Health

10.38 Achieving an acceptable standard of good health amongst the general population of the country is the main objective of the National Health Policy, 2002 (NHP). Improvement in the health status of the population is sought to be achieved through improvement in health services in the country with a special focus on underserved and underprivileged segments of the population. Larger investment in health will be needed even to maintain the current health situation, as the technology required for tackling resistant infections and non-communicable diseases are expensive and result in escalation of health care costs. The NHP-2002 envisages increasing public health investment from the current level of 0.9 per cent of GDP to 2 per cent of GDP by 2010.

10.39 A vast health care delivery system has been created in the country by the government, voluntary and private sectors (Box 10.5). The health care delivery system, however, has created a paradoxical situation with a plethora of hospitals but few located in areas with high morbidity. Moreover, there are many hospitals in the public, voluntary and private sectors without appropriate manpower, diagnostic and therapeutic services and drugs. There are massive interstate/inter-district/ urban-rural differences in performance, availability and utilization of services. Facilities are poorest in the most needy remote rural areas in the states. There are unused diagnostic facilities and drugs in some places while others suffer from shortages mainly because of defined norms for care at each level and referral. Overcrowding in some

Box 10.5 : Time trends (1951-2003) in health care.

	1951	1981	2003	(Period/Source)
SC/PHC/CHC*	725	57,363	1,63,195	(March 2001-RHS**)
Dispensaries and Hospitals (all)	9,209	23,555	38,031	(January 1, 2002-CBHI***)
Beds (Private and Public)	1,17,198	5,69,495	9,14,543	(January 1, 2002-CBHI)
Nursing Personnel	18,054	1,43,887	8,32,000	(December 31,2001-INC@)
Doctors (Modern System)	61,800	2,68,700	6,05,840	(December 31,2002-MCI@@)
Malaria (Cases in million)	75	2.7	1.65	(2003) provisional
Leprosy (Cases/ 10,000 population)	38.1	57.3	2.4	(2004) provisional
Polio (no. of cases)	29,709	225	214	(December 31, 2003)

*** SC/PHC/CHC : Sub Centres/Primary Health Centres/Community Health Centres.**
**** RHS : Rural Health Statistics.**
***** CBHI: Central Bureau of Health Intelligence.**
@ INC : Indian Nursing Council.
@@ MCI : Medical Council of India.

Source : Planning Commission, Ministry of Health and Family Welfare.

hospitals coexists with under utilisation in others. Most secondary and tertiary care institutions have good facilities with skilled staff, but they face difficulty in running institutions because of changing health care needs, rapid advances in technology, obsolescence of equipment and rapid turn over of staff. Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) has been designed to reduce these gaps (Box 10.6).

Box 10.6 : Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)

PMSSY has been designed with an objective, to reduce the gaps that remain in the availability of tertiary care hospitals/medical colleges providing speciality/super speciality services across various states and to mitigate the difficulties of people from under developed states who have to travel to institutions like AIIMS, New Delhi leading to inconvenience and high cost to patients. Under the scheme, AIIMS like institutions are proposed to be set up in six backward states of Bihar, Chattisgarh, Madhya Pradesh, Orissa, Rajasthan and Uttaranchal. The scheme will also provide one time assistance to one institution in each of six other states of Andhra Pradesh, Jammu and Kashmir, Jharkhand, Tamil Nadu, Uttar Pradesh and West Bengal to enable these institutions to upgrade their facilities to AIIMS level.

10.40 In order to reduce these imbalances in the health care delivery system, the focus areas of Tenth Five Year Plan (2002-07) inter-alia includes the reorganization and restructuring of existing healthcare infrastructure at primary, secondary and tertiary levels so that they have the capacity to render health care services to the population residing in well defined geographical areas and have appropriate referral linkages with each other. Other focus areas of the Tenth Plan include appropriate delegation of powers to Panchayati Raj Institutions (PRI) to ensure local accountability of public healthcare providers; horizontal integration of all aspects of the current vertical disease control programs, building up an effective system of disease surveillance; effective implementation of the provisions for food and drugs safety; building up a fully functional, accurate Health Management Information System (HMIS) utilizing currently available information technology (IT) tools; developing capabilities at all levels for emergency and disaster management, and exploring alternative systems of healthcare financing including health insurance so that essential, need based and affordable healthcare is available to all. The approach during the Tenth Plan is to provide essential primary healthcare, emergency life saving services, services under the National Disease Control Programs free of cost to all individuals and essential healthcare service to people below poverty line.

10.41 The Plan outlay for the Central Health Sector Schemes during 2003-04 is pegged at Rs.1,550 crore, which is same as that for 2002-03. About 55 per cent of the Plan outlay continues to be spent on centrally sponsored disease control programs for major communicable and non-communicable diseases like malaria, tuberculosis (TB), leprosy, AIDS, blindness, cancer and mental disorders.

