CHAPTER - III
AN OVERVIEW OF STATUS OF HEALTHCARE SYSTEM IN INDIA AND KARNATAKA
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Section: A

Facets of Health and Healthcare Services

3.1.1 Introduction

It is universally accepted that health of the people plays an important role in socio-economic development of the country, so all the countries have paid special attention towards healthcare, the same is discussed in this chapter with respect to health, healthcare, healthcare system; characteristics of healthcare; types of healthcare; public healthcare; private healthcare; role of government in healthcare; public private partnership in healthcare; other sectors involved in health care.

3.1.2 Health, Healthcare and Healthcare System

Health:

As defined by World Health Organization (WHO), "A State of complete physical, mental, and social well-being and not merely the absence of disease or infirmity". Health is a dynamic condition resulting from a body's constant adjustment and adaptation in response to stresses and changes in the environment for maintaining an inner equilibrium called homeostasis.

"A healthcare system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A healthcare system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home, private providers, behavior change programs, vector-control campaigns, health insurance organizations, occupational health and safety legislation. It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health". ¹⁰²

Healthcare:

Healthcare is one of the most important components of our life, disease or illness can really mean a down turn in our life. The biggest asset we have in our life is health.

Healthcare is normally defined as the management or treatment of any health problem through the services like medical, nursing, dental and other related services. When we discuss about healthcare, then we are discussing of all goods and services that are produced and utilized to improve health, like curative, preventative or even palliative solutions. A system of healthcare is one that is organized to give health services to the population of the country.

Healthcare can be for an individual or for a large group of people depending on how the systems of that country are organized. Governments have the responsibility to create and formulate policies that will favor people. Good systems of health can be erected by the top most leadership of a state.

The importance of good healthcare can be seen in the hopes of people who are yearning for health. To become rich or to produce something in life, ability or strength is necessary. If people are sick, their productivity will also be low. Therefore health is wealth and this is the biggest lesson that should be learnt today. When it comes to preventative healthcare like the use of vaccinations, it is going ahead of time and making sure that all are safe from future illnesses. When it comes to prevention of pregnancy as part of care for health, we are able to structure our lives and take control.103

Healthcare refers to an act of taking preventative or necessary medical procedures to improve a person's well-being and it may be done with surgery, the administering of medicine, or other alterations in a person's lifestyle. These services are typically offered through a healthcare system made up of hospitals and physicians.104


Healthcare System:

Healthcare System refers to the system by which healthcare is made available to the population and financed by government, private enterprise, or both. In a larger sense, the elements of a healthcare system embrace the following:

1. Personal healthcare services for individuals and families, available at hospitals, clinics, neighborhood centers, and similar agencies, in physicians' offices, and in the clients' own homes.
2. The public health services needed to maintain a healthy environment, such as control of water and food supplies, regulation of drugs, and safety regulations intended to protect a given population.
3. Teaching and research activities related to the prevention, detection, and treatment of disease.
4. Third party (health insurance) coverage of system services.

Healthcare System refers to the manner in which medical services are organized, managed, and provided. Healthcare delivery System consists of the professionals who provide the required services. Three major agents of healthcare system are:

i. The Health Authority (Ministry of Health).
ii. The hospital-based physicians and individuals in need for medical treatment (patients).
iii. The health authority is responsible for providing public healthcare, assumed to be free of charge for the patients at the point of consumption. Physicians decide to work in a public hospital or establish their own private practice. Since private healthcare is not funded by government, patients are charged a (full-cost) price if they decide to visit a private hospital.

105 “Health Care System”, online available at<http://medical-dictionary.thefreedictionary.com/health+care+system> accessed on 15/03/2013

3.1.2.1 Characteristics of Quality Healthcare

Quality Healthcare:

The Institute of Medicine defines healthcare quality as the extent to which health services provided to individuals and patient populations improve desired health outcomes. The care should be based on the strongest clinical evidence and provided in a technically and culturally competent manner with good communication and shared decision making.

Total quality is best defined as an attitude, an orientation that permeates an entire organization, and the way in which that organization performs its internal and external business. People who work in organizations dedicated to the concept of total quality constantly strive for excellence and continuous quality improvement in all that they do.

Characteristics of Quality Healthcare:

1. Safe: Avoiding preventable injuries, reducing medical errors
2. Effective: Providing services based on scientific knowledge (clinical guidelines)
3. Patient centered: Care that is respectful and responsive to individuals
4. Efficient: Avoiding wasting time and other resources
5. Timely: Reducing waiting times, improving the practice flow
6. Equitable: Consistent care regardless of patient characteristics and demographics.\(^{107}\)

3.1.3 Types of Healthcare System

Health systems vary substantially from country to country. Some countries have public healthcare systems, others have private systems, and some have a combination of both. Most healthcare systems involve a mixture of public and private provision and participation. Traditionally, healthcare is mainly provided publicly and financed by general taxation rather than private insurance payments. Still there exists a private sector alongside the public one in most countries. An important difference, though, is that patients generally receive public healthcare for free, while seeking

private healthcare they often have to cover the costs of the medical treatment by themselves.\footnote{“Healthcare Systems: Public, Private and Mixed”, online available at <http://www.technofunc.com/index.php/domain-knowledge/healthcare-industry/item/healthcare-systems-public-private-and-mixed> accessed on 20/03/2013.}

### 3.1.3.1 Public Healthcare System

The public system runs by the government through Medicare which is paid by our taxes. People won’t pay anything to go to a public hospital, but they might not get to choose which hospital, or which doctors will treat them. They also might have to go on the Public Hospital Waiting List and wait a while for treatment. If there is an emergency they will be treated straight away.

