Faster, Sustainable and More Inclusive Growth

An Approach to the Twelfth Five Year Plan

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Health

9.1 The Eleventh Plan had noted that although the total expenditure on health in India as a per centage of GDP was around 5.0 per cent, (which is roughly comparable to other developing countries), there was a disproportionally high reliance on private, particularly household's out of pocket expenditure. This reflected a critical imbalance in the healthcare system, which stemmed from deficiencies in the public sector's capacity to deliver basic healthcare. The private sector too was characterised by wide variations. At one end of the spectrum were private hospitals with world class facilities and personnel offering services, which were competitively priced compared to similar services abroad, but remained beyond the capacity of most Indians. At the other end, there was an unregulated private sector which was more affordable, but offered services of varying quality, often by under-qualified practitioners.

9.2 The Eleventh Plan sought to correct this imbalance by raising the share of Public Expenditure on Health (both Plan and non-Plan) in the Centre and States taken together from less than 1.0 per cent of GDP in 2006-07 to 2.0 to 3.0 per cent of GDP to be achieved over a period of time. The National Rural Health Mission launched in 2005 aimed at strengthening the healthcare infrastructure in rural areas, providing sub centres, primary health centres, community health centres, etc. The Plan also set seven measurable targets, reflecting the health status to be achieved by the end of the Plan period. These targets related to (i) Infant Mortality Rate (IMR), (ii) Maternal Mortality Ratio (MMR), (iii) Total Fertility Rate (TFR), (iv) under-nutrition among children, (v) anaemia among women and girls, (vi) provision of clean drinking water for all and (vii) improving child sex ratio for age group 0-6 years.

9.3 Data on health outcome achievements for the Eleventh Plan period are available only up to the year 2009. This data suggests that while there has been progress, it is less than what was targeted. Public health expenditure is likely to reach 1.4 per cent of GDP (including drinking water and sanitation to 1.8 per cent of GDP) by the end of Eleventh Plan. We should aim at raising total health expenditure to 2.5 per cent of GDP by the end of the Twelfth Plan.

Towards Comprehensive Health Care

9.4 To help define appropriate strategies for the Twelfth Plan, the Planning Commission constituted a High Level Expert Group on Universal Health Coverage under the Chairmanship of Prof. K Srinath Reddy. The High Level Expert Group is expected to submit its report before the finalisation of the Plan. Their recommendations will be an important input in defining a comprehensive health strategy for the next 10 years.

9.5 While the Twelfth Plan must re-strategise to achieve faster progress towards the seven goals listed above, it must also define its health care strategy more broadly. The NRHM has focussed heavily on child birth and pre-natal care. It must however expand to a more comprehensive vision of health care, which includes service delivery for a much broader range of conditions, covering both preventive and curative services. The Twelfth Plan will prioritise convergence among all the existing National Health Programs

under the NRHM umbrella, namely those for Mental Health, AIDS control, Deafness control, Care of the Elderly, Information, Education and Communication, Cancer Control, Tobacco Control, Cardio Vascular Diseases, Oral health, Fluorosis, Human Rabies control, and Leptospirosis. Physical fitness is a prime and basic requirement for insuring good health and there is a growing recognition of the importance of sports for health, physical fitness and nutrition.

9.6 Other innovative management reforms within health delivery systems will be encouraged with a view to improve efficiency, effectiveness and accountability. The Tamil Nadu intervention of creating a separate public health cadre and maternal death audit will be promoted. Programmes/schemes will be evaluated on the basis of outcomes rather than outlays.

9.7 An accountability matrix will be devised in order to improve the seven health related goals articulated in the current Plan. The matrix will define the responsibilities of functionaries of the Health, Women and Child Development, and Water and Sanitation departments at the Block and habitation levels. Definite roles and accountabilities will also be assigned to Civil Society Organisations, processes like real time data collection, community-based validation, and medical audits to ensure quality, cost-effectiveness and promptness of healthcare will be introduced.

