Urban Services Planning
Professor Debapratim Pandit
Department of Architecture and Regional Planning
Indian Institute of Technology, Kharagpur
Module 10
Municipal Health Services
Lecture 47
Healthcare Facility Standards - Part II

Welcome back in Lecture 47 we will talk about healthcare Facility Standards. This is the second part of the lecture.

(Refer Slide Time: 00:32)

So, the concepts that we will cover are the 2022 IPHS guidelines. Then IPHS guidelines in regards to district and sub-district hospitals. Then guidelines in regards to community health centers, then for health and wellness centers primary health centers. And finally, we will do gap analysis.

(Refer Slide Time: 01:00)

So, the 2022 IPHS guidelines, these are prepared, as you understand that we have discussed about the earlier guidelines, this health standard guidelines for India, this was last revised in 2022. But with the, but after Corona and also after the National health Policy has been set up, has been proposed into, has been drafted in 2017, so, after that and also after Corona, after this pandemic, we had, the government has realized the a lot of inadequacies in our health care system and so on.

So, the new guidelines have come up in the year 2022, this particular year. So, this suggests a lot of changes in the way healthcare has to be provided in urban areas. And these are the new standards which should be followed when determining how much healthcare facilities has to be provided in urban areas or what kind of healthcare facilities has to be provided in urban areas. So, these are prepared, following at this new guidelines are prepared following a target based and outcome oriented approach.

So, that is at the end of the day, there has to be some targets and there has to be some outcome. So, all the guidelines are decided in such a way, so that at the end we can reach some goal, and not an input based and normative approach to reach under serviced areas. So, we have got figures and a general idea about where some services are there, not there. So, that is fine.

So, earlier it we used to give services over there but now it is more about for different areas we can have different targets and we have to achieve targets for different areas and accordingly we should provide the services. Now, delivery of services through public health sector, again, we are not talking about private health sector, we are really talking about public health sector. So, it follows the three-tier structure, as we have discussed earlier, which was suggested earlier in the National health Mission.

So, here you can see that the three-tier structure is primary health care facilities, secondary health care facilities or tertiary healthcare facilities or healthcare services you can talk about. So, this tertiary, secondary and primary, the same categorization we will maintain for also creating all standards. So, again the standards are now has to be created for both rural and urban areas because we have talked about both the national rural mission as well as the urban health missions.

So, we have to have standards for both areas. Then we have to have standards for infrastructure, health workers, drugs, equipment, health information system and finances which are all required for running this kind of healthcare services. But anyway, we are not going in details about infrastructure or the number of health workers or what kind of drugs should be available.

So, if you are interested, you can go into the detailed standards and you can study that. I have given the references we have listed the name of those standards at all. But at the same point of time, we are mostly concerned about what number of beds, what kind of facilities, how many of those facilities has to be provided in urban areas. So, all these inputs regarding infrastructure, health workers, even though we are only concerned with one aspect of it. But all these inputs has to be combined to provide quality health services.

So, we are not only talking about provision of infrastructure or facilities, we are also talking about provision of health services. Earlier we used to set up a hospital that people use to or a primary health center and people are supposed to come and meet there. But now, we are mostly focusing on community, we are also focusing on community outreach where we have to reach the people, we have to reach and then there are referral system from the lower community level, people may come to the primary center for primary center they may be referred to higher order tertiary facilities as well.

So, that means it is a integrated health care approach, provision approach and that can be only possible and overall this entire system design is possible when all these aspects are looked together. So, for provision of services, all these inputs are combined, but at the same point of time, we when we talk about facilities and all, we would be mostly focusing on the number of facilities, number of beds and how much area has to be provided, reserved for those kind of facilities.

Health services should be equitable, accessible, affordable and responsive to the needs of the population. So, that is as per following national policy on health care provision. Now, the new guidelines, unlike the last guidelines, now talks about also four kinds of, earlier it was four categories of facilities, here also we talk about four category facilities but there are some changes.

For example, the first category is district hospitals and sub-district hospitals. So, this is the highest order facility or you can say it is a secondary order facilities or maybe some case it could be also referred to as a tertiary facility also. Say it could it is a secondary order facility, other medical colleges and all these things are tertiary order facilities. Whereas the the next order is the Community Health Center which is CHC for both has to be present in rural and urban areas.

