

INTRODUCTION

Madhya Pradesh is one of the largest states of the Republic of India. The state is marked with a complex social structure, a predominantly agrarian economy, a difficult and inaccessible terrain, and scattered settlements over vast area that together pose several formidable problems to health service delivery systems. According to the 2001 census, Madhya Pradesh has a population of about 60 million, which is around 6% per cent of the country's population. Ranking 7th in terms of population size and 23rd in terms of population density among the 35 states and union territories, it is a large state with a widely dispersed population and relatively low density. From the point of view of per capita income, literacy, urbanization, infrastructure facilities and other development indicators, Madhya Pradesh belongs to the category of less developed states of the country.

In spite of the best of efforts on behalf of the Government institutions, the people of the state are not satisfied and the health status, though improved from yesteryears, is far below when compared on the national scale (as reflected by the health indices). For every 100 rupees spent on health, rupees 75 come from private (out of pocket) sources. According to Budget, 2000-2001 (GoMP) the overall spending on health care is Rs. 150 per capita. Although Government Health Expenditure has risen in absolute terms, it has by and large remained static in per capita terms^[1]. The share of salaries in non-plan health expenditure is 86.7%^[1]. However, the government is not getting fair returns on its investment in health care and there is widespread dissatisfaction with the access and quality of health care in the government health care institutions. On the other hand, there are serious questions about the economic access and quality of health care in private sector, particularly in the rural areas. The problem is compounded as government does not have an effective monitoring, surveillance or control function with regard to private health care.

The policy identifies some core issues to improve the access, quality and coverage of health care in MP. The financing for health care is inadequate and should be increased particularly from the public sources. Further, the financing, as out of pocket payment at the time of receiving services is regressive from equity perspective, and is also against the interest of the poor. The present management system for the government

institutions is inefficient mainly due to lack of financial and managerial (e.g. management of personnel) autonomy. Thus, innovative thinking in financing, financing mechanism for health care and modern management (financial, personnel) with defined autonomy, responsibility, output and outcome orientation, will go a long way to improve the health of the people in the state of MP.

VISION

All people living in the state of Madhya Pradesh will have the knowledge and skills required to keep themselves healthy, and have equity in access to effective and affordable health care, as close to the family as possible, that enhances their quality of life*, and enables them to lead a healthy productive life.

*Quality of life is the perceived physical and mental health of a person or group over time.

GOALS

- 1 **Ensuring geographic and economic access to primary and secondary quality health care and family welfare services to all people of Madhya Pradesh within a span of five to seven years. Following will be the core characteristics of the health care:**
 - Health care would be Gender sensitive
 - Health care to address; health promotion, prevention, treatment (curative) and rehabilitation.
 - All health care resources including NGOs and private providers would be utilized for health care provision.
 - Public fund would primarily focus on rural and urban poor.
 - Focus will be on communicable diseases (diseases of poverty), reproductive health conditions and preventive actions to reduce chronic diseases e.g. Cardiovascular diseases, cancer, mental disorders, diabetes (secondary prevention), hypertension (secondary prevention) etc.
 - Address the increasing incidence of injuries by prevention and treatment.
- 2 **Prevention of disaster, to the extent possible, and preparedness for disaster management as and when necessary.**
- 3 **Reducing the MMR to 220 by 2011 from the level of 498 (1997 level).**
- 4 **Reducing the IMR to 62 by 2011 from the level of 97 (1997 level).**
- 5 **Total Fertility Rate to reach replacement level fertility (i.e. a**

TFR of 2.1) by the year 2011.

- 6 Stabilize the prevalence of HIV/AIDS at low level (present level) and further decrease it.
- 7 Address problems related to mental health and initiate action to create information base and preventive intervention for improved mental health in the state.

To achieve the HEALTH vision and goals of the state, the following strategies will be implemented:

I. EQUITY

It is commonly known that poor people have worse health indicators and MP is no exception. However, there are other aspects of equity that are related to income and health. In MP there are geographical inequity in both access to health care and health status, urban - rural inequity, gender inequity and inequity due to lack of education. Details of geographic, economic, urban/rural and gender inequity are presented in Annex XXX. However following is the summary of the situation.