9.8 While preventive health care is much cheaper than curative care, it has so far not received the attention it deserved. Existing frontline health educators and counsellors should play a lead role in compiling and disseminating preventive health practices in every nook and corner of the country. The State should play a lead role in building a culture of familiarity and knowledge around public health by involving Panchayati Raj Institutions (PRIs), Rogi Kalyan Samitis, Village Health, Sanitation and Nutrition Committees, Urban Local Bodies (ULBs) and the available cadre of frontline health workers, through innovative use of folk and electronic media, mobile telephony, multimedia tools and Community Service Centers. But most importantly, families and communities must be empowered to create an environment for healthy living.

9.9 The effectiveness of a healthcare system is also affected by the ability of the community itself to participate in designing and implementing delivery of services. The opportunity to design and manage such delivery provides empowerment to the community as well as better access, accountability and transparency. In essence, the healthcare delivery must be made more consultative and inclusive. This can be achieved through a three dimensional approach of (1) strengthening PRIs/ULBs through improved devolution and capacity building for better designing and management (2) increasing users' participation through institutionalised audits of health care service delivery for better accountability and (3) bi-annual evaluation of this process by empowered agencies of civil society organisations for greater transparency. Methodologies based on community based monitoring, which have proved successful in some parts of the country, will need to be introduced in other parts.

9.10 The Twelfth Plan must break the vicious cycle of multiple deprivations faced by girls and women because of gender discrimination and under-nutrition. This cycle is epitomised by continued deterioration in the sex ratio in the 0-6 year age group, revealed by the Census 2011; by high maternal and child mortality and morbidity, and by the fact that every third woman in India is undernourished (35.6 per cent have low Body Mass Index) and every second woman is anaemic (55.3 per cent). Ending gender based inequities, discrimination and violence faced by girls and women must be accorded the highest priority and these needs to be done in several ways such as achievement of optimal learning outcomes in primary education, interventions for reducing under-nutrition and anaemia, and promoting menstrual hygiene

in adolescent girls and providing maternity support. Also certain essential interventions outside the commonly understood 'area of health' need to be made, such as provision of sanitation facilities, including construction of toilets with water facility in schools, higher education opportunities and subsequent linkages to skill development. The effort to promote women's health cannot be without participation of men; hence, imaginative programs to draw men into taking part in their health seeking behaviour and practices must be devised.

9.11 The Twelfth Plan must make children an urgent priority. This will involve convergence of Health and Child Care services. At present, Health and Child Care services to 83 Crore Rural Indians residing across 14 lakh habitations, 6.4 lakh villages and 2.3 lakh Gram Panchayats are provided, rather independently, through a network of around 11 lakh Anganwadi Centres (AWCs) of the Women and Child Development Department and 1.47 lakh Sub-Centres of the Health Department.

9.12 Often, women attending AWCs with their children have to travel long distances to avail primary health care. While there is a case for expanding the network of AWCs to all habitations, even more urgent is the need to create a direct reporting relationship between AWCs and Sub-Centres so that interventions are better synergized, resources are optimized, while women and children attending AWCs continue to get health and nutritional services under one roof. Here, it is also important to mention that there are groups within the SC and ST populations, like Primitive Tribal Groups and De-notified and Nomadic Tribes, as also internally displaced people, who continue to be under covered. We must consciously include them while making provisions for sub-centres and anganwadis.

9.13 The Twelfth Plan should aim at locating a Health Sub-centre in every Panchayat and an AWC in every habitation, their formal inter-linkage being a must for integrating the delivery of health, nutrition and pre-school education services. Through this approach, at least one ASHA would get positioned in each AWC; and at least one Auxiliary Nurse Midwife (ANM) / Health Worker (Female) would be available for a cluster of AWCs within every panchayat. Both could be brought under the oversight of the panchayat level health, nutrition and sanitation committee recently notified by the Ministry of Health and Family Welfare.

9.14 The health policy must focus on the special requirements of different groups, e.g., integrated geriatric health care and other needs specific to the elderly, 'adolescent friendly' health support services (and counselling) for victims of sexual or substance abuse, those infected with HIV/AIDS, those who are differently-abled, and those who belong to the lesbian, gay, bisexual, and transgendered (LGBT) community. Regional disparities must be addressed especially with respect to maternal health and child under nutrition in the 264 high focus districts of the NRHM. The high rate of growth of the population, particularly in certain States, must also be addressed. Mental health services, including psycho-social care and counselling, should be prioritized, in settings of transition due to migration, areas of conflict and disturbances, especially in the NER and J&K and in areas of natural disasters/calamities.

