an immunization session and 150 (US$2.30) for each individual who undergoes family planning. ASHAs are expected to attend a Wednesday meeting at the local primary health centre (PHC); beyond this requirement, the time ASHAs spend on their CHW tasks is relatively flexible.

4.3. Evaluation of ASHA programme in Karnataka under the National Rural Health Mission

The Accredited Social Health Activist (ASHA) programme of the National Rural Health Mission (NRHM) is considered as being vital to achieving the goal of increasing community participation with the health system, and is one of the key components of NRHM, India's flagship programme in health launched in 2005. The problem of evaluating ASHA is compounded by multiple and contesting narratives of what constitutes the legitimate role of an ASHA. The discourse on the ASHA's role centres around three typologies: ASHA as an activist, ASHA as a link worker or facilitator, and ASHA as a community level health care provider. Another problem for evaluation is that the ASHA programme is implemented concurrently with a number of other components of the NRHM such as the *Janani Suraksha Yojana* (JSY) and the emergency transport (108) programme and it is impossible to isolate or attribute outcomes as being due to the ASHA programme alone. Methodologically, there is also no baseline status for comparison after the introduction of the ASHA programme in a classical 'before-and-after' study mode.

The duties of AHSA Workers as follows;

a) ASHA must primarily be a woman resident of the village married/ widowed/ divorced, preferably in the age group of 25 to 45 years.
b) She should be a literate woman with due preference in selection to those who are qualified up to 10 standard wherever they are interested and available in good numbers. This may be relaxed only if no suitable person with this qualification is available.

c) ASHA will be chosen through a rigorous process of selection involving various community groups, self-help groups, Anganwadi Institutions, the Block Nodal officer, District Nodal officer, the village Health Committee and the Gram Sabha.
d) Capacity building of ASHA is being seen as a continuous process. ASHA will have to undergo series of training episodes to acquire the necessary knowledge, skills and confidence for performing her spelled out roles.
e) The ASHAs will receive performance-based incentives for promoting universal immunization, referral and escort services for Reproductive & Child Health (RCH) and other healthcare programmes, and construction of household toilets.
f) Empowered with knowledge and a drug-kit to deliver first-contact healthcare, every ASHA is expected to be a fountainhead of community participation in public health programmes in her village.
g) ASHA will be the first port of call for any health related demands of deprived sections of the population, especially women and children, who find it difficult to access health services.
h) ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services.
i) She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.
j) ASHA will provide information to the community on determinants of health such as nutrition, basic sanitation & hygienic practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health & family welfare services.
k) She will counsel women on birth preparedness, importance of safe delivery, breast-feeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infections (RTIs/STIs) and care of the young child.
l) ASHA will mobilise the community and facilitate them in accessing health and health related services available at the Anganwadi/sub-centre/primary health centers, such as immunisation, Ante Natal Check-up (ANC), Post Natal Check-up supplementary nutrition, sanitation and other services being provided by the government.
m) She will act as a depot older for essential provisions being made available to all habitations like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet(IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.
n) At the village level it is recognised that ASHA cannot function without adequate institutional support. Women's committees (like self-help groups or women's health committees), village Health & Sanitation Committee of the Gram Panchayat, peripheral health workers especially ANMs and Anganwadi workers, and the trainers of ASHA and in-service periodic training would be a major source of support to ASHA.

It is a move that will bring a positive change to preventive healthcare, including maternal and disease-control programmes. The State government is all set to provide mobile phones to all the 35,000 Accredited Social Health Activists (ASHAs) in the State. These activists are community health workers in the World Bank-sponsored National Rural Health Mission (NRHM), which is being implemented by the Union government across

the country. According to the NRHM guidelines, ASHAs are paid performance-based incentives for promoting universal immunisation, referral and escort services for Reproductive and Child Health (RCH) and other healthcare programmes.

Principal Secretary to Government (Health and Family Welfare) M. Madan Gopal told The Hindu on Monday that it was for the first time in the country that ASHAs are being provided mobile phones. “The Health Ministry has agreed to provide Closed User Group (CUG) SIM cards under the NRHM. The handsets will be procured through the Karnataka Health Systems Development and Reforms Project with World Bank assistance.”

Selected from the village itself and accountable to it, ASHAs are trained to work as an interface between the community and the public health system. They are the first port of call to meet the health needs of people at the village level. “It is essential to recognise the services of these activists and equip them with adequate financial support and technological tools,” Mr. Madan Gopal said. He said the decision was based on the success of the State government’s experiment with Mother and Child Tracking System (MCTS). “This is at present up to Auxiliary Nurse Midwives (ANM) level and we have found it to be quite useful in improving the efficiency of the programme,” he said.

NRHM Mission Director Suresh Kunhi Mohammed explained that every ASHA is expected to be a fountainhead of community participation in public health programmes in her village. The pre-paid mobile phones will be for specific usage to promote health programmes. It will help ASHAs communicate effectively with the people as well as the health system, such as doctors, nurses and Auxiliary Nurse Midwives (ANMs), he said.

The Karnataka State Samyukta ASHA Workers’ Association has welcomed the decision. Association general secretary D. Nagalakshmi said the mobile phones would be of great help for the activists as they are spending their own money to submit daily reports to the ANMs and doctors. “With several villages coming under one primary health centre (PHC), it is very important for ASHAs to find out the availability of the doctor and medicines before escorting the patient to the PHC. The mobile phone will help us to communicate better,” Ms. Nagalakshmi said.

Pointing out that there were several other pending demands that were yet to be considered, she said: “ASHAs are responsible for creating awareness on health and its social determinants. They will provide information to the community on nutrition, basic sanitation and hygiene practices, healthy living and working conditions, information on existing health services and the need for timely utilisation of health and family welfare services.”