- **Income inequity**

Income influences both the access to health care and health status. For example for one poor rural person that uses public services, there are eight non-poor persons using the publicly funded services (NCAER, 2001). Infant Mortality Rate is double and Child Mortality Rate more than five times in poor families compared to non-poor. Only 12% of the children in poor families are vaccinated as compared to ~ 50% of the rich. There is also a lower utilization by poor people in a key area like institutional delivery^[2]. Benefit incidence analysis shows that nearly half of the public health subsidies accrue to the top 20% of the population. The bottom quintile accounts for just 6.6% of the hospitalization. Analysis also shows that the rich use the private sector more but they also use a much larger share of the public provision as .

- **Gender inequity**

Women have a limited role in key decisions related to maternal and child health. Mortality rates for girls are higher than boys except during early infancy. As per NFHS 2 data, the IMR for male in 1995 was 79 whereas it was 100 for females. Similarly, the Under 5 Mortality rate for boys in 1995 was 114 whereas for girls it was 152. Percentage of boys getting vaccinated is greater than girls. Girls are more likely to be underweight

than boys. Boy preference is growing and incidents of female foeticide are increasing thus adversely affecting the sex ratio.

- **Rural urban inequity**

The per capita public expenditure on rural areas amount to less than a third of that spent per capita in urban areas. IMR in rural areas is significantly higher than urban. ANC services are almost two and half times more in urban areas as compared to rural. More than 86% of deliveries in rural areas were at home as compared to 50% in urban areas. 61% of the deliveries in urban areas were assisted by doctors or trained personnel as compared to 21% in rural .

- **Regional inequity**

Amongst the six regions of MP, Vindhyan region has the worst and the Malwa region has the best health .

- **Education inequity**

NFHS 2 data has clearly established that the education level of mothers has direct influence on utilization of health services. The higher the level of education of mothers, the higher the utilization of health services. Around 86% of high school pass mothers availed ANC services, the corresponding figure for those mothers having completed middle school was ~70%, those with middle school education level, 65% and only 45% of the illiterate mothers had availed ANC services.

To redress the inequitable situation with regard to access to health and health status, the health sector can contribute considerably. However, all inequities in the health status cannot be addressed by only the health sector and other sectors (e.g. agriculture, education, women and child development, employment etc.) also need to have health and equity oriented policies and strategies.

The health sector has the ambition to improve economic and geographic equity as well as coverage of population for access to effective and good quality health care through new strategies described below. To improve the geographic and coverage access to care, new financial resources need to be made available to the health sector, health infrastructure needs to be expanded and existing infrastructure renovated

and made appropriate for the staff and patient's need. To improve economic access to health care, the system of out of pocket payment at the time of receiving health care needs to be reformed. As mentioned earlier, this system is regressive from equity perspective and negatively affects the access of health care for the poor section of the society. Measures like reviewing and defining norms for geographic access to primary and secondary care, making provisions for health workers at the village level to provide basic health care, developing a community based health care financing for primary and secondary care etc. are some of the suggested solutions. Further, to ensure equitable access amongst the entire cross section of the society and thus obliterate social barriers to access, the policy intends to ensure access to knowledge and skills to achieve appropriate health behavior for individual, family and community to promote health and prevent disease and also to provide rehabilitation; thereby improving the quality of life of all people living in the state.

STRATEGIES

- To develop multiple ways to finance the health care in the state. This could include tax based financing, risk-sharing mechanisms e.g. insurance (individual and group insurances, Community based Health Financing), co-payment, service fees, donations etc. In particular, to develop community based health care financing system for primary and secondary care with the participation of government, family and community.
- To increase the government budget allocation from 0.89% of GDP to 2% over the next five years. Budget allocation should be biased towards rural areas.
- To increase the efficiency of the government run health care through improved management i.e. increased financial autonomy - budget and expenditure, and managerial autonomy - personnel and systems, and output and outcome orientation. The autonomous management should be applied first to the districts with large urban population.
- To increase the number of Sub Health Centers in the state (taking census 2001 as the base) and ensure the facility for institutional delivery at each SHC.
- To achieve equity in access to quality health care, health care interventions of proven effectiveness (evidence based) for

diagnosis and treatment of conditions / diseases of children, adolescents and adults (males and female) will be supported from public / public assisted funds.