Malaria

10.42 The malaria situation after 1984 has remained more or less static (annual malaria cases and Pf cases over 2 million and 1 million respectively) with marginal fluctuations. However, the number of malaria cases has gone down to less than 2 million in 2002 and 2003. National Filaria Control Program (NFCP) and Kala-azar Control Program had been operative in the country till 2002-03. In pursuance of the concept of convergence, a National Vector Borne Disease Control Program (NVBCP) has been started from 2003-04 through convergence of three ongoing programs and inclusion of Japanese Encephalitis and Dengue/DHF. The main objective of the program is the prevention and efficient control of vector borne diseases to pursue the goals set under the NHP-2002. The NHP-2002 has envisaged kala-azar elimination by the year 2010, filarial elimination by the year 2015 and reduction in mortality on account of malaria and other vector borne diseases by 50 per cent by the year 2010.

Tuberculosis

10.43 Tuberculosis (TB) is a serious public health problem in India. Approximately 18 lakh new cases of which about 8 lakh are highly infectious smear positive are reported every year. About 4.17 lakh persons die of TB every year in the country. The Revised National TB Control Programme (RNTCP) using Directly Observed Treatment, Short course (DOTS) strategy, with the objective of curing at least 85 per cent of new sputum positive patients and detecting at least 70 per cent of such patients was evolved. It is presently being implemented in a phased manner since 1997 with assistance from World Bank, DANIDA, DFID, USAID, GDF and GFATM. Till date, the RNTCP has placed more than 25 lakh patients on treatment, averting more than 4.5 lakh deaths. Overall performance of RNTCP has been excellent with cure/treatment completion rate consistently above 80 per cent, and death rate reduced to less than 5 per cent. The aim is to extend RNTCP which presently covers population of 870 million to the entire country by 2005.

Leprosy

10.44 The leprosy prevalence rate for the country as a whole is estimated at 2.4 per 10,000 population during 2004. The World Bank assisted National Leprosy Elimination Programme, which is presently under implementation in the country, has been decentralized to State/District Leprosy Societies and services under the programme have been integrated with general health care services for greater reach of Leprosy services.

HIV/AIDS

10.45 As compared to 3.5 million in 1998, an estimated 4.58 million men, women and children were living with HIV/AIDS in the country at the end of 2002, with an adult (15-49 years) prevalence rate of 0.8 per cent. India accounts for 10 per cent of the global HIV burden. These figures are a cause of increasing concern as persons infected with HIV will progress to AIDS, resulting in a steep increase in number of AIDS patients in the country with consequent medical, economic and social implications. Presently HIV infection in India is being traced among the general population in all states across urban and rural areas. The States of Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu are categorized as high prevalence states. Gujarat, Goa and Pondicherry are categorized as moderate prevalence states with the remaining States/ UTs. are categorized as low prevalence states. In order to prevent and control the spread of HIV/AIDS in India a comprehensive National AIDS Control Programme is under implementation throughout the country.

10.46 Government support is available for treatment of opportunistic infections among people living with HIV/AIDS who access public sector hospitals. A single dose of anti-retroviral (nevirapine) is also provided to the HIV positive mother and baby pairs in the centers established for Prevention of Parent to Child Transmission (PPTCT). Government is committed to providing Anti-Retroviral treatment free of cost in a phased manner to the priority segment of people living with HIV/ AIDS, such as women covered under PPTCT, children with AIDS under 15 years of age and AIDS cases seeking treatment in public sector hospitals in the six high-prevalence states. Recently WHO and UNAIDS have announced an initiative which seeks to provide access to Anti-Retroviral treatment for three million people living with HIV/AIDS by the year 2005.

Control of non-communicable diseases (NCD)

10.47 Non-communicable diseases cover a wide range of heterogeneous conditions affecting different organs and systems in different age and socio-economic groups. Over the last two decades, morbidity and mortality due to cardio-vascular diseases, mental disorders, cancers and trauma have been rising with increases in the number of senior citizens with higher prevalence of non-communicable diseases, prevalence of non-communicable diseases in younger people because of life-style changes, obesity and stress, and exposure to environmental risk factors and use of tobacco. During the Tenth Plan, efforts will be made to improve

preventive, curative and rehabilitative services for non-communicable diseases throughout the country at all levels of care. Some of the areas of major thrust are a well-structured Information, Education, Communication and Monitoring (IEC&M) for primary and secondary prevention of non-communicable diseases; re-orientation and skill up-gradation of health care providers in diagnosis and management of non-communicable diseases at different levels of care, establishment of referral linkages among primary, secondary and tertiary institutions, and creation of an epidemiological database on non-communicable diseases especially Cardiovascular Deaths (CVDs), stroke and diabetes. The National Program for Control of Blindness, National Cancer Control Program, National Mental Health Program and Iodine Deficiency Disorders (IDD) control Programs are continuing in the Tenth Plan.