Medicare doesn’t usually cover the full cost of doctor’s visits, tests and prescription medicines, so some time they have to pay some money towards the cost of such services.\footnote{Online available at <https://www.nib.com.au/home/newtonib/whynib/pages/publicandprivatesystem.aspx> Accessed on 10/03/2013.}

Government runs public healthcare system and it is paid from our taxes. The term “government” includes a wide range of entities, from the national or federal government, provincial governments, regional authorities, and local or municipal governments. Today, most governments recognize the importance of public health programs in reducing the incidence of disease, disability, the effects of ageing and health inequities. Public healthcare is generally administered by a different government health acts that have the basic objective and aim of providing universal healthcare coverage to all of its citizens.

It is designed to ensure all eligible people in the country have reasonable access to insured health services on a prepaid or free basis, with no direct charges at the point of service. Public healthcare is paid by the government, using money collected from taxpayers. It is generally designed to ensure the delivery of care is consistent across the country - that everyone under the program receives the same level and same quality of treatment.

Public participation has different forms. At a minimum, the state may regulate the healthcare system by imposing laws governing the delivery and financing of
healthcare. The state may play a more extensive role such as providing and funding healthcare services, employing healthcare professionals, owning or controlling hospitals and clinics and directly administering and financing public health insurance schemes.\footnote{“Healthcare Systems: Public, Private and Mixed”, online available at<http://www.technofunc.com/index.php/domain-knowledge/healthcare-industry/item/healthcare-systems-public-private-and-mixed> accessed on 20/03/2013.}

Major Features of Public Healthcare System

i. Long waiting period and long queues.

ii. Duty doctor will treat the patient.

iii. Free medicines are provided.

3.1.3.2 Private Healthcare System

The private, or non-government part of the healthcare system, is made up of private hospitals, private health insurance companies. Governments don’t pay for the services and the private healthcare system includes things like treatment in a private hospital.

Non-government in this context includes for-profit businesses, charitable and non-profit organizations, as well as individuals and families. Private participation may occur in the delivery of healthcare services through private for-profit or non-profit hospitals and clinics and the financing of services through individual out-of-pocket payments and private health insurance.

In a private healthcare system, people can choose the services they require and the provider they want. They pay out of their own pocket or through insurance, which is either paid by themselves or their employer. Most developing economies are covered by private healthcare.

Major Features of Private Healthcare System:

i. No waiting period and no long queues.

ii. Self-selection of hospital and doctor to be treated.

iii. Free medicines are not provided.
3.1.4 Role of Government in Public Welfare and Healthcare

In olden times (1830–1870) the state’s role was to maintain only law and order, so it was considered as 'police-state' which had negative role to perform. Administration of justice and collection of taxes were also included. As a result of the socio-economic and political changes, things have changed and the concept of state has also changed to give way for the principle of 'welfare state'. The following resource explains the concept of welfare states, extent of welfare measures and the characteristics of a welfare state and more.

The establishment of welfare states in democratic countries was a remarkable development of the 20th century. In a welfare state, the role and functions of government are extensive and diversified. In modern times, the responsibilities and functions of governments have increased beyond the limits. The concept of state in the early periods was mainly of a 'police state'. i.e., the governments had to perform the sovereign functions along with the establishment of public safety and security and these formed the primary duties of every government. But democracy changed the role and functions of the government. Today, the concept of ‘welfare state’ has redefined the very meaning of democracy.

A welfare state is a state or a government meant for the welfare, or the wellbeing of its population. In other words, it is a government which primarily aims at the 'welfare' of the people. A welfare state takes the responsibility of the welfare and the economic and social wellbeing of its citizens. Welfare implies the benefits or different modes of aid provided to the people. It can be in terms of money or services. Cash payments, subsidies, concessions, grants and public distribution come under the term welfare. All these welfare measures amount to the redistribution of governmental revenue to the needy.

The sick, the poor, the disabled, the unemployed and similar groups of people are to be taken care of in a welfare state. It has the duty of eliminating economic inequalities to ensure a reasonable and equitable standard of living, to all citizens of the country through better Education, healthcare, social insurance, housing, old age
pensions and medical care have become the responsibility of welfare states. They even bother to provide unemployment compensation payments to the unemployed\textsuperscript{111}.

So, the Indian Government has given priority to Public Health and Welfare since from its First Five Year Plan with the recommendation of different Health Sector Committees. A detailed discussion is being made in section-B i.e., Healthcare Programmes and Policies with reference to India and Karnataka.

\subsection{3.1.5 Public Private Partnership in Healthcare (PPP)}

There is no widely accepted definition of a Public Private Partnership (PPP). In broad terms, PPP refers to an arrangement between the public and private sectors with clear agreement on shared objectives for the delivery of public infrastructure and/or public services. It is an approach that public authorities adopt to increase private sector involvement in the delivery of public services. In many countries, PPPs are now a central feature of ongoing efforts to modernize public services and infrastructure.

Public-Private Partnerships (PPPs) is a special feature of governance; it is an organizational innovation that allows for improved provision of public services with limited budget, by tapping the financial, technical and outreach-related strengths of the private sector. Under a PPP, a local authority or a central-government agency enters a long term contractual agreement with a private supplier for the construction of public infrastructure or the delivery of a public service, such that resources, risks and rewards are optimally shared among the partners\textsuperscript{112}.

“A means to bring together a set of actors for the common goal of improving the health of a population based on the mutually agreed roles and principles”\textsuperscript{113}

The Government of India defines PPPs as\textsuperscript{114}: ‘A partnership between a public sector entity (sponsoring authority) and a private sector entity (a legal entity in which

\begin{enumerate}
\end{enumerate}
51% or more of equity is with the private partner(s) for the creation and/or management of infrastructure for public purpose for a specified period of time (concession period) on commercial terms and in which the private partner has been procured through a transparent and open procurement system’.