So, this is, you can say this is sometimes the primary care facility. Health and wellness centers, within under that it is a Primary Health Center PHC which is for, which has to be present in both rural and urban areas and there is also multi-specialty which are also facilities which are also known as polyclinics, these are known as UPHCs and these are mostly for urban areas like Urban Primary Health Center.

So, these are primary health center, these are community health centers. So, sometimes the community health center can be the first referral point of the first primary health care provision but usually we start at the more bottom level where we have primary health centers and above that we have the community health centers which provide higher order services.

And below the primary health centers there are sub-health centers and this again could be provided in rural areas and also urban areas where this are known as urban health and wellness

center and rural areas these are known as this sub-health center, this health and wellness center. So, that is the terminology people are using now. So, this is health.

So, instead of just health centers, we are using that adding the term wellness that means we are not only looking into standard healthcare provision but also we are trying to promote other kinds of health care provision which actually improves the overall wellness of an individual. So, that is why these are known as health and wellness centers but these are at subhealth centers, primary health centers and then there are community health centers. So, these are the different hierarchy that has been created.

(Refer Slide Time: 08:13)

2022 IPHS guidelines

1946 Bhore Committee report: 1 bed for every 1000 population (Essential)
The National Health Policy, 2017: 2 beds per 1000 population (Desirable)

Normative district population: 20 lakh (Census 2011)
2000 in-patient hospital beds (Essential) 4000 beds (Desirable)

This number should be determined:
- Actual population
- Local epidemiology
- Burden of disease
- Community requirements
- Health-seeking behaviour of the population
- Contribution of the private sector

District Health Action Plan (DHAP): Health facilities are mapped as per type and level of services they provide

Now, coming to how we interpret these guidelines or how we actually determine what number of facilities what kind of facilities has to be provided. So, as per the 1946 Bhore committee report, it was said that in India, we require one bed for every thousand population. So, this is the minimum amount of beds required for population.

But the problem is even though this is the minimum bed required and it has been recommended in the year 1946, till now many states have not been able to achieve this. So, the current guidelines state that this one bed per every thousand population is the essential number of bed or the bare minimum number of beds that has to be provided. Whereas the National Health Policy 2017 refers to, it says that we require around two beds per thousand population.

So, obviously, this is double than the number of beds that was suggested earlier. Now, why this is suggested? Because many areas of the country, the country is growing overall, affluence is growing, our affordability is growing, healthcare cost also, healthcare provision is changing and also there is growth in the healthcare market to a large extent.

Now, the problem is not all areas have growing in the same pace, and at the same point of time while there are some it is which is not able to grow at this particular pace but there are other areas which has growed beyond. So, for there, the higher order requirement could be decided and we are saying that these are the desirable levels of facilities.

So, that is this is the bare essential and this is what is desired, that is what should be maximum we can provide. So, this is what is desired which would have been better. So, this is the basis for creating of this new IPHS guidelines. So, we will give essential as well as desirable figures for different kind of healthcare facilities.

Now, coming to the way we decide or how many beds has to be provided for an urban area or for the any area for that matters, usually, it was based on the assumption that on for a particular time, because we are talking about different kinds of, we should start with a district level and we say that within a district, based on the number of population, we have to determine what number of beds has to be provided.

So, the normative district population or you can say average is something around 19 lakhs but the normative one is 20 lakhs, as per Census 2011, so, based on this particular figure of population, we can say that at least a 2000 in-patient hospital beds are required. So, these are in-patient hospital beds. We will define what are in-patient hospital beds later on but 2000 of them are required which is essential. But of course, we are now also talking about desired as well.

So, that means where the desired is 4000 beds. So, for each district, there should be at least 2000 beds which should be available. So, how this should be provided? It should be provided based on many criteria; it should be based through many facilities. But actual number, what should be provided depends on many factors. How will you distribute these facilities in a particular area?

So, that depends on the actual population and the distribution of that population in that area. The local epidemiology that means what sort of diseases are happening, where it is spreading, which

location it is happening. So, based on that we can determine. Burden of disease, depending on the cost of disease which diseases is leading to what sort of mortality, mobility, what sort of cost.

So, based on that we can decide on what kind of facilities should be provided to treat what kind of diseases and so on. Then overall community requirements, health seeking behavior of the population, what sort of facilities people want and the contribution of the private sector. That means what sort of facilities the private sector is coming up with.

Because they will all, the people will also try to make profit by running this as a business. So, of course, they will come out with certain kinds of facilities. So, the government can consider that while deciding on what it should provide. So, these are the different factors which it can consider while deciding how many public health facilities or how many public beds has to be provided or where these public beds has to be provided.