4.4. Monitoring and Evaluation under National Rural Health Mission

A baseline survey is to be taken at the district level. It is for fixing decentralized monitoring goals and indicators. The community monitoring would be at the village level. Planning commission would be the eventual monitor of outcomes. External evaluation will be taken up in frequent intervals.

4.5. Impact of incentive-based work on Health services

A study on effectiveness of "ASHA INCENTIVE" on enhancing the functioning of ASHA in motivating couples having two or less children to undergo permanent sterilization in Surendranagar district of Gujarat, India by Nimavat Jh et al., shows contribution of ASHAs toward achievements in female sterilization shows that maximum motivation was done by ASHAs, and ASHAs performance was increased; 1.13 times for eligible couples and 1.14 times for couples having two or less children after introduction of an incentive, and incentive showed a significant impact on motivation of eligible couples ($\chi 2 = 121.744$, $df = 1$, $P < 0.0001$) and motivation couple having two or less children ($\chi 2 = 74.893$, $df = 1$, $P < 0.0001$) for female sterilization method by ASHAs.

5. Conclusion and Suggestions

The right to work includes the right to equal pay for equal work which is denied to ASHA workers in promoting the rural health in India. The role of ASHA workers in promotion of rural health in Karnataka is in need to create awareness among the rural households in matters relating to the protection of health and to take precautionary measures to avoid dangerous diseases among the rural masses. There is need of providing the minimum wages to the workers with social security benefits to the family members of the workers while they are rendering service to the society and to the State as well.

Adequate numbers of trained health-care providers and technical health-care workers should be ensured by giving primacy to Primary Health-Care, increasing HRH density to achieve World Health Organization norms of at least 23 health workers (Doctors, Nurses, Auxiliary Nurse Midwives)/10,000 population, as well as recruiting adequate number of dentists, pharmacists, physiotherapists, technicians, and other allied health professionals at appropriate levels of health-care delivery, strengthening existing State Regional Institutes of Family Welfare State, establishing District Health Knowledge Institutes, Health Science Universities, and National Council for Human Resources in Health.

Suggestions to improve healthcare

1. **Community participation**

Existing village and health sanitation committees should be transformed into participating health councils. The role of elected representatives, Panchayat Raj Institutions in rural areas and local bodies in urban areas should be enhanced. Regular health assemblies at different levels to enable community review of health plans and their performance should be organized. Civil society and non-governmental organizations should be strengthened and utilized to contribute effectively for community mobilization, information dissemination; community based monitoring of health services. A system of the formal grievance redresssal mechanism should be instituted at the block level to deal with confidential complaints and grievances about the health services.

2. **Access to medicines and vaccines**

Price control and price regulation on essential and commonly prescribed drugs should be enforced. The essential drugs list should be revised and extended and rational use of drugs should be ensured. The public sector to be strengthened to protect the domestic drug and vaccine industry to meet national needs and the Ministry of Health and Family Welfare should be empowered to strengthen the drug regulatory system.

3. **Management and institutional reforms**

The public health sector should assume the roles of promoter, provider, contractor, regulator, and steward. Good referral systems, better transportation, improved management of human resources, robust supply chains and data, and upgraded facilities should be ensured. This could be done by introducing, All India and State Public Health Cadres, adopting better human resource practices, developing a national health information technology network, streamlining regular fund flow and ensuring accountability to patients and communities. To achieve the above reforms establishment of National Health Regulatory and Development Authority having a system support unit, a National Health and Medical Facil ities Accreditation Unit and Health System Evaluation Unit have been recommended. In addition, establishment of a National Drug Regulatory and Development Authority to regulate pharmaceuticals and medical devices as well as National Health Promotion and Protection Trust to facilitate the promotion of better health culture amongst people, health providers and policy makers has also been recommended.

4. **Areas of Concern**

The key areas of concern in fulfilling the objectives of achieving UHC by 2022, which remain to be addressed include broad agreement on the financing model for health-care delivery; type and duration of

training for senior functionaries in public health, entitlement package and the cost of health-care interventions, enactment of National Health Bill 2009 as Health Act and declining State budget allocations for public health.

5. Reasons for Hope

Global experience has shown that Universal Health-Care is affordable and feasible. The political will reflected by the Government's commitment for higher allocation of resources, recent bold social policy initiatives and enactments such as Mahatma Gandhi National Rural Employment Guarantee Act 2005, Disaster Management Act 2005, Clinical Establishments (Registration Regulation) Act 2012, Fundamental Right to Education 2012 and Food Security Bill 2012 will help in reducing the burden of disease and sufferings by generation of more employment, alleviation of poverty, improvement of literacy etc., Enhanced participation by civil society in all health matters, success of polio elimination, smallpox and guinea worm eradication, and a major initiative to bring rigorous quality control measures in Maternal and Child Health services in Primary Health Centres in Tamil Nadu are good enough reasons for hope that UHC can be achieved by 2022.

The following recommendations are suggested:

a) Focus on mass surveillance of 'at risk' and 'vulnerable populations' for non-communicable diseases like cancer, diabetes and hypertension.

b) Well-planned system and policy for monitoring occupational health diseases and introduction of the concept of occupational health physicians and nurses by formulating post-graduate courses for the latter are needed.

c) Provision of hazard identification units in industrial set-ups.

d) Geographical coverage for endemic diseases.

e) Introducing prevention-based health checkups at outpatient departments of every government health facility.

f) Establishing a structured and well-organised referral system in the villages, providing comprehensive services on the concept of primary healthcare.

g) Financial compensation to basic health workers working on population-based targets.