A variety of co-operative arrangements between the government and private sector in delivering public goods or services provides a vehicle for coordinating with non-governmental actor to undertake integrated, comprehensive efforts to meet community needs to take advantage of the expertise of each partner, so that resources, risks and rewards can be allocated in a way that best meets clearly defined public needs.115

Emergence of Public Private Partnership in Healthcare in India:

The Public healthcare system is not able to meet the growing demands for healthcare facilities. The gap between demand and supply has to be bridged by the private players and this has facilitated the growth of the corporate healthcare industry in India. Emergence of strong corporate players is not a substitute for expansion for public sector health facilities but it has led to professionalization of the industry, better hospital management and higher investment in health infrastructure facilities.116

3.1.6 Other Sectors Connected to Healthcare like NGO and Insurance Companies

Life is full of uncertainties. Risk lurks in every nook and corner of human life. In short, life is unpredictable. We need to be prepared for such circumstances. Leading a happy life, involves good planning and analysis for your personal health. Accidents do happen and you need to be prepared for such situations. In times of high health cost, you need to get covered for health risks.


To overcome uncertainties in human life and lead a life free from stress, insurance plays an important role. A good insurance should cover Doctor Visits, Lab tests, Hospital stays and Diagnostic tests.\textsuperscript{117}

**Health Insurance:**

A type of insurance coverage that pays for medical and surgical expenses, which are incurred by the insured, Health insurance can either reimburse the insured for expenses incurred from illness or injury or pay the care provider directly. Health insurance is often included in employer benefit packages as a means of enticing quality employees.\textsuperscript{118}

The ILO definition of health insurance is “The reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individuals or households who are included in a common fund that makes good the loss caused to any one member” (ILO, 1996).

Thus, in a health insurance programme, people who have the risk of a certain event contribute a small amount (premium) towards a health insurance fund. This fund is then used to treat patients who experience that particular event (e.g. hospitalization).\textsuperscript{119}

**Health Insurance in India:**

The establishment of the Insurance Regulatory and Development Authority Act in 1999 paved the way for the opening of the health insurance market for private competition by 2000. The introduction of Third Party Administrators (TPA) in an effort to provide better services as well as cashless transactions to the insured has reduced administration hassles. Thus, the administrative costs, which were the secondary objective of the TPA, can be capped. Moreover, the collection of premium increased Centre for Public Policy Research over 100 per cent in 2004-05. Post

\textsuperscript{117} “Health Insurance”, online available at <http://www.medindia.net/patients/insurance/health_insurance.htm> accessed on 20/10/2012.

\textsuperscript{118} “Health Insurance”, online available at <http://www.investopedia.com/terms/h/healthinsurance.asp> accessed on 16/03/2013.

\textsuperscript{119} Marathe Sujata, “Health Insurance on Healthcare Delivery by Private Hospitals in Mumbai”, (2009), A project report submitted to Tata Institute of Social Sciences, Mumbai.
liberalization, the health insurance industry stands at 90:10 in favour of public insurance companies.\textsuperscript{120}

**Importance of Health Insurance:**

The importance of Health Insurance can never be undervalued for the following reasons:

- Provides security to human life which is of prime importance to every individual.
- Closely bonds Insurance Companies, Hospitals, Policyholders and TPAs together for the benefit of Indian masses.
- An answer to the solution of uncertainties and risks those are prevalent and ever-pervading in human life.
- Prevention and minimization of unforeseen losses.
- Access to quality healthcare.
- Means of savings and a safe investment option.
- Provides financial stability in life.
- A tax-saving instrument that significantly contributes in reduction of tax deductions.
- Reduces tensions and stress caused on account of hospitalization.
- Greatly contributes in leading a stress-free life.\textsuperscript{121}


\textsuperscript{121} Online available at \texttt{<http://www.medindia.net/patients/insurance/awareness-healthcare-insurance-india.htm>} accessed on 21/10/2012.
### Table No.3.1
Growth of Health Insurance Sector in India
(In Percent)