So, the district action plans are created where health facilities are mapped as per their type and level of service they provide. So, for in a district there could be different kinds of healthcare facilities and those are mapped based on what kind of services are available and what quality of service they are providing. And based on that people can determine where to go and what to go for what kind of disease or if it is a higher order, what sort of infrastructure is provided there based on that they can go there.

(Refer Slide Time: 13:24)

So, now, we come to the actual guidelines which is the guide, the first set of guidelines is for districts and sub-district hospitals. Now, essential number of beds in a district. So, we are talking about essential and desired number of beds. So, essential number of beds should come from public health tertiary care which are medical colleges. Secondary care facilities which are district hospitals, sub-district hospitals, some community health centers.

Then primary care facility, some primary care facilities may have some beds provisions in them. So, that some of them can be considered as well. So, usually the total number of beds are added up by adding up the beds in each of this particular facilities. And this leads to the essential number of beds that are required in a district. So, tertiary care facilities catered to people from the entire state and even from outside the state so should preferably be considered at the end.

That means when we are adding up the number of beds after we add up all primary care, secondary care facilities and all, after that we will consider if some additional beds that should come from tertiary care. So, we will try to make up everything from within this secondary care facilities, this could be additional. But if there is lots and lots of beds available in this kind of facilities then we can also take some beds from there as well.

So, the desirable number of beds how do I assume calculate that? That is not only the essential ones, that is the this kind of facilities that we discussed but also beds available in the private sector, beds available in railway, armed forces, power grid, coal fields, employee state insurance and other public sector undertaking hospitals.

All these different under public sector undertakings run their own hospitals and this PSU hospitals could be, the capacity of PSU hospitals could be added up with the private sector hospitals and other beds and then adding up with the essential beds that are there and this together should lead to the desirable number of beds.

So, that is how when government should plan for number of beds that should be provided, it should spread it out among this sort of facilities. And we can add the private sector and all the other hospital beds and all, and to see how much this are we able to reach the desired number of facilities. If not then we can also promote, we can facilitate development of other private sector hospitals or health centers or clinic, polyclinics and so on. So, by beds what is meant?

By beds it is meant inpatient hospital beds. That is beds available and functioning for more than 24 hours. So, that is what an inpatient hospital bed means. So, in addition some critical care beds are also added in that. What is not added are emergency beds. In emergency sections of the hospitals or facilities LDR, dialysis, day-care and pre and post-operative beds which are just for resting and for some sort of diagnosis or some sort of healthcare, primary ambulatory service that has to be provided on a daily service that has to be provided, those beds are not considered as inpatient hospital beds.

Inpatient hospital beds are the ones where a person can get admitted and can stay beyond 24 hours. So, that is why this is how we should decide or the number of beds should decide what number of facilities, how the bed should be provided. So, coming to the actual figures or standards given by the IPHS guidelines, we can see that for population less than 2 lakhs, we require 50 beds plus 15 additional these are emergency and day-care beds. So, this is the extra beds.

Desirable beds is around 100 which is just double of that. Between 2 to 5 lakh 100 beds plus 25 additional and of course this is double and so on, where more than 30 lakhs, it should be 500 beds plus 65 additional beds and desirable beds is 700. So, this is what the number of beds that should be there in different districts of the country.

Now, secondary health services. For district lesser than 5 lakh population with district hospitals do not require sub-district hospitals. So, if a district is of less than 5 lakh population, in that case, if a district hospital is already there there is no need for other sub-district hospitals. But if a district is more than 5 lakhs, maybe in the range of 5 to 10 lakhs, we have we can add one sub-divisional hospitals or sub-district. Sorry, sub-district hospitals.

Now, additional one, now, a district may have got 20, 30 or 40 lakh people residing in that. So, that means for every additional 10 lakh population, we can add on one SDH, in addition to whatever is there. So, if suppose, there are 30 lakh people living in a particular ULB, in that particular case, we will have one district hospital and then we can have one sub-divisional hospital.

So, that is up to 10 lakh and then another 2 sub-district hospital for that extra 20 lakhs. So, total we have got three SDH and one DH for a particular district. But that does not means that all the beds that we are proposing over here should be present in this (())(19:25) this suppose it is a 30 lakh district, so, in that case, we have got around 700 beds desirable. So, what it means is these hospitals plus primary health centers, community health centers plus private sector, all together will contribute to these 700 beds which is required for that particular district.

