Policy on Provision of Health Care Services
To
Medically Under-served Areas (MUAs)

Draft

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(Note: comments not for inclusion in the policy text are given in italics)

Background:

A number of areas in the state and certain segments of the population remain uncovered by any of the basic medical or paramedical services that are their right over the last few decades. These areas contribute a disproportionate share to the gaps in meeting health service delivery goals. These areas also contribute disproportionately to the mortality and the morbidity in the state. As the routine processes of recruitment and deployment of staff have been unable to close this gap a policy specific to these areas and these population segments is being adopted.

Definitions:

Medically Under-served Area: Any sector that has no doctor for over the last one year.

Paramedically Under-served Area : Any section that has received inadequate or no paramedical services (as evidenced by measles immunization; at least once antenatal care coverage or skilled delivery at birth) over the last one year. This shall include urban populations which have less than one ANM for a population of 5000 and where the service delivery has been inadequate.

Under-served and Un-served Areas: If coverage of all the above three services is less than 50% we would define it as Para medically under-served. If coverage of all the above three services is less than 10% we would define it as paramedically un-served area.

Medically Under-served Block: Any block where half or more of the sectors qualify for being called medically under-served.

Medically Under-served district: Any district where half or more of the blocks qualify for being called medically under-served district.

Paramedically Under-served Sector (or Block): Any sector (or block) where the majority of sections (or sectors) qualify for being notified as paramedically under-served.

Sector: An area of population of 30,000 in non tribal areas and 20,000 in tribal areas demarcated by the health department for coverage by a primary health center facility.

Section: An area of population of 5,000 in non-tribal areas and 3000 in tribal areas demarcated by the health department for coverage by a health sub-center /Female multipurpose worker for provision of immunization ,antenatal care and skilled care at child-birth.

Doctor: Any person qualified with an MBBS or equivalent degree from a recognized institute or a four year BAMS degree from a recognized institute.

Skilled Care at birth: The ability to assist in delivery with training in midwifery sufficient to recognize and manage appropriately the three stage of labour and give oxytocics rationally and manage basic complications and recognize obstruction or dangerous hemorrhage in a timely manner.

Under-served and Un-served Hamlets, villages or panchayats: These are areas where paramedical services as defined above have not reached 50% of the population or even 10% of the population. However for such under-served hamlets, villages or panchayats there are other areas within the section where they fall which are receiving these services and the problem is of extending outreach – usually through camps or community level arrangements.

Difficult Posting Areas: The list of difficult posting blocks and within them difficult posting sectors and sections would be drawn up with an incentive scheme to work in these blocks and within these blocks in difficult posting sectors and sections will be drawn up. Mostly these would be areas where there is no regular public transport and all weather roads and no acceptable quality high school facilities and no fair quality accommodation available even on rent.

Policy Text:

Identification and Notification of MUAs

1. The government shall notify the list of medically under-served areas and paramedically under-served and un-served areas.
2. These areas will remain designated as under-served areas for the next five years.
3. Every year on or by October 2nd the list shall be updated -noting those areas that are now covered with medical or paramedical services and those that are still uncovered and also adding in new areas that need coverage. No area will be denotified for reasons of coverage till the end of the five year period.
4. The notifications shall be made at the district level by the district collector.
5. The notification shall be made on the recommendation of the district chief medical officer as modified after consultations with the gram panchayat and block and district panchayat heads and by other information that the district collector gathers. This process must be documented and evidentiary sources recorded for verification and to facilitate modification on an annual basis.

6. Under-served or un-served hamlets, villages and panchayats within sections or sectors which are otherwise not under-served would also be notified but not designated an MUA.
7. Before notification of an area as an MUA (or even as an under-served hamlets or village or panchayat), the possibilities of extending coverage to that area by optimization of location of subcentres and other facility should be exhausted. The GIS mapping of all health facilities already completed would be used to assist such optimization as well as display of the MUAs

Choice of scheme to cover the MUA

1. This policy understands that no one scheme can cater to the needs of all MUAs given different subjective perceptions and objective conditions in these areas. It therefore moots a menu of eight schemes from which one or more may be chosen for this area.

2. The choice of the scheme (s) to be applied to the notified area would be decided in a special meeting of the janpad panchayat/ urban local body where district collector and district chief medical officer and concerned block medical officer is present. The district chief medical officer would present a note to the janpad panchayat of the applicability and potential of the different schemes to provide medical and paramedical coverage and the preparatory work that has been done in this regard.

3. The janpad panchayat/urban local body would then send its recommendation for finalization by the district health society.(currently district RCH society).If the district health society is not in agreement with the recommendations of the janpad panchayat, the reasons should be recorded and it may be referred back to janpad panchayat for reconsideration once. If the same recommendation or any other recommendation made is still not acceptable to district health society, it may be forwarded to the department of health and family welfare for final decision and this would be binding.

The Eight scheme option.

The eight special schemes to cover MUAs shall be:

1. Special incentive package for government doctor/paramedical worker.: This is applicable to only to MUAs which fulfill the definitions of medically under-served area and also are classified as difficult areas . The scheme is essentially notifying the vacancy to all the existing medical staff and through advertisement and providing transfer for already serving doctor or immediate contractual appointment to any new qualified recruit who wants to work in this area. All those who choose to work here would get the same incentive package as applicable to any doctors/paramedicals who work in most difficult posting areas. In addition the

janpad panchayat may offer some incentives in terms of housing facilities or even an incentive payment and this can be done in discussion with the doctor /paramedical worker by the chairperson and CEO of the janpad panchayat.