<table>
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</thead>
<tbody>
<tr>
<td><strong>Public Sector Health Insurance</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>New India Insurance</td>
<td>54.96</td>
<td>21.10</td>
<td>39.52</td>
<td>14.34</td>
<td>58.03</td>
<td>12.11</td>
<td>14.49</td>
<td>28.43</td>
<td>17.33</td>
</tr>
<tr>
<td>Oriental Insurance</td>
<td>7.86</td>
<td>10.18</td>
<td>31.53</td>
<td>23.30</td>
<td>23.42</td>
<td>30.32</td>
<td>49.06</td>
<td>25.13</td>
<td>-0.48</td>
</tr>
<tr>
<td>National Insurance</td>
<td>42.37</td>
<td>10.41</td>
<td>-7.63</td>
<td>13.20</td>
<td>105.54</td>
<td>24.72</td>
<td>26.17</td>
<td>45.92</td>
<td>34.20</td>
</tr>
<tr>
<td>United India Insurance</td>
<td>10.84</td>
<td>5.15</td>
<td>22.23</td>
<td>20.97</td>
<td>59.90</td>
<td>29.61</td>
<td>39.45</td>
<td>33.86</td>
<td>32.72</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28.29</td>
<td>12.64</td>
<td>23.20</td>
<td>17.48</td>
<td>58.68</td>
<td>21.92</td>
<td>29.43</td>
<td>32.91</td>
<td>21.69</td>
</tr>
<tr>
<td><strong>Private Sector Insurance</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Royal Sundaram</td>
<td>66.84</td>
<td>86.54</td>
<td>70.56</td>
<td>92.62</td>
<td>11.45</td>
<td>5.38</td>
<td>9.61</td>
<td>24.31</td>
<td>40.97</td>
</tr>
<tr>
<td>Tata AIG</td>
<td>45.94</td>
<td>34.61</td>
<td>14.93</td>
<td>48.10</td>
<td>51.95</td>
<td>14.56</td>
<td>5.63</td>
<td>32.75</td>
<td>24.35</td>
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<tr>
<td>Reliance</td>
<td>50.38</td>
<td>2.43</td>
<td>7.89</td>
<td>686.17</td>
<td>307.17</td>
<td>12.77</td>
<td>-23.18</td>
<td>6.50</td>
<td>-11.40</td>
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<td>IFFCO-TOKYO</td>
<td>65.52</td>
<td>73.30</td>
<td>83.16</td>
<td>38.32</td>
<td>58.60</td>
<td>23.65</td>
<td>16.47</td>
<td>7.70</td>
<td>-8.18</td>
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<td>ICICI Lombard</td>
<td>290.91</td>
<td>126.42</td>
<td>131.06</td>
<td>168.10</td>
<td>20.20</td>
<td>16.62</td>
<td>-11.62</td>
<td>47.17</td>
<td>11.72</td>
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<tr>
<td>Bajaj Allianz</td>
<td>311.67</td>
<td>90.42</td>
<td>38.46</td>
<td>62.00</td>
<td>53.70</td>
<td>36.49</td>
<td>-11.03</td>
<td>14.92</td>
<td>27.54</td>
</tr>
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<td>HDFC-CHUBB</td>
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<td>N.A</td>
<td>129.80</td>
<td>123.73</td>
<td>176.03</td>
<td>61.92</td>
<td>490.63</td>
<td>22.32</td>
<td>25.17</td>
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<td>Cholamandalam</td>
<td>739.45</td>
<td>119.89</td>
<td>4.92</td>
<td>82.85</td>
<td>183.36</td>
<td>51.67</td>
<td>-9.87</td>
<td>-0.963</td>
<td>58.96</td>
</tr>
<tr>
<td>Apollo DKV</td>
<td>N.A</td>
<td>N.A</td>
<td>N.A</td>
<td>N.A</td>
<td>N.A</td>
<td>1391.0</td>
<td>139.43</td>
<td>154.45</td>
<td>69.46</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>157.02</td>
<td>91.84</td>
<td>77.45</td>
<td>129.12</td>
<td>60.83</td>
<td>38.58</td>
<td>19.42</td>
<td>32.47</td>
<td>12.46</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td>36.78</td>
<td>21.81</td>
<td>33.08</td>
<td>44.58</td>
<td>59.51</td>
<td>28.38</td>
<td>25.24</td>
<td>32.73</td>
<td>18.01</td>
</tr>
</tbody>
</table>

*Source: www.irda.gov.in*

Table 3.1 deals with the growth pattern of public and private sector health insurance players in India from financial year 2002-03 to 2011-12. In 2003-04, there was 36.78 percent growth in total premium out of which private sector growth rate was 157.02 percent and that of public sector was 28.89 percent, this shows fastest growth of private players compared to public players. The total growth of 21.81 percent comprises 12.64 percent and 91.84 percent growth by public and private health insurance sector respectively in 2004-05. In 2005-06, 77.45 percent and 23.20 percent growth was displayed by private and public health insurers respectively. In 2006-07 growth of public and private health insurers was 44.58 percent out of which
public sector growth was 17.48 percent and that of public sector has shown a decrease of 5.72 percent in growth as compared to 2005-06. In the same year, New India Assurance suffered a decrease of 25.18 percent as followed by Oriental Insurance with 8.23 percent decrease in growth. Private sector experienced 129.12 percent growth in 2006-07 and 77.45 percent in 2005-06. Private sector expanded by 51.67 percent in 2006-07 over the previous year. Reliance emerged as the topper with 686.17 percent growth and ICICI ranked second with 168.10 percent. In 2008-09 growth of all health insurers was 28.38 percent. The public sector contributed 21.92 percent growth and 23.67 percent was contributed by private sector health insurance sector. In 2009-10 the health insurance sector grew by 25.24 percent however, it was 3.14 percent less over the previous year. In 2010-11, the growth of health insurance sector was 32.73 percent with an increase of 7.89 percent over the previous year. In this year public sector showed a dismal of increase by 2.48 percent over the previous year and in private sector growth was approximately 13.05 percent. In 2011-12 the overall growth was fallen by 14.72 percent whereas private and public sector also registered fall of 20 and 11.22 percent respectively. The growth rate of private sector has been higher than public sector, which shows a remarkable progress and performance in private health insurance sector.

The following Table No.3.2 explains about the timely reforms undertaken by Government of India in the area of health insurance sector from 1912 to 2011 as per the requirement through various committees and groups and it is noticed that, Indian government has changed the policies according to the demand of various categories like: workers, government employees, MPs, Judges, and Freedom Fighters etc.
TABLE 3.2
A Chronological List of Important Milestones in the Healthcare Insurance Segment\(^{122}\)

<table>
<thead>
<tr>
<th>YEAR</th>
<th>IMPORTANT EVENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1912</td>
<td>Insurance Act, 1912 passed, setting down rules and regulations specific to insurance industry.</td>
</tr>
<tr>
<td>1923</td>
<td>Workman’s Compensation Act passed, aims to provide workmen and/or dependents some relief in case of accidents arising out of or in the course of employment, causing death or disablement.</td>
</tr>
<tr>
<td>1938</td>
<td>Insurance Act, 1938 passed, recognizing two categories, i.e. Life and non-life (general) insurance. Led to an insurance wing being set-up, attached to the Ministry of Finance.</td>
</tr>
<tr>
<td>1948</td>
<td>Employee’s State Insurance (ESI) Act passed, providing protection to workers &amp; dependents in the organized sector for sickness, maternity and death.</td>
</tr>
<tr>
<td>1954</td>
<td>The Central Government Health Scheme started in 1954, providing health cover to employees of Central Government, MPs, Judges, Freedom Fighters and their families.</td>
</tr>
<tr>
<td>1956</td>
<td>Life Insurance Industry nationalized and Life Insurance Corporation of India (LIC) set up subsequently.</td>
</tr>
<tr>
<td>1959</td>
<td>Mudaliar Committee constituted, recommended provision of long-range health insurance policy for all and strengthening Primary Health Centres</td>
</tr>
<tr>
<td>1972</td>
<td>General Insurance industry nationalized; General Insurance Corporation of India came into being in 1973 with more than a hundred private companies merged into the four subsidiaries of GIC, namely; NICL, NIACL, OICL and UIICL. Before GIC came into existence, a number of private insurers offered group health cover to corporate bodies. GIC offered Limited hospitalization Centre for Public Policy Research cover since 1981</td>
</tr>
</tbody>
</table>