(Refer Slide Time: 19:49)

IPHS guidelines: Community health centers

FRU: First Referral Unit

Non-FRU CHCs (rural): 30 essential beds
- Essential services including preventive, promotive, curative, palliative, and rehabilitative services etc.
- Curative services include normal delivery, stabilisation of common emergencies

FRU CHCs (rural and urban):
- Provide basic(given above) + specialised care by specialists (physicians, surgeons, obstetricians, paediatricians, and anaesthesiologists) and related infrastructure (functional operation theatre and blood storage unit)
- Both elective and emergency surgical services (secondary level care)

Rural areas Community health centers: Non-FRU CHC or FRU CHC (ratio flexible)
FRU CHC : 30 beds (maternity and surgical services(essential))
50 beds (additional ophthalmic, orthopaedic, and ENT services (desirable))
Urban areas(UCHC): FRU UCHCs (Number flexible as per other health facilities (polyclinics, maternity homes, SDH/DH, and tertiary/medical college hospitals)
50 beds (maternity and surgical services (essential))
100 beds (additional ophthalmic, orthopaedic, and ENT services (desirable) and also for metropolitan cities/cities with population of more than 1 million

Now, the next are the standards for community health center which are again given in this volume 2, I think. This is the other, these are guidelines are created in separate volumes of IPHS guidelines. And here we are coming with another term which is FRU which is known as the First Referral Unit that is from the initial community points where do you refer for a particular medical emergency where your the patients are referred.

So, FRUs, usually, these community health centers in rural areas are the first, could be a first referral unit or it could be a non-first referral unit as well. So, there are two kinds of community health centers which are suggested. One is the FRU and the other is a non-FRU. So, non-FRUs will have 30 essential beds and essential services include preventive medicine, promotive medicine or services, promotive services, curative services, palliative services and rehabilitative services.

Now, what is a preventive service? Preventive service is measures which is taken to prevent the onset of diseases, like immunization programs and many other things can be come under that. Promotive services are overall different kinds of programs and all which can be undertaken so that we can promote good health among the people. Curative is for curing certain patients in some when in case of certain diseases or not.

Palliative in case of perennial problems like heart diseases or cancer then we give palliative care. And relatively services as you can know this is self-explainatory. So, in addition to the essential services, curative services are also provided which include normal deliveries and stabilization of common emergencies.

Now, these are for non-FRUs but in case it acts as a FRU or a first referral unit that means it is where people are referred to. In that case, in both urban and rural areas, this kind of particular facilities, this not only provide basic services which are given over here, the standard medical treatment that is provided and some delivery and stabilization can happen, but in addition to that, there is specialized care by specialist could be given like physicians, surgeons, obstetricians, pediatricians and anastologists could be there in this kind of facilities.

And the relative infrastructure which is required for their different operations and other kinds of handling of emergencies and all that is different functional operation theater, blood storage unit, all these things are required. So, that we can do more more complex operations and so on.

So, as you can understand, this is a basic kind of facility. So, with basic but still some amount of delivery and all these things can happen. But this is where you can do some sort of operations and all these things. So, this is not a hospital but it is a second layer of you can say facility where some of the hospital services which are provided at the hospital could be also done over here.

Both elective and emergency surgical services of secondary level care could be provided in this kind of services, in this kind of facilities. So, this is where, this is how your, what are community health centers. Now, how do I distribute them? So, for example, in rural areas, this could be either non-FRU CHCs or FRU CHCs. So, in that case, the ratio is flexible.

You have to decide the planners or the decision makers have to decide what has to be the ratio between these two kinds of community health centers. For FRU CHCs, there could be 30 bed

facilities where maternity and surgical services essential ones can be provided. Whereas it in case, additional ophthalmic, orthopedic, ENT services are provided which can be said as desirable then it should be a 50 bed facility.

So, non-FRU is we are not talking we are talking about FRU facilities which are the the first referral units, in that case, it could be a 30 bed and a 50 bed facility. Whereas in case of non-FRU there is no question of beds. Because its mostly direct care that is being curative and other cares that are given.

Emergency we can have some deliveries and all but that does not means in-patient or this hospitalization all these things are allowed. In urban areas, for urban community health centers, this number of FRUs are flexible. Why? Because in urban areas, we have got polyclinics, maternity homes, then maybe your SDH and DH is located over here.