9.15 Available estimates of HIV/AIDS show that there were about 23.95 lakh people living with HIV/AIDS (PLHAs) in 2008-09 in India. Of these 38.7 per cent are women and 4.4 per cent children. Women who are not able to exercise control over their sexuality form a considerable proportion of those affected by HIV/AIDS. A positive feature is that the prevalence of the infection has stabilised and has marginally declined in some places. In keeping with the general focus on women in the Twelfth Plan, and the promise of making service delivery more community-centric, the Plan shall encourage the use of frontline workers - AWWs, ASHAs, ANMs, and also women of the community, to provide comprehensive

care for affected women, men and children. Special attention will be accorded to the needs of vulnerable groups like female sex workers, men having sex with men, and injection drug users. Infrastructure needs of high prevalence regions, especially the North East will be reviewed.

9.16 Other infectious diseases such as tuberculosis, malaria, also need focussed attention and a continued commitment to prevention and control. India also faces an escalating threat of non-communicable diseases like cardiovascular diseases, diabetes, cancers and chronic respiratory diseases which are major killers, especially in middle age. We have to respond through a package of policy interventions including tobacco control, early detection and effective control of high blood pressure and diabetes and screening for common and treatable cancers. These strategies should be integrated into the NRHM and the NUHM (National Urban Health Mission). The Twelfth Plan should also encourage States to enact a Public Health Act (PHA), which enables proactive measures to avert threats to public health before an emergency occurs.

Population Stabilisation

9.17 On the population front, while the decadal growth during 2001-11 (17.6 per cent) was lower than the decadal growth during the 1991- 2001 (21.5 per cent), the Total Fertility Rate (SDR-2009) remains high at 2.6, far above the replacement rate of 2.1 per cent that was supposed to be achieved by the end of the Eleventh Plan. The couple protection rate has stagnated around 40.0 per cent. All southern and ten other States have achieved below replacement levels of fertility, but TFR continues to be above 3.3 in the four large North Indian States, namely, Bihar, Uttar Pradesh, Madhya Pradesh and Rajasthan. While continued high rates of population growth put a strain on limited resources, widely differing rates of population growth in a democratic set-up could potentially generate regional conflicts. The need for population stabilization is urgent. The Twelfth Plan hopes to address this issue by providing dedicated funding for family planning services in high fertility states, bundled with RCH services under NRHM. Convergence must also be established with programmes that address the underlying factors of high fertility like child mortality, women's empowerment, early age of marriage etc.

Health Infrastructure

9.18 One of the major reasons for the poor quality of health services is the lack of capital investment in health for prolonged period of time. The National Rural Health Mission had sought to strengthen the necessary infrastructure in terms of Sub-centres, Primary Health Centres and Community Health Centres. While some of the gaps have been filled, much remains to be done. According to the Rural Health Statistics (RHS), 2010, there is shortage of 19,590 Sub-centres; 4,252 PHCs and 2,115 CHCs in the country.

9.19 It is essential to complete the basic infrastructure needed for good health services delivery in rural areas by the end of the Twelfth Plan. This will require substantial Plan assistance to the states for upgrading existing PHCs and CHCs to IPHS norms, building Labour rooms and Operation Theatres, which are critical to reducing Maternal mortality and also building new PHCs. Government diagnostic services will have to be strengthened at the block and district levels. This would require not only infrastructural upgrades but also adequate human resource support and well developed service delivery protocols. States also lack infrastructure for ancillary services like drug storage and warehousing, medical waste management, surveillance and cold chain management. Such facilities will have to be ensured at the District level.