- To realize the vision of the government for achieving knowledge and skills for healthy living, community level groups and institutions would be supported for information, education and communication and behavior changes. Further, the educational institutes, particularly the schools will be utilised for achieving appropriate health seeking behaviour

II. ORGANISATION OF HEALTH CARE

Madhya Pradesh is a state enriched with traditional knowledge on alternative systems of medicine like Ayurveda, Homeopathy etc. that have been time tested. In the current scenario, these systems of medicine are not receiving adequate promotional avenues from the state. The policy therefore suggests measures to mainstream these alternative systems of medicine.

In the context of achieving overall health gains for the community, the Government's role is fourfold, namely, **facilitator, provider, monitor and regulator**. However, in the present scenario, the provider function overshadows all others, with resultant reduction in time-availability of the department for the other three important roles. The situation therefore calls for the Government to propose organizational reform to effectively fulfill the other three roles. The policy proposes to enhance the role of Government in providing stewardship in developing policies and monitoring their implementation (by the public, private, NGO and other health care providers) through appropriate surveillance systems in order to achieve health for all sections of the society. Modern management skills also need to be applied in the provision of health care. Managerial autonomy, with clearly demarcated roles and responsibilities for the management of all resources- financial, services and personnel, and having an output and outcome orientation, is necessary to achieve efficiency in the publicly funded health care services. Further, the type of services should be rationalized to invest in such health care interventions that have proven effectiveness (evidence based), in order to improve the allocative efficiency of the available resources.

STRATEGIES

A. Encouraging Indian systems of medicine

- Mainstreaming Indian systems of medicine through Increased and stronger collaboration between the DoHFW and DoISM&H and have integrated functioning rather than an isolated approach.
- To have common policies governing the two Directorates. (The policy prescriptions of the Health Policy will be applicable to both the systems).

B. Organizational reform

- To establish a SPU (Strategic Planning Unit) at the Directorate of Health & Family Welfare Services in order to provide policy inputs for all health care sectors. The SPU will have an advisory role, will be technical in nature, representing wide spectrum of competence in health and located within the directorate of health services.
- To have each regional division led by a full Director with the specific mandate to monitor and provide surveillance for health care services. The regional director will have responsibilities for monitoring and surveillance of health and health care in their jurisdiction and will also be responsible for implementation of the government funded health services. At the state capital level, the Directorate could be converted to a Directorate General level, the main function of which would be to look into policy matters, planning and development.
- *Review and reform the role and organization of IEC Bureau at Bhopal in view of the renewed vision of the government for achieving knowledge and skill among all citizens of the state.*
- *Review the role of State HIV/AIDS Society with the view of mainstreaming its activities through various government ministries, NGOs and private sector.*

C. Management reform

- *To develop new criteria for management of government health care institutions (PHCs, CHCs and district hospitals) to provide financial and managerial autonomy with responsibilities for output and outcome.*
- *To develop norms (minimum and maximum) for the availability of key components of primary, secondary and tertiary care (diagnostic facilities, inpatient beds,*

pharmacies etc.) in specific geographic areas and population load in urban as well as rural areas.

D. Surveillance for health and disease in private and public sector

- To develop a disease and outcome oriented surveillance (through a surveillance organization), which could be positioned at divisional level. This surveillance system would encompass both the public and private health care providers.

E. Health Research for increasing efficiency in health care

- To strengthen the newly created Operations Research Unit in the directorate through recruitment of competent personnel and encourage research (health systems research) to utilize health care resources effectively and efficiently.

III. IMPROVING QUALITY AND QUANTITY OF HUMAN RESOURCE FOR HEALTH CARE.

The functioning of any organization is affected by the nature of Human Resource Management. Issues like frequent transfer, unequal work allocation, accountability etc. adversely affects the motivation of the Health Department personnel. There is a need to increase the effectiveness of the existing human resources of the health department. Improving the quality of the staff and filling the vacancies/creating more posts to increase the quantity of the health personnel could achieve this. This would require having a detail Human Resource Development Plan, and if essential, formulate a separate policy for the same. Developing competency in Public Health, Health Care and Hospital Management, is also felt essential to bring about improvements in the status of health. The need for specialists in these fields has surfaced time and again and will prove to be both functionally and cost effective. The policy also recommends provision for ensuring the provision of skilled birth attendants, which is essential for addressing the high MMR. Lastly, the policy suggests measures to more effectively reach the rural population with quality health care through provisions like licentiate course and recognizing the service of the already practicing health care providers at the village level.