There could be tertiary medical colleges and so on. So, there are a lot of facilities which can provide this kind of services like this kind of operation and other kinds of services. So, that is why there is no need for specialized FRUs. So, you are flexible, in this case, these are not that available like there are not too many private hospitals, there are not too many, there are not any tertiary facility, in that case we can have some number of FRUs as well or urban community health centers, community health centers.

In that case, you have to decide on the number, how many of them has to be provided. So, if provided then there can be 50 bed hospitals where maternity and surgical services essential can be provided where there are 100 bed ones where additional ophthalmic, orthopedic and ENT services can be provided which are desirable.

And these are also provided for metropolitan cities with population more than 1 million, this sort of 100 bed facilities has to be provided. So, this is how we have two hierarchies that is the district and the sub-district hospital and then we have the community health centers which are mostly providing this not only basic services but also advanced services such as operations and different kinds of medical, treatment of medical emergencies and so on.

(Refer Slide Time: 26:17)

IPHS guidelines: Community health centers

CHCs at block headquarters:
- Block Public Health Units (BPHU) and act as referral units for HWC- PHC and HWC-SHC at the block and provide all primary health care (clinical and public health) services
- Decentralized planning of public health activities
- Effective disease surveillance, forecasting and data reporting

Community Health Centre in rural areas (CHC) : 1 for 80,000 (in hilly and tribal areas)
1 for and 1,20,000 (in plains)
1 CHC at the Community Development Block/Taluka/Tehsil/Circle Level
(As per the 3 tier Panchayati System: Gram Panchayat, Block Panchayat and Zila Panchayat)

Community Health Centre in urban areas (UCHC) : Secondary care referral centre
Metro cities >5 lakh population
Non-metro cities >2.5 lakh
Adds to existing SDH/DH,
1 UCHC at the Ward/Town/ULB/Block/City/District level
50 bed/100 bed as per population

Now, coming to CHs, community health centers at block headquarters. Again you see that we maintain we are maintaining that hierarchy while planning for this kind of, spread of this kind of facilities. Block public health units act as referral units for this health wellness this primary health centers and this sub-health centers at the nblock can provide all primary health care like clinical and public health services.

So, that means all these smaller facilities at the block level can refer to the blocked level community health center. So, that is how you organize the hierarchy and that is how you organize the different kinds of facilities. So, this results in decentralized planning of public health activities and if this can result in effective disease surveillance, forecasting and data reporting can be done from the different data that is being collected and this could be done at the community health centers at the block level.

Now, community health centers in rural areas in terms of how many has to be provided. The standard says 1 for 80,000, particularly, in hilly and tribal areas and 1 for 1,20,000 in case of plains. So, for every 1,20,000 people, we can provide one community health center. Now, one community health center at the community development block, taluka, tehsils, circle level.

So, at least one should be there at the block level or it is also taluka, tehsil or circle, whatever term is being utilized. And as per the 3-tier panchayati raj system, this is the block panchayat or

gram panchayat and zila panchat. So, this is the district level this is the block level. So, this community health center aligns with the block level whereas the district hospital aligns with the zila level.

And gram panchayats are mostly where we talk about this primary health center and this subhealth centers. So, community health center in urban areas, say, these are again we say that these are not this may not be given or they can be given the number of them can be determined based on availability of all other facilities. So, this can be provided where in case of metro city is greater than 5 lakh population, in case of non-metro cities with more than 2.5 lakh population, we can provide this kind of community health health centers.

Now, this adds to the existing SDH and DH and maybe other tertiary facilities. So, this facilities are additions on that and so we can say that one UCHC at the ward, town or ULB block city district level. And this could be a 50 bed or a 100 bed facility as per the population like we have discussed that in case the population is more than 5 lakhs, we go for this 100 bed facility or if 2.5 lakhs then we can go for a 50 bed facility.

So, usually again you can see similar to over here where we are providing, in the rural area we are providing one CHC at the block level, here we are providing one UCHC at the ward level or town level or ULB level, whatever the case may be.

(Refer Slide Time: 29:32)

IPHS guidelines: Health And Wellness Centre-Primary health centers

HWC-PHCs: (rural areas)
- Preferably 24x7 facilities (at least the ones conducting deliveries)
- Provide routine care + preventive and promotive health interventions
  1 for 20,000 (in hilly and tribal areas)
  1 for 30,000 (in plains)
- Preferably aligned with Panchayats for effective convergence and citizen centric services
- PHC linked with a cluster of Sub Health Centre - HWCs can deliver more primary care services
- Act as FRU for all linked SHC-HWCs

Urban HWC-PHCs:
- Provide routine OPD care along with preventive and promotive health interventions
- No need for deliveries due to presence of other facilities (ones already conducting deliveries can continue 24x7)
  1 for 50,000 population and in close proximity to urban slums.