9.20 District Hospitals need to be greatly strengthened in terms of both equipment and staffing for a wide range of secondary care services and also some tertiary level services. They should actually be viewed as District Knowledge Centres for training a broad array of health workers including nurses, mid-level health workers (e.g. Bachelor of Rural Health Care or Bachelor of Primary Health Practice), Paramedics and other public health and health management professionals. New medical and nursing colleges should preferably be linked to district hospitals in under-served States and districts, ensuring that districts with a population of 25 lakhs and above are prioritized for establishment of such colleges if they presently lack them. Each medical college, allopathic as well as AYUSH should be given responsibility of monitoring the status of health of the population in a defined surrounding geographical area, and work for the realisation of Plan targets in coordination with health care institutions and facilities in that area. States without any medical college can work with adjoining states for a similar arrangement. Such an arrangement will improve medical practice and link medical education to the unique needs of health care in each region.

9.21 The network of expanded Sub-centres, and fully functional PHCs and CHCs would be effective as a system only if prompt services for transportation of referred cases are available. The existing 1084 Mobile Medical Units (MMUs) will be expanded to have a presence in each CHC. MMUs may also be dedicated to certain areas which have a marked presence of moving populations. It will have to be ensured that each MMUs has requisite emergency equipment, drugs, basic diagnostics and a trained paramedic assigned to it. The possibility of transferring the Mobile Medical Units to the Fire-Brigade department, as is the practice in many developed nations, will be explored.

9.22 While the National Rural Health Mission has taken up the task of providing health infrastructure in rural areas, there is no such public health care infrastructure at the urban level available to the common person. A major challenge in the Twelfth Plan is to ensure that all urban slums and settlements are covered with Sub-centres, and ICDS centres and PHCs, through NUHM. This infrastructure cannot be based on mechanical application of population based norms since many people in urban areas have access to private medical care. However, after taking these factors into account, there is need for further expansion, especially in areas where lower income people reside. The Twelfth Plan will innovate by creating local, low-cost treatment centres around relevant disease groups rather than generic ones, thus using resources more efficiently.

9.23 The Twelfth Plan must also aim at computerizing and interlinking all health facilities (Sub-centres, Primary Health Centres, Community Health Centres, District hospitals, Referral Hospitals and Medical Colleges) and use IT/Mobile technology for creating new interfaces. IT can be used to create and sustain robust surveillance systems to remedy the present absence of accurate information on disease burdens as well as the frailty of early alert system for outbreak of infectious diseases. The Integrated Disease Surveillance System (ISDP) has not fully delivered and surveillance of non-communicable diseases has just started. The district health system must be strengthened and links established with non-governmental health care providers to develop a reliable and accurate reporting network for infectious diseases and risk factors of non-communicable diseases. Without such information, policy and programme planning will be enfeebled and impact evaluation will be difficult to undertake. Thus, there is a need to build a vibrant Health Information System for monitoring and evaluation.

9.24 Ensuring delivery of safe drugs is a major challenge. The Tamil Nadu Medical Services Corporation (TNMSC) provides a tested model for procurement and distribution to achieve economies of scale and use of monopsony power for procuring drugs at substantially marked down prices. The following may

be done: a) Emphasis on local production of drugs, especially those that are relevant to the local disease burden. Public Sector Units (PSUs), which have manufacturing capabilities, can play an important role in ensuring reasonably priced supply of essential drugs and they should be strengthened for this process, b) Making the prescription of unbranded generic medicines mandatory by State government and Central government institutional doctors and mechanism to ensure its compliance by appropriate audit processes, and c) Availability of drugs to be ensured through expansion of the existing Jan Aushadhi Stores in all district, Sub-division and Block hospitals.

9.25 In the Twelfth Plan, we must fund research into finding locally appropriate solutions to health issues. This would include studies to understand the uniqueness of disease epidemiology in the Indian population, development of effective and locally acceptable health practices, and scientifically validating best practices of Indian Systems of Medicine and Homoeopathy. Teaching in Medical Colleges should also be oriented to the unique needs of primary healthcare in the Indian population.

Human Resources for Health

9.26 Lack of human resources is as responsible for inadequate provision of health services as lack of physical infrastructure, especially in rural areas. According to Rural Health Statistics (RHS) 2010, there is shortage of 2,433 doctors at PHCs (10.27 per cent of the required number); 11,361 specialists at CHCs (62.6 per cent of the required number); and 13,683 nurses at PHCs and CHCs combined (i.e., 24.69 per cent of the required number). In addition 7,655 Pharmacists and 14,225 Laboratory Technicians are needed at PHCs &CHCs (27.13 per cent and 50.42 per cent of the required number) in the country.