(*The main limiting factor in this is the availability of such a doctor or paramedical worker even after the incentives are announced. Also this may just transfer a vacancy from one difficult posting area to another rendering a new area as under-served.*)

2. Private sector partnership: Any existing clinic or practitioner in this area would be accredited as a private sector partner and be provided reimbursement for a package of services as specified in the Matratv Suraksha scheme for private sector partners. In brief all BPL patients would have a free package of antenatal, natal and postpartum facilities including emergency care while all patients would have free family planning services. The government would reimburse the private sector partner at previously decided rates.

(The *main limiting factor in this is the current availability of a private sector partner. Also though potentially we can have paramedical partners for essential obstetric care and basic FP services the availability of this in the existing private sector in even more limited. This is readily used option in urban MUAs.)*

3. State led franchisee system - private facility: Here the setting up of a private facility is facilitated through a package that includes bank credit, referrals and brand image building to ensure volumes; with the reimbursements as stated for private sector partners. On the other hand the rates for all RCH services would be fixed.

(*This assumes that the "matrtav suraksha scheme" of suraksha centers and suraksha hospitals is ongoing.)*

4. Contracting Service package out to NGO or Not-for-Profit agency: here the services for the MUA is contracted out to an NGO. Their would be three packages for which they could be reimbursed – one is comprehensive medical RCH package – that includes the presence of a doctor (full time or part time) and the ability to provide both essential and emergency obstetric care and all the paramedical services required in a medically under-served block. This requires having a referral hospital linkage as well and is valid only at the block level or above or to an urban MUA usually an urban slum situation. The second is a basic medical RCH package for the sector which includes the presence of a doctor and ability to run a 24 hour paramedical facility for institutional delivery at the sector level and provide the entire package of paramedical services as given by an ANM in the entire sector or . The third is a paramedical package to provide the entire range of services at the section level. One or more notified paramedically under-served areas can be given to an NGO with capability to undertake this task and who can recruit suitable skilled workers for this purpose. The package of services provided shall be specified. n all the three of the above those who are already undertaking or willing to undertake mobile hospital work may find it easier to

deliver these services. The MOU reached with the MOU shall state which of the three packages and in what areas the NGO shall provide these services.

(*This scheme is particularly applicable and feasible for urban slums but may find takers for a few remote MUAs as well.)*

5. Mobile hospital coverage: There is an existing scheme for mobile hospitals to visit each haat market held in that areas along a pre- planned schedule. This package will be built upon with incentivised referrals to Mitanins in these blocks to ensure that effective coverage of paramedical services is ensured in the sections or sectors that are paramedically under-served. This would also be linked to private and public sector facilities for institutional delivery.

(*This can be favourably combined with the NGO scheme or any of the others with the mobile hospital also acting as ambulance.)*

6. Janpad Panchayat organized Government type services: Here the contracting out agency is the janpad panchayat itself and the package that they would have to deliver is any one of the above two – mobile hospital or the contracting out to NGO package. This depends on their ability to hire a doctor or Para- medical worker on a fee arrangement. However the scheme would differ from the NGO scheme in that paramedical workers and medical officers would be paid on par with government contractual appointments along with difficult area benefits though they are now employees of the janpad panchayat. The janpad panchayat is also free to negotiate terms of work as it desires fit and pay more from its own funds.

7. Visiting doctor from the CHC: The janpad panchayats agrees to a weekly once or thrice weekly or daily visit to the sector PHC from a doctor posted in the neighbouring CHC. The doctor comes by government vehicle or his own vehicle with fixed TA provision as agreed and stays in the CHC providing call duty services over there like the other CHC doctors. The advantage of this scheme is that it is the most practical one for immediate closure of the gap for medically under-served sectors. The sector PHC would however be run as a 24 hour paramedically run facility. The reason that this is proposed as the last option is so that the local public and their representatives as well as department officials have satisfied themselves that other options are not available except for this politically less acceptable one. However in terms of quality of care the sector PHC would have no loss from such a system as over current arrangements.

8. Private sector visiting doctor: This is the same as the above but the visiting doctor is not in government service and is reimbursed on a per visit basis with a contract that provides some measure of reliability of visits. The payment should be through the janpad panchayat.

Technical and Training support*:*

It would not be possible for all the above agencies to make the correct choices without technical support and preparation. Operational sing and managing the programmes and even monitoring it would require support. Such support shall be provided by the state institute of health and family welfare and the SHRC at the state level and the district training centers and a “district health resource center” at the district level.
The district health resource center may be a cell made within the district RCH society or it may be a civil society partner contracted in -like the SHRC at the state level.

Monitoring and Evaluation:

This is an essential component. It would be particularly difficult to monitor in remote areas. This would require a sample based evaluation by an external agency in addition to the implementing agencies own reports**.** The government would be responsible to monitor both access and outreach of services and its quality and take corrective action where required.

Medically under-served hamlets or villages or panchayat that are located in non-MUA sectors or sections.

Here the aim would be to increase outreach of the programmes through outreach camps, and also provide community level arrangements centered around the Mitanin and women's' groups by which the community also extends its hands to close the service delivery gaps. Where required mobility arrangements for paramedical and medical workers would more effectively close the gaps then any other alternative scheme. However, identifying such hamlets, villages and panchayats would be undertaken as part of the overall policy to reach out to MUAs.

Rules and Regulatory body:

The state RCH/Health society shall lay down the rules and finalize the operational details of the eight schemes and the reimbursement rates and the exact packages of services and the text of the MOU to be signed with NGOs /not for profit hospitals once this policy is adopted. The state RCH society would also allocate funds for the Technical and training support and the monitoring functions.