STRATEGIES

- *To develop a Human Resource Development plan and policy which nurtures a motivated team and good working environment. Further, develop staff appointment and transfer policy balancing the needs of the government and the individuals.*

- To start a Master of Public Health (degree) program with emphasis on Public Health planning, management and surveillance of health and diseases. The program is planned with a view that a managerial cadre of doctors will be developed for the public health and hospital management.
- To introduce compulsory rural (training) posting for two years for new graduates from the state medical colleges. The training may follow the pattern in Maharashtra.
- To develop a licentiate course of three years to increase the supply of qualified health care providers in rural areas.
- To increase the supply of skilled birth care providers through a new midwifery education in obstetrics care (a cadre between medical doctor and ANM in the health system). A legislation with respect to this provision is pending with the Government, this will be reviewed and revised, if necessary, for the consideration of the government. To provide a career plan for village based Dais.
- To develop terms of reference to recognize the services of the already practicing health care providers at the village level. Further, the recognition should be conditioned upon their contribution in Public Health (e.g. implementation of National Health Programs). The Government will also need to define the requirements of additional training, to reach a certification level.

IV. PUBLIC PRIVATE PARTNERSHIP FOR IMPROVED HEALTH

From health financing perspective, for each 100 rupees spent on health care in MP, 75 rupees come from out of pocket - private funding. For the service provision, there is a rural urban divide - 70% of qualified providers are in urban areas and only 30% in the rural parts of the state. Seven out of about eight persons in selected health care staff categories work in the private sector. This does not include the public sector health employees (e.g. doctors, nurses and others) who practice privately after the duty hours. There are about 5000 qualified doctors (including 1500 ISM&H practitioners) in government service compared to 20,000 in the private sector. The DoHFW's 16,900 MPW (male) and ANMs could be contrasted with RMPs and Dais (50,000 each) offering health services at the household level particularly in rural areas (Ref:: Situation Analysis- The Health Sector in MP, June 2002, HLSP Consulting Ltd., MSG).

Although the government employs qualified health care practitioners and in many rural areas, the government staff is the only source of qualified health care, the less than qualified providers (non registered practitioners) predominate in rural areas and this trend is also increasing in some urban and semi-urban areas. On an average, 70% of the first contacts for

health care take place in private sector and private sector is the predominant provider of curative health care. Rich and poor often use private health care; poor often using the care from less than qualified private providers.

Given the numbers and spread of private health care providers in rural areas (often the less than qualified providers) and substantial presence of qualified and less than qualified providers in urban areas, it is obvious to explore possibilities of the role the private sector can play for improved public health in the state. So far, the private health services have operated in isolation, with no or minimum control for quality. In general, the technical qualities of care in government facilities are far better than in the private sector (particularly in the rural areas). To address the issues related to access and quality of health care in private sector, government proposes strategies and interventions to use the potential of the private health care sector for improvement in population (public) health. Government puts forward specific measures for encouraging public - private collaboration in the fields of immunization, reduction of maternal mortality and control of infectious diseases (tuberculosis, leprosy etc.). Further, measures are suggested to use the human and financial resources of non-government organizations (NGOs) and private sector for management of some government owned facilities.

STRATEGIES

- To Identify and create inventory and mapping of all types of health service as well as social services providers and devising a sustainable system to update the inventory mechanism.
- To review the Nursing Home Act and, if necessary, modify it.
- To encourage cooperative bodies, professional bodies (Medical and Nursing associations), NGOs, private and corporate institutions and charitable organizations to manage the Government health institutions (on contract or other arrangements).
- To promote partnerships (e.g. public private partnerships) of various types and levels for effective provision of health services; like contracting out a semi-urban or extremely rural PHC to NGOs / private sector / charitable organizations under the scheme 90/10 of the Government of India.
- To promote active involvement of the rural practitioners (less than qualified) / para-medical workers in rural and urban areas for national and state public Health program through training and recognition.