\(^{122}\)“Trends of Indian Health Insurance Industry”, online available at <http://shodhganga.inflibnet.ac.in/bitstream/10603/9222/13/13_chapter%204.pdf> accessed on 01/12/2013.
<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1986</td>
<td>GIC introduced Mediclaim insurance; modified in 1996 to allow differentials in premium for six age groups.</td>
</tr>
<tr>
<td>1999</td>
<td>Insurance Regulatory and Development Authority (IRDA) Act passed; opening up the insurance sector to private players allowing 26% Foreign Direct Investment in the sector.</td>
</tr>
<tr>
<td>2000</td>
<td>Indian Insurance Amendment Act, 2001 GIC became a re-insurer, its earlier role of co-ordination between the four subsidiaries taken over by a new body, General Insurance (Public Sector Companies) Association (GIPSA). IRDA introduced several insurance regulations including provisions for Third Party Administrators (TPA) system in health insurance.</td>
</tr>
<tr>
<td>2001</td>
<td>IRDA introduced several insurance regulations including provisions for Third Party Administrators system in health insurance.</td>
</tr>
<tr>
<td>2002</td>
<td>IRDA introduced Regulatory and Development Authority (Protection of Policy holders Interests) Regulations, 2002 was passed to safeguard the interest of the policy holder.</td>
</tr>
<tr>
<td>2003</td>
<td>IRDA set up a National Health Insurance Working Group. This committee was formed with the objective of identifying the existing problems in the health insurance industry and to make recommendations to enable and to encourage a large number of companies to participate in the growth of insurance in health financing.</td>
</tr>
<tr>
<td>2004</td>
<td>IRDA appointed a sub-committee to specifically to look into the areas of registration of standalone health insurance companies and to suggest innovations in health insurance products.</td>
</tr>
<tr>
<td>2005</td>
<td>Roadmap made for de-tariffication of general insurance market rolled out by IRDA.</td>
</tr>
<tr>
<td>2006</td>
<td>First Standalone Health insurance company came into business with a capital requirement of Rs.100 crore. The guidelines on file and user requirements for general insurance products were issued which superseded the earlier IRDA guidelines.</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>2007</td>
<td>The insurance market was de-tariffed. Earlier 70 percent of the General Insurance business was driven by various tariffs being prescribed by TAC, established under Sec.64 UM of Insurance Act, to control and regulate the rates, advantages, terms and conditions that may be offered by insurers in respect of general insurance business. Since any breach of tariffs constitutes a violation of Insurance Act, 1938, in a tariff driven market, the leverage for taking flexible decisions regarding the pricing based on the merit of individual risk was virtually nil.</td>
</tr>
<tr>
<td>2008</td>
<td>Insurance Information bureau set up by IRDA (primarily working on Health and motor data). General insurance Council for the first time defined the &quot;Pre-existing&quot; clause and made it standard across the industry.</td>
</tr>
<tr>
<td>2009</td>
<td>The Renewability of Health insurance policies circular issued on 31st March 2009 advises non-life insurers not to generally decline renewals except for certain specified reasons. Detailed instructions on Health Insurance for Senior Citizens stipulate that all health insurance products filed on or after 1st July, 2009 must allow entry up to 65 years of age, and also to make adequate dissemination of product information on websites. Also, the FICCI report on Health Insurance released in July 2009 includes Standard Treatment Guidelines for 21 common causes of hospitalization.</td>
</tr>
<tr>
<td>2010</td>
<td>The Preferred Provider Network (PPN) of hospitals introduced in July 2010 to offer cashless medical treatment following the initiative taken by the four public insurers to bring discipline on the pricing of hospital services. The health insurance market continues to be dominated by the four state-owned general insurers, which together accounted for almost 60 percent of the premiums.</td>
</tr>
<tr>
<td>2011</td>
<td>A key development was the announcement of portability of health insurance policies by IRDA. The regulator has issued guidelines for the arrangement to be effective from 1 July 2011, which will allow policyholders to switch providers on the same policy terms, particularly without losing the credit gained for pre-existing conditions in terms of waiting period. Circular on “De-Listing of Hospitals” and guidelines on “Distance Marketing” also rolled out.</td>
</tr>
</tbody>
</table>

NGOs and Self Help Groups:

NGOs are playing an important role in the overall development process. This is due to the various policies adopted by the Government of India. Many NGOs have grown in size and capabilities conducting research and training’s and developing effective and innovative programmes in the fields of education, micro-financing, and income generation activities etc. These have made an important contribution in the effort to eradicate various socio-economic problems up to certain extent, because all these are all closely intertwined with the vital health. The role of NGOs in sensitizing people and make them demand their entitlements for health rights is very significant. Research evidences have shown that NGOs have done positive impact in the field of primary health care development in many part of India.