Blindness

10.48 Due to the large population base and increased life expectancy, the number of cataract cases is expected to increase in the coming years. The World Bank assisted Cataract Blindness Control Project, which was successfully completed in June, 2002, resulted in an increase in number of cataract surgeries to 38.57 lakh in 2002-03 and 40.75 lakh during 2003-04. Government is implementing the National Blindness Control Program. During the Tenth Plan, attempts will be made to clear the backlog of blindness due to cataracts by performing 4.5 million cataracts operation per year up to 2007. New initiatives will be taken during the Tenth Plan to control childhood blindness, corneal blindness and emerging causes of blindness like diabetic retinopathy and glaucoma.

Cancer

10.49 Cancer has become a major public health problem due to increase in life expectancy and changing life styles. There are about 20-25 lakh cases of cancer in the country at any given point of time and approximately 7-9 lakh cases come up every year. During the Tenth Plan, the National Cancer Control Program has been made a Centrally Sponsored Scheme. Primary prevention of cancers by health education, secondary prevention by early detection and diagnosis of common cancer and tertiary prevention by strengthening the existing institutions are the objectives of this program.

Indian Systems of Medicine and Homoeopathy (ISM&H)

10.50 Globally, there has been a revival of interest in a complementary system of healthcare, especially in the prevention and management of chronic lifestyle-related non-communicable diseases and diseases for which there are no effective drugs in the modern system of medicine. India is currently undergoing a demographic and lifestyle transition which will result in the increasing prevalence of non-communicable diseases and lifestyle related disorders. ISM&H, which includes Ayurveda, Siddha, Unani, Homoeopathy, Yoga and Naturopathy, can play an important role in the prevention and management of these disorders. A vast infrastructure has been created under ISM&H, which includes 3,005 hospitals, 60,681 beds and 23,028 dispensaries. During the Tenth Plan, a major thrust will be given to mainstream the ISM&H system, with focus on improvement and upgradation of standards of education in Ayurveda, Yoga, Unani, Siddha, and Homeopathy, standardisation of drugs and quality control, ensuring sustained availability of raw materials, i.e. medicinal plants, metals, minerals and materials of animal origin, Research and Development, participation of ISM&H in the National Health Delivery System, National Health and Family Welfare Programs, Information, Education and Communication (IEC) including building awareness about efficacy of the systems domestically and internationally. The Tenth Plan allocation for ISM&H is Rs.775 crore. The budgetary allocation for the year 2003-04 is Rs.145 crores under plan and Rs.51 crore under non-plan.

Health Insurance

10.51 The public sector general insurance companies were encouraged to design a community-based universal health insurance scheme during 2003-04. Under this scheme,

a premium equivalent to Re 1 per day (or Rs. 365 per year) for an individual, Rs. 1.50 per day for a family of five, and Rs. 2 per day for a family of seven, entitle eligibility to reimbursement of medical expenses up to Rs. 30,000 towards hospitalization, a cover for death due to accident of Rs.25,000 and compensation due to loss of earning at the rate of Rs. 50 per day up to a maximum of 15 days. To make the scheme affordable to the BPL families, the Government has announed a subsidy of Rs.100 per year towards their annual premium. A Community-based 'Universal Health Insurance Scheme' was launched by the four public sector general insurance companies in July 2003. Up to March 31, 2004, 4.17 lakh families involving 11.62 lakh persons have been covered under the scheme. Some of the State Governments have taken initiatives to formulate health insurance for people below poverty line (Box 10.7).

Box 10.7: Ongoing initiatives by States for health insurance

- For meeting hospitalisation cost of BPL families, Kerala has proposed a Health Insurance Scheme with contribution from the individual, State and the PRI administered through the Kutumbashree self-help group.
- In Delhi, a government funded health insurance scheme 'Arogya Nidhi' is being taken up. For secondary care in government institutions, the state plans to initiate a pilot project on health insurance for people below the poverty line.
- In Andhra Pradesh a health insurance scheme is being implemented, under which a cover of Rs 20,000 towards hospitalisation charges for a period of five years is assured for the acceptor of sterilization and his/ her two children, subject to a maximum of Rs. 4,000 per year
- Madhya Pradesh and Himachal Pradesh are in the process of launching Community Health Insurance Schemes.

10.52 On a pilot basis in 50 districts in the country, on January 23, 2004, the Government launched a social security scheme for workers drawing pay/wages/income not more than Rs.6, 500 per month in the unorganized sector. The scheme will be funded by contributions at a rate of Rs. 50 per month by eligible workers in the age group of 18-35 years and of Rs.100 per month by those in the age group of 36-50 years. The employers, wherever identifiable, in both cases will contribute at a rate of Rs.100 per month. The government will contribute at the rate of 1.16 per cent of the monthly wages of the worker taking as base the average national floor level wages as notified by the Government from time to time. The scheme will be implemented by the Employees Provident Fund Organisation (EPFO), which will provide single window service to the workers for all the three components of the scheme. EPFO will be assisted by the Workers Facilitation Centres (WFCs), Centre and State Labour machinery, Panchayati Raj Institutions, Local bodies, SHGs and NGOs.