Specialist UPHC/Polyclinic (Urban):
"Multispecialty UPHC/Polyclinics" for specialist services on ambulatory/day care basis(outpatient care)
  1 for 2.5 to 3 lakhs (covering 5-6 U-PHCs)
  (depending on geographic location, population density, available infrastructure, etc.)

Next, we will talk about the health and wellness centers, primary health centers. So, there are two kinds of health and wellness center, one is the primary health center and the other is a sub-health center. So, in case of primary health centers in rural areas, it should be preferably a 24 - 7 facility, at least the ones which are conducting deliveries where deliveries are allowed there we can have a 24 - 7 facility.

Otherwise, it is not required to be a 24 - 7 facility. That means only in the daytime people may come consult with the doctors and then they can go back. They can provide routine care plus some amount of preventive and promotive health interventions as well. So, that means its general curative care plus preventive and promotive health care. So, usually the standard says 1 for 20,000 people in hilly and tribal areas and 1 for 30,000 people in plain areas.

This again is following the same hierarchy, we will preferably align this primary health center with a panchayat level for and for and this helps in effective convergence of this alignment of the different hierarchies of services and we can be able to provide citizen centric services at the panchat level as well.

So, PHCs linked with the cluster of sub-health centers, so that means here also we can have several sub-health centers linked to a PHCs. So, that means where some services are not been able to be delivered at this sub-health center, these people can go to the linked PHC and those primary care services could be delivered over there. So, this can also act as a FRU, first referral unit for all linked these sub-health centers.

So, that means this is the first level of referral, from this level of referral, we can go to the next level of referral which is the primary health center and if that also is not a problem we can directly go to the or we can directly instead of primary health center, if those facilities are not there, we can directly go to the district hospital and so on.

Now, in case of urban primary health center, in this case, these provide routine outpatient department outpatient care and this along with also they can provide preventive and promotive health interventions as well, similar to the rural areas. And there is no need for deliveries because in an urban area the spread is not too much, people do not have, we get other kinds of facilities.

So, no need for presence of delivery facilities over there, and as because of that there is no need to have any kind of 24 - 7 facility. But existing facilities which are already doing deliveries in urban areas for this kind of primary health centers, so, there we can continue to operate for 24 - 7 or deliveries can happen.

But new centers, there is no need for provision of this kind of beds or deliveries over there. So, usually we provide 1 for 50,000 population and it should be in close proximity to urban slum areas. Because the focus is to provide services for urban slums or poor people. Now, there could be some specialist UPHCs, this primary health centers or polyclinics also known as polyclinics.

So, these multi specialty polyclinics are provided for specialist services on ambulatory or daycare and but they are on daycare basis and there is only outpatient care but these are for specialized services and usually these are provided for 1 for 2.5 to 3 lakhs for 1 facility for 2.5 to 3 lakh people.

So, you can see that for every 5 to 6 primary health care center, primary health centers you can have 1 multi-specialty center. So, that means while for 50,000 we provide one primary center or primary health center, we can have for around 2.5 lakh or more population, we can have 1 extra multi specialty center. And where it should be located? This can be depended on geographic location, population density, available infrastructure and so on.

(Refer Slide Time: 33:44)

IPHS guidelines: Health And Wellness Centre-Sub health centers

Health and Wellness Centre - Sub Health Centre in rural areas

1 for every 5000 population in plain areas

1 for every 3000 population in hilly/tribal/desert areas.

Urban Health & Wellness Centre in urban areas

1 per 15,000-20,000 population and caters mainly to poor and vulnerable populations residing in slums etc.

These standards can be used for framing a new comprehensive guideline for provision of urban healthcare facilities.