The Indian healthcare industry is amongst the fastest growing service sectors in the world. Within the next decade, it is expected to grow at a rate of 15% every year. India has also become a major centre for medical tourism. People from around the world visit the country to get treated for numerous problems.\(^{123}\)

These players are generally involved in the implementation of Community Health Insurance Plans and insurance schemes in remote places. They help in complimenting formal health insurance companies in advocating health insurances. There are, at present, 64 groups involved in these practices. The most successful players are Self Employed Women’s Association (SEWA) of Gujarat, DHAN (Development of Humane Action) Foundation and ACCORD (Action for Community Organisation, Rehabilitation and Development) of Tamil Nadu, and Yeshasvini Trust of Karnataka.

NGOs participate in a wide spectrum of health-related activities during humanitarian emergencies and with significant capacity. When working with UN agencies and IOs, NGOs serve as the front-line combatant against epidemics, large-scale malnutrition, and ultimately high mortality rates. It is essential to understand that some NGOs specialize in health care, UN agencies like the World Health Organization (WHO), Pan American Health Organization (PAHO), UNHCR and

UNICEF, for example, are all key leaders and partners in assisting NGOs with their missions and capabilities particularly in health. NGOs provide ground level information about health needs of displaced and non-displaced populations, and are also the implementing agent for health programs. WHO and UNICEF, meanwhile, are often the backbone of support for shipments, surveillance, comprehensive data compilation, guidelines, and technical services.

The health sector incorporates a large swath of sectoral activities. NGOs are often, as mentioned, the first actors into an emergency setting and just as often the last to leave. NGOs provide valuable ground-level information for the international community as well as the ground-level implementation of health services.¹²⁴

Recent years have seen a growing capacity of nongovernmental organizations to develop patterns of cooperation among themselves locally, nationally, and internationally, for consultation and exchange of information, or for joint action. In the area of Primary Health Care and Development NGOs can play pivotal roles in the two major developmental approaches such as a) Integrated Human Development and b) Community participation.

Non-Government Organization played and can continue to play in the area of development of primary health care in India with an integrated and combined approach to poverty and health, especially in the context of the Millennium Development Goals to improve the well-being of the poor masses.¹²⁵

SHGs are small, voluntary associations of people from the same socio-economic background that have been established for the purpose of solving shared social and economic problems through self-help and mutual help. Such grass-roots commonality, it has been assumed, will promote community empowerment and prevent economic marginalization. Such an assumption is largely based on the global, neo-liberal agenda of seeing the withdrawal of the State from social provisioning.

SHGs have been widely adopted in India, especially to eliminate the social exclusion of poor women and improve their access to health.\textsuperscript{126}

3.1.7 Conclusion:

Health plays a vital role in the life of people and development of the country hence, health is one of the indicators of human development. Generally it is accepted that, Government is responsible for providing basic healthcare facilities and services to its population through Public healthcare system with free of cost or at subsidized prices. Sometimes, government fails to provide Tertiary care because of lack of services and facilities, in this situation; private sector comes forward to provide the same but, with higher charges. Solution for certain deficiencies like, lack of facilities and higher charges is Public Private Partnership (PPP) in healthcare. PPP provides healthcare with expertise and with minimum cost to its population. These are the three major players in provision of healthcare. Addition to these insurance sector (public and private), NGO and SHGs also helps to improve the required healthcare.

\textsuperscript{126} Anant Kumar, “Health inequity and women’s self-help groups in India: The role of caste and class”, online available at <http://hsr.e-ontentmanagement.com/archives/vol/16/issue/2/article/484/health-inequity-and-women%E2%80%99s-selfhelp-groups-in> accessed on 15/11/2012
Section: B

An Overview of Healthcare System in India and Karnataka

3.2.1 Introduction

Health is defined as a state of complete physical, mental and social well-being and just not the non-existence of disease or ailment. Health is a primary human right and has been accorded due importance by the Constitution through Article 21. Though Article 21 stresses upon state governments to safeguard the health and nutritional well-being of the people, the central government also plays an active role in the sector.\textsuperscript{127}

3.2.2 Public Healthcare System in India

Health sectors in India consists of three major players, Public sector comprising (Central, State and Local governments), private for profit sector and private not for profit sector (i.e., NGOs)

The public health services in India are further categorized in terms of Primary, Secondary and Tertiary care.

i. Primary healthcare services are provided by sub-centers (SCs) and primary health centers (PHCs).

ii. Secondary healthcare services are provided by community health centers (CHCs) and District hospitals.

iii. Tertiary healthcare services provide teaching and specialty hospitals.

Public Healthcare in Indian Constitution:

Health security is one of the major components of human development. Good health is not only an end product of development but also a necessary condition for

economic development. Improved health contributes to economic growth by reducing production losses due to illness of workers. There is significant relation between income growth and health.

Healthcare is also an important component of social security. Indeed medical care is widely regarded as the primary branch of social security since health is of concern to all age groups and all categories of employees. All comprehensive social security programmes, therefore, make provision for medical care.\footnote{International Labour Organisation (ILO) Convention No. 130 and Recommendation No. 69 Contains guidelines for the provision of medical care under social security.}

According to the Directive Principles of State Policy laid down in the Constitution, raising the level of nutrition and standard of living and the improvement of public health are among the primary duties of the State. Improvement in the health status of the population has been one of the major thrust areas for the social development programmes of the country.

Public spending on health in India at 1 percent of GDP is amongst the lowest of the world whereas its proportion of private spending on health is one of the highest. Households in India spend about 5-6 percent of their consumption expenditure on health, but the cost of services in the private sector makes it unaffordable for the poor and underprivileged.\footnote{Pandya Rameshwari, “Health, Family Planning and Nutrition in India” First Five Year Plan (1951-56) to Eleventh Five Year Plan (2007-12), New Century Publications, New Delhi 2009, p. 4}

### 3.2.2.1 Pre-Independence Period

The earliest indigenous system of medicine can be traced back to the development of Vedic medicine following the Aryan migration to the Indus Valley. The Vedic Samhitas which were religious texts, contain the concepts of anatomy, physiology and Pathology which were quite impressive, Ashok Maurya (279 - 236 B C) was responsible for the spread of social medicine, manifested in a public healthcare system that included hospitals and Sanitaria for men, women and children.