V. ACCESS TO EFFECTIVE, GOOD QUALITY AND SAFE PHARMACEUTICALS FOR ALL

Availability of reliable, safe, cheap and effective drugs is an essential element of a well functioning health system. They are important in the treatment and prevention of disease and one of the factors that promote health seeking among the population in facilities where their availability is assured. This requires an efficient, transparent, accountable and responsive drug management system and an attitude towards rational prescribing among providers and appropriate use by the population. Such a requirement would apply to medicines and supplies necessary in all systems of medicine. Finances earmarked to ensure this end also need to be streamlined. This calls for a stewardship role of Government to provide a policy framework for procurement of drugs and their rational use in allopathic as well other systems of medicine.

STRATEGIES

- Implementation of an approved drug policy. Procurement of drug to be centralized in the public sector and a passbook system should be introduced for supply of drugs to government institutions at state and district level.
- Implementation of Essential Drug Concept i.e. the use of essential drugs and standard treatment guidelines in the public and private health care system.
- Promote throughout the state rational drug use through the formation of active Drugs & Therapeutic Committees, effective public private partnerships and appropriate IEC within the community.
- Review and strengthen the control functions of Office of the Controller Food and Drugs as an enforcement agency- to act as a transparent and effective body in ensuring the quality of essential drugs in the drug supply chain

VI. CARING FOR WORKERS HEALTH

A safe and healthy work environment is a right of every worker. Occupational health embraces all types of employment including commercial enterprises, service trades, forestry, agriculture, and ergonomics and focus on the issue of industrial hygiene, industrial diseases, industrial accidents, toxicology in relation to industrial hazards, industrial rehabilitation, etc. The magnitude of the problem is greater

than is usually believed. From an epidemiological survey, carried out in many countries by WHO, it was reported that workers still suffer from severe, acute and chronic occupational illness affecting their health and working capacities. In spite of these negative effects of work related illness on the health status of the global population, 20-90% of workers, depending on the country, have no access to occupational health services. The need for such services is particularly acute in the developing countries, which constitute the majority. Much legislation exists to protect workers rights and health but they are not implemented properly and only elite workers enjoy the benefits. The policy therefore proposes to ensure the health of persons working in places like factories, mines, offices, farms, prison, hospitals, and other establishments, including unorganized sector, through appropriate working environment and use of modern occupational health techniques.

STRATEGIES

- Ministry of Health should provide stewardship to co-ordinate health care activities of various agencies (e.g. industry, employee insurance schemes, NGOs, small scale industries, etc) working for the mines, factories, offices, farms, prison, hospitals, other establishments including unorganized sector, in order to improve efficiency of the total system
- Ensuring adequate measures for prevention of man made disasters and preparedness to meet natural disasters.

VII. IMPROVING MENTAL HEALTH OF STATE CITIZENS

Madhya Pradesh is characterized by low incomes, high prevalence of communicable diseases and malnutrition, low life expectancy and a weak public health system. Mental health issues are often last on the list of priorities in a state where mortality is mostly the result of infectious diseases and malnutrition. Morbidity and mortality from mental illness receive very little attention from the Government though anecdotal experience seems to suggest that mental illness burden in the state is not low. The area of mental health is an important area which has been studied little and appropriate services to promote mental health have been even less in the state. The policy aims to address issues related to mental health, to recognize and reduce the prevalence of mental illness, and to provide the best cost effective care and support to patients with mental illness in the state

STRATEGIES

- Setting up an apex institute of Mental Health in the State to provide direction for an overall mental health program in the state in terms of policy towards mental health, services and research. This institute can be located in the currently underutilized State Institute of Health Management & Communication, Gwalior and associated with the Mental Hospital in Gwalior.

[1]. Ref. *Gopalakrishnan & Agnani*, Rajiv Gandhi Mission: Occasional Papers, Document: 8, March 2001

[2]. Ref: Situation Analysis: The Health Sector in Madhya Pradesh, June 2002.