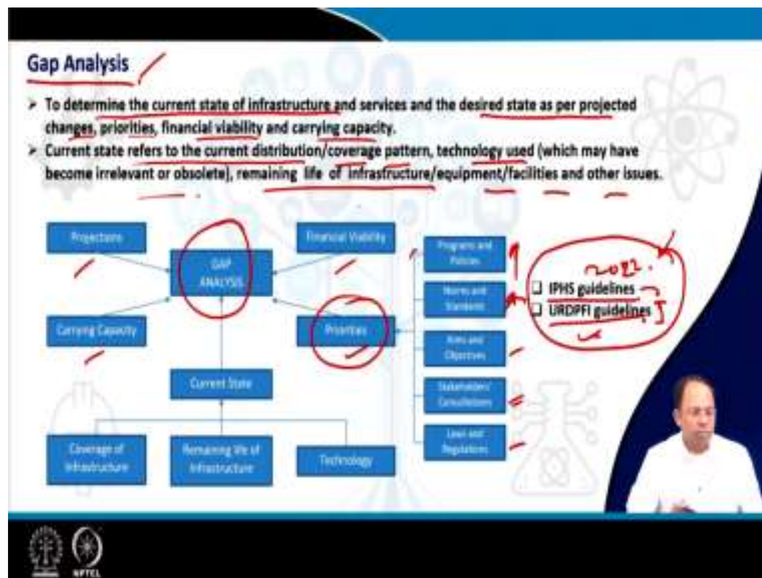
Finally, we come to the health and wellness center at the sub-health central level. So, this is the smallest or the basic level service that is being provided. So, this is sub-health centers in rural areas, these are provided 1 for every 5000 population. That means it is provided in a village and in for hilly or tribal or desert areas, it could be provided for 1 or 3,000 people because in there the villages are more sparsely populated and so on. So, that is why 1 for every 3,000 people.

In case of urban areas and this could be 1 per 15 to 20,000 population and caters mainly to the poor and vulnerable population residing in slums. So, in slum areas or near slum areas or a concentration of slum areas we can have one of this centers. So, as you can see that these guidelines has changed from earlier, this IPHS guidelines.

So, accordingly, we also need to change our URDPFI guidelines which or we have to prepare a new set of URDPFI guidelines where we have to is consider this health and wellness in the way we are providing this kind of services or the calculation of number of beds, how we are going about it.

So, that has to be really looked into, we have looked into what sort of facilities overall can be this and how they can be distributed and so on and then we have to propose our new guidelines. So, that needs to be updated. So, these standards can be used for framing new comprehensive guidelines for provision of urban healthcare services which can be taken up in future URDPFI divisions and so on.

(Refer Slide Time: 35:21)



Now, I will come to another part of it. Because when we are are planning for this kind or setting this kind of facilities and all, we have already discussed or determining that how many of these facilities has to be provided. So, we have discussed something in the, during our in the second module we have talked about Gap Analysis, particularly, for provision of social infrastructure services.

So, this just to remind, as a reminder, to remind you gap analysis is to determine the current state of infrastructure and services and the desired state as per the projected changes, priorities, financial liability and carrying capacity of an area. So, we need to determine how many kind healthcare facilities are required in the future. Now, on what do we base that? We base that on different things.

We we will base it on new IPHS guidelines, we can base it on URDPFI guidelines or maybe the modified URDPFI guidelines, we can utilize based on new 2022 IPHS guidelines, we can have new set of URDPFI guidelines. So, this will give me the norms and standard that has to be followed.

But everything else like what are my aims and objectives, what does the stakeholders prioritize, different laws and regulations for the urban area, all these things and the different programs and

policies that are going on will determine that what should be prioritized, what sort of health centers should be coming up in an area.

So, along with projections for population, carrying capacity analysis, determining of what is required, financial viability we determine how much amount of facilities that needs to be provided. So, to do that we need to do current state, we need to understand what is the current state and then what is the gap what has to be bridged or fulfilled.

So, this current state refers to the current distribution coverage pattern, technology used which may have become irrelevant or obsolete, some technologies are not useful nowadays, maybe some facility is there like some kind of X-rays and all which is now has to be changed and new facilities has to be brought in.

So, that is some intervention that has to be done. Remaining life of infrastructure equipment facilities and other things that will be considered when we say that this is the current state of workable state or or things which can be used and in future this is what we required. So, what is the gap, accordingly, we have to provide those kind of services. So, this gap analysis, we have discussed in detail earlier.

So, I am not going in detail but what it means is we these guidelines that we just learned including the URDPFI guidelines are considered as the initial point where we start determining what sort of facilities are required. But that does not means that the final plan that we will prepare for an urban area will have exactly as per these guidelines, it considers many other things into consideration which are given over here or how the everything, how this facilities would be distributed at different parts of the city or for which population group, so, that has to be analyzed as per that particular local context.