During the medieval period, physicians from west Asia who were trained in Unani system, compiled and translated Ayurvedic texts Hakim Yooufi (16th century) a physician in the court of Baber and Humayun is said to have synthesized Arabian,
Persian and Ayurvedic thought and produced a composite and integrated medical system. The late 19th and 20th century saw the method of Ayurvedic Physicians who were radically different from the classical texts and were deeply influenced by the Unani traditions in Islamic Medicine.\textsuperscript{130}

During the colonial period, state sponsored health services were essentially available to meet the health needs of the British army and British civilians living in India this is evident from the fact that the health and hygiene measures were concentrated mostly in cantonments and headquarters, Indian population was largely dependent on indigenous system of medicine and a limited number of available of missionary hospitals, government hospitals and dispensaries. British government provided public health services to the Indian population only when there was a outbreak of the epidemics. This trend continued until it was realized that the health of working population was closely linked with the productivity of the nation and its capacity to generate revenue. So after realizing that the minimum immunization services against small pox and basic curative services, they were started in the urban areas were introduced. This selective health intervention during colonial period resulted in the foundation of the western medicine in India. This led to the establishment of institutes to train health personnel, conduct basic research on tropical diseases and health services for the country but during the process of establishing western medicine in India, negligible efforts were made to assimilate the local health traditions. On the contrary, the indigenous system and the folk practices were looked upon the contempt, causing immense damage and decline of indigenous systems. This was the beginning of the elitism in health services in India. The people’s essentially holistic outlook on the health was eroded and gradually replaced by the drugs-diseases-doctor orientation.

Before Independence, socio-political and economic degradation in India had reached a level where hunger and malnutrition were rampant. The life expectancy at birth was as low as 26.9 years for males, 26.5 years for females and half the children used to die before the age of 5 years. Proportion of deaths among children less than ten years was accounting approximately 50 percent of the total deaths during 1930’s

\textsuperscript{130} “Health Sector in India: An Overview”, online available at <http://shodhganga.inflibnet.ac.in/bitstream/10603/1866/10/10_chapter1.pdf> accessed on 01/12/2012.
and 1940’s. Infant Mortality Rate (IMR) was as high as 162 infant deaths per 1000 live births; similarly Maternal Mortality Ratio was 20 per 1000 live births.

Of the communicable diseases, malaria accounted for 100 million cases every year, with very high mortality rate. The other deadly diseases were tuberculosis, cholera, smallpox, enteric fever, dysenteries, tetanus and diphtheria which also took a heavy toll of life. While millions lost their eye sights to trachoma, conjunctivitis, small pox and injuries, many more were crippled due to leprosy, filarial, worm infestation and venereal diseases. Estimates too these diseases show that the medical services were inadequate, both in number and the kind of medical care they delivered. The primary healthcare was non-existent. One health center served a population of about 105,626 which was spread across around 200 villages. The total number of available beds was 73,000. The situation was equally bad with respect to the availability of the medical professionals. The following table shows the ratio of the health service providers to the total population i.e., 300 million in India during British Rule.

**Table No. 3.3**

**Ratio of Health Providers to Population at the Time of Independence**

<table>
<thead>
<tr>
<th>Medical Professionals</th>
<th>Number Available</th>
<th>Ratio to the Total Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors</td>
<td>47,400</td>
<td>1 to 6,300</td>
</tr>
<tr>
<td>Nurses</td>
<td>7,000</td>
<td>1 to 43,000</td>
</tr>
<tr>
<td>Midwives</td>
<td>5,000</td>
<td>1 to 60,000</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>75</td>
<td>1 to 4,000,000</td>
</tr>
<tr>
<td>Dentist</td>
<td>1,000</td>
<td>1 to 300,000</td>
</tr>
</tbody>
</table>


The above figures clarifies that there was a lot of scarcity of doctors, nurses & health professionals to the ratio of total population. So in Post-independence period the healthcare evolved as a system and efforts were channelized to provide health services to all sections of the society. Health planning was accepted as an integral part of the overall planning for the socio-economic development of the country.131

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3.2.2.2 Post Independence period

At the time of Independence in 1947, healthcare services in India were utterly inadequate, urban-based and curative in nature. Majority of the population, especially the poor and those residing in rural areas did not have access to modern health facilities, so improvement in the health status of the population has been one of the major thrust areas in socio-economic development programmes of India since Independence.

Over the past six decades India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care levels in the government, private and voluntary sectors manned by professionals and paramedicals. India has invested massive amounts under the successive five year plans in medical education, training and research which have ensured large manpower from the super specialist to auxiliary midwives.

Current policies and programmes are aimed to provide essential supplies, improve efficiency and ensure accountability especially in states where performance is sub-optimal. In view of the massive inter-regional differences in the availability and utilization of health services and health indices of the population, a differential strategy is envisaged so that there is incremental improvement in all states and districts within a country.