9.27 The status of Human Resources for Health (HRH) has improved during the Eleventh Five year Plan period, however much more needs to be done. The density of doctors in India is 0.6 per 1,000 and that of nurses and midwives is 1.30 per 1,000, representing jointly 1.9 health workers per 1,000. While no norms for Health Human Resource have been set for the country, if one takes a threshold of 2.5 health workers (including midwives, nurses, and doctors) per 1,000 population, there is an acute shortage of health workers. Furthermore, because of a skewed distribution of all cadres of health workers, the vulnerable populations in rural, tribal and hilly areas continue to be extremely under-served.

9.28 The Twelfth Plan must therefore, ensure a sizeable expansion in teaching institutions for doctors, nurses and paramedics. Only 193 districts of a total of 640 districts have medical colleges – the remaining 447 districts do not have any medical colleges. Further, the existing teaching capacity for creating paramedical professionals is grossly inadequate. Against 335 medical colleges, there are 319 ANM training schools, 49 Health and Family Welfare Training Schools and only 34 LHV training schools. To fill the gap in training needs of paramedical professionals, the Twelfth Plan proposes to develop each of the District Hospitals into knowledge centres, and CHCs (4535) into training institutions.

9.29 The ongoing initiatives for integrating AYUSH and capacity development of other traditional health care providers such as Registered Medical Practitioners (RMPs) and Traditional Birth Attendants(TBAs) must be strengthened. Positive traditional care practices and local remedies should be encouraged. Efforts will be made to improve the working conditions and remuneration of frontline workers- both contractual and regular- and build positive environment which will reduce their sense of isolation.

9.30 The shortage of personnel to serve in rural and remote areas has led to a tendency to fill vacancies through Plan schemes which allow appointments being made on a contractual basis. Contractual appointments account for almost half of the doctors in the public sector (RHS, 2010). However, this

practice also leads to high rates of attrition of staff. CAG has pointed out that more than half of the contractual staff does not complete their entire tenure. Thus while the ability to appoint doctors on contractual basis gives much needed flexibility; it is not a substitute for developing sustainable health care capacities at the State level through regular personnel.

9.31 Even with the proposed levels of human resource training in district hospitals and CHCs, issues of regional equity, rural-urban distribution and quality would need special attention. In this regard, women from marginalized communities should be trained and hired to participate in the healthcare workforce. The strategy to enhance capabilities of these women in health, skill development, and access to sustainable employment will lead to their empowerment. Accordingly, scholarship and outreach schemes should be formulated to encourage them to train as nurses and paramedics.

9.32 Public health education must be developed as a multi-disciplinary, health system- connected, problem solving professional course and be open to both physicians and non-physicians. Expanding capacity of examination, certification and accreditation bodies is imperative. A start was made in the Eleventh Plan, but increased resources and a more evolved strategy is required to continue the work.

9.33 The Twelfth Plan will establish a Human Resource Health Management system for improved recruitment, retention and performance; rationalise pay, allowances and incentive structures; and create career tracks for competence-based professional advancement.

Publicly Financed Healthcare

9.34 Public financing of healthcare does not necessarily mean provision of the service by public providers. It is possible to have public financing while the service itself is provided by private sector players, subject to appropriate regulation and oversight. This type of partnership is common in many areas, but its scope has not been fully explored in the health sector. However, a number of experiments are now in operation which allow for private sector participation. At the Central level, the Rashtriya Swasthya Bima Yojana (RSBY) is a health insurance scheme available to the poor and other identified target groups where the Central Government and the State Governments share the premium in the 75:25 ratio. RSBY covers more than 700 in-patient procedures with a cost of up to Rs. 30,000/-per annum for a nominal registration fee of Rs. 30/-. Cashless coverage, absence of any bar based on pre-existing conditions and age limit are other unique features of this scheme. A total of 2.4 crore families have been covered under RSBY and over 8,600 health care providers are enrolled in the selected districts across 29 States and Union Territories. In several Central Government hospitals, pathology and radiology services are outsourced to private providers. State Governments are also experimenting with various types of PPP arrangements which at times also include actual provision of healthcare by private practitioners. Public Private Partnership (PPP) as a mode to finance healthcare services, if properly regulated can be of use to the intended beneficiaries. However, care needs to be taken to ensure proper oversight and regulation including public scrutiny of PPP contracts in the social sector to ensure freedom from potential conflicts of interest and effective accountability.