(Refer Slide Time: 38:26)

Gap Analysis

Hierarchy of social infrastructure/services

For higher order facilities:

a) Higher population size than actual (25%)

b) Consider top tier facilities beyond the standard measure

A higher order facility can be provided in a lower order settlement considering other constraints.

Proximity

Local level facilities should be provided considering non-motorized transportation (300-800 m / 5-15 minutes walking distance)

Participation

Location should consider participation of the community it is designed to serve

Ownership

Private and government facilities

Location choice is determined based on several factors which varies as per the service that is provided

Facilities such as medical dispensaries, clinics, hospitals, are developed as an business opportunity by private individuals

Multiple use

So, to do that we can follow some basic rules. One is, of course, the hierarchy of this social infrastructure services. That means we have already learned this earlier that for higher order facilities, we have already learned the hierarchy already in the guidelines we were seeing the hierarchy of different kinds of health infrastructure.

So, we can follow that. But we have to also understand that higher order facilities are actually catering to modes number of population and the top tier facilities are catering to not only my local population but population from surrounding area. So, to do that we have to add some extra capacity to those particular facilities.

So, around 25 percent capacity can be added, so that we are comfortable with extra sergeons during certain times or we can also consider like in case of more number of people come to one facility or there is concentration of one facility may be that facility has a good reputation, so we have to take some precautions for that.

So, then the other parameter that we will consider is a proximity. Some facilities has to be provided it at the local level so that we can intervene with the community. So, in that case, local level facilities should be provided considering non-motorized transportation. So, distance is a key rule.

So, maybe within 5 to 15 minutes walking distance. So, it depends on what sort of facility, what is the walking distance accordingly we can decide. So, proximity plays a rule. That means physical accessibility of that particular facility.

Then participation, if the particular this healthcare, sub-health center is supposed to do some community level programs and all, they should be in close proximity to the community where it should do those programs. So, that is what participation is all about. Location should consider participation of the community it is designed to serve.

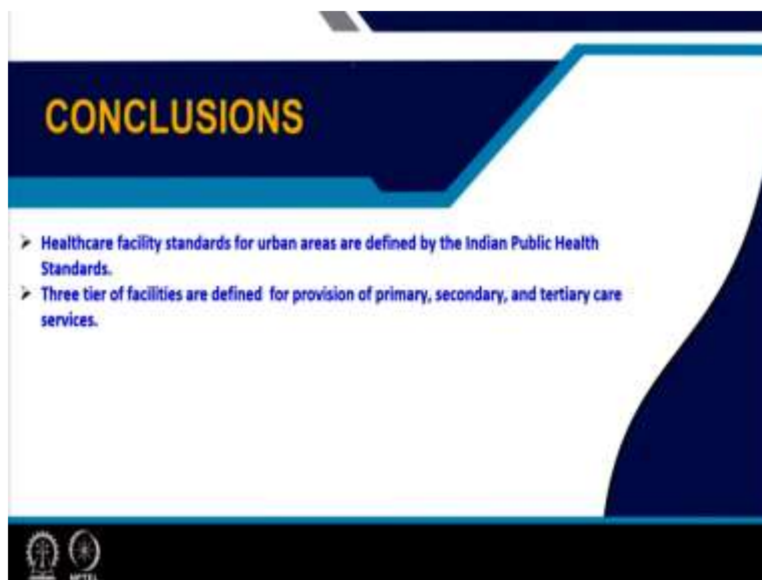
Finally ownership. Some facilities are private, some are government facilities. Now, location choice of these facilities are determined by many factors which depends as per what kind of service, is it a primary health center, is it a district health center, district hospital, so depending on that we will decide, depending on land availability, dependent on location, transportation availability, all this plays a role in determining location choice.

Whereas private facilities are developed as a business opportunity in most cases. So, they are also like dispensaries, clinics, hospitals in that case, private individuals decide based on their considerations where should their location of that facility. Finally, facilities got we also utilize for multiple purposes and that may also determine their location as well as distribution. So, that is how in addition to the hierarchy of services or as per the standards, we have to consider other aspects all as well to determine how we should actually locate these facilities in urban area.

(Refer Slide Time: 41:25)

So, these are the references that you can study.

(Refer Slide Time: 41:29)



And to conclude, healthcare facility standards for urban areas are defined by the Indian Public Health Standards and 3-tier of facilities are defined for provision of primary, secondary and tertiary care services. Thank you.