9.35 As noted earlier, the burden of financing healthcare falls excessively on households in the form of out of pocket expenses. This burden can be lightened by expanding the supply of publicly financed healthcare services in primary, secondary and tertiary care. Ideally, this should be done through high quality, district level plans for health services provision, funded primarily by the states. These plans should become the basis for resource allocation and be made a public document to enable social audits of the progress made towards the goals.

9.36 The district plan must articulate a road map for providing assured universal preventive, promotive, curative and rehabilitative care needed for a population within the district itself- with only very few disease conditions requiring highly specialised care outside the districts. The financing of facilities within the districts must match the varying case loads and range of services being provided. It should act as a lever to ensure that every facility provides an externally certified minimum acceptable quality of care. Areas/districts which are more marginalised, or have greater problems of access, should receive a greater investment of human and financial resources.

9.37 Any social security system must aim at providing some basic Universal Health Care. The Twelfth Plan will explore the possibilities of introducing a government funded health insurance plan for every citizen along the lines of the RSBY, which is currently limited to the poor and for certain select groups. Insurance under the plan will focus on both preventive and curative services. The premiums should be contributed by the beneficiaries and their employers. Fiscal incentives could be devised to encourage employers and employees to contribute to such a health insurance scheme.

Child Nutrition and Restructuring Integrated Child Development Scheme (ICDS)

9.38 The ICDS is a 35 year old programme aimed at nutrition and pre-school education. It can play a major role in promoting nutrition and therefore health outcomes, though as presently conceived, it has flaws. It focusses mainly on children in the age group of 3 to 6 years who actually attend Anganwadis, whereas the greatest need for nutritional support is in the age group of 0-3 years. The programme needs to be radically restructured to focus on reaching pregnant and lactating mothers, and also the more vulnerable children in the 0-3 age group. Restructuring should promote decentralisation of administration, and laying stress not only on expansion, but also on quality. Other proposals include ensuring greater flexibility in implementation, capacity development, greater community ownership with participation of women's/mothers groups, management reform and strengthening of convergence with related flagship and other programmes.

9.39 A major shift is needed towards family and community based interventions, like a strong emphasis on breastfeeding in particular. The ICDS should be seen as the critical link between children and women and the health care systems, as well as with the elementary education system, and ensure that focus is brought on children in the critical window of 0-3 years of age. One initiative should be the effective linking of AWCs with Health Sub-centres as well as with drinking water and sanitation services.

9.40 On the direction given by Prime Minister's National Council on India's Nutritional Challenges, an Inter-Ministerial Working Group has been set up to draft a comprehensive ICDS restructuring proposal.

9.41 There is no national system of nutrition monitoring, mapping and surveillance in the country. District level disaggregated data are not available from existing surveys. District Level Health Survey (DLHS) remains inadequate in its coverage. There is a need to generate reliable District level disaggregated data so that we are able to monitor the progress made on under-nutrition. An innovative health and nutrition monitoring and surveillance system should be put in place. It can be used as a major enabler for performance management including financial management through real time data flow to the health system and for the restructured ICDS. It should have a vibrant community based monitoring component, which will function in partnership with civil society organisations, women/community groups and

Panchayati Raj Institutions. The development of an e-health database with health-ID cards capturing complete digital histories will be planned.

9.42 The Twelfth Plan provides an opportunity of bringing together the world's largest health and child care systems through flexible frameworks that ensure a continuum of care with normative standards, while responding to local needs at village and habitation levels. Convergent action over the next Plan period will translate this vision into programmes that will touch the lives of all citizens, meet their expectations and also fulfilling their rights – particularly the rights of women and children in the communities, where they live and grow.