Health Sector Trends in India

Improvement in the health status of population is a major thrust area under the social development programmes being undertaken in the country. This can be achieved through improvement in the access to and utilization of health services in the country with special focus on under-served and under-privileged segments of the population. India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care in government, voluntary and private sectors. Technological advances and improvement in access to healthcare technologies have resulted in a substantial improvement in health indices of the population and a steep decline in mortality. Trends from 1951 to 2011 are discussed in Table No. 3.4 and sharp improvement is noticed in the establishment of Sub-centers, Primary health
centers, Community health centers, nurse and doctor, result of the expansion of healthcare facilities polio has been eradicated and malaria has been reduced.\(^{132}\)

### Table No. 3.4


<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-centres, Primary health centres and Community health centres</td>
<td>725</td>
<td>57,363</td>
<td>1,63,181</td>
<td>1,76,820(^{133})</td>
</tr>
<tr>
<td>Dispensaries and Hospitals</td>
<td>9,209</td>
<td>23,555</td>
<td>43,322</td>
<td>NA</td>
</tr>
<tr>
<td>Beds (Public and Private)</td>
<td>1,11,198</td>
<td>5,69,495</td>
<td>8,70,161</td>
<td>NA</td>
</tr>
<tr>
<td>Nursing personnel</td>
<td>18,054</td>
<td>1,43,887</td>
<td>7,37,000</td>
<td>7,43,324(^{134})</td>
</tr>
<tr>
<td>Doctors (modern system)</td>
<td>61,800</td>
<td>2,68,700</td>
<td>5,03,900</td>
<td>6,91,633(^{135})</td>
</tr>
<tr>
<td>Malaria (cases in millions)</td>
<td>75</td>
<td>2.7</td>
<td>2.5</td>
<td>1.53(^{136})</td>
</tr>
<tr>
<td>Polio (number of cases)</td>
<td>29,709</td>
<td>265</td>
<td>Eradicated</td>
<td>Eradicated</td>
</tr>
</tbody>
</table>

*Source: National Health Policy, 2002.*

Note: NA - Not Available


\(^{133}\) Online available at <https://nrhm-mis.nic.in/UI/RHS/RHS%202011/RHS%20-March%202011-%20Tables-%20Final%20April%202012.pdf> accessed on 25/12/2012


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a. Healthcare under Five Year Plan

Health of a nation is an essential component of development, vital to its economic growth and internal stability. Assuring a minimal level of healthcare to the population is a significant constituent of the development process. There is a strong link between poverty and ill-health, ill-health leads to low productivity.

Health is fundamental to national progress in any sphere. In terms of resources for economic development, nothing can be considered of higher importance than the health of the people which is a measure of their energy and capacity as well as of the potential of man-hours for productive work in relation to the total number of persons maintained by the nation. For the efficiency of industry and of agriculture, the health of the worker is an essential consideration.

Health is a positive state of well-being in which the harmonious development of physical and mental capacities of the individual lead to the enjoyment of a rich and full life. It is not a negative state of mere absence of disease. Health further implies complete adjustment of the individual to his total environment, physical and social. Health involves primarily the application of medical science for the benefit of the individual and of society. But many other factors such as social, economic and educational have an intimate bearing on the health of the community. Health is thus a vital part of a concurrent and integrated programme of development of all aspects of community life.

Improvement in the health status of population is the thrust area of socio-economic developmental programmes in India. With this background India has built up a vast health infrastructure and manpower at primary, secondary and tertiary care levels in the government, voluntary and private sectors manned by professionals and paramedicals. India has invested massive amounts under the successive Five Year Plans in medical education, training and research, which have ensured large manpower from the super-specialists to the auxiliary midwives. Current policies and programmes are aimed to provide essential supplies, improve efficiency and ensure accountability especially in the backward states. Healthcare under Five Year Plan is discussed in Table No. 3.5, which examines that the outlay for health since First Five Year Plan is around only 2 and 3 percent of the total plan outlay but, it rose to 4 and 6 percent during Ninth and Eleventh Plan.
### Table No. 3.5

Allocation of Amount for Healthcare Schemes during Five Year Plans  
(Rs. in crores)

<table>
<thead>
<tr>
<th>SL. NO</th>
<th>Plan Period</th>
<th>Total Plan Investment Outlay (All Heads of Department) of India</th>
<th>Health Sector</th>
<th>Health (%)</th>
<th>Family Welfare (%)</th>
<th>AYUSH (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>First Plan (1951-56)</td>
<td>1960.0</td>
<td></td>
<td>65.2 (3.3)</td>
<td>0.1 (0.1)</td>
<td>-</td>
<td>65.3 (3.4)</td>
</tr>
<tr>
<td>2</td>
<td>Second Plan (1956-61)</td>
<td>4672.0</td>
<td></td>
<td>140.8 (3.0)</td>
<td>5.0 (0.1)</td>
<td>-</td>
<td>145.8 (3.1)</td>
</tr>
<tr>
<td>3</td>
<td>Third Plan (1961-66)</td>
<td>8576.5</td>
<td></td>
<td>225.9 (2.6)</td>
<td>24.9 (0.3)</td>
<td>-</td>
<td>250.8 (2.9)</td>
</tr>
<tr>
<td>4</td>
<td>Annual Plan (1966-69)</td>
<td>6625.4</td>
<td></td>
<td>140.2 (2.1)</td>
<td>70.4 (1.1)</td>
<td>-</td>
<td>210.6 (3.2)</td>
</tr>
<tr>
<td>5</td>
<td>Fourth Plan (1969-74)</td>
<td>15778.8</td>
<td></td>
<td>335.5 (2.1)</td>
<td>278.0 (1.8)</td>
<td>-</td>
<td>613.5 (3.9)</td>
</tr>
<tr>
<td>6</td>
<td>Fifth Plan (1974-79)</td>
<td>39426.2</td>
<td></td>
<td>760.8 (1.9)</td>
<td>491.8 (1.2)</td>
<td>-</td>
<td>1252.6 (3.1)</td>
</tr>
<tr>
<td>7</td>
<td>Annual Plan (1979-80)</td>
<td>12176.5</td>
<td></td>
<td>223.1 (1.8)</td>
<td>118.5 (1.0)</td>
<td>-</td>
<td>341.6 (2.8)</td>
</tr>
<tr>
<td>8</td>
<td>Sixth Plan (1980-85)</td>
<td>109291.7</td>
<td></td>
<td>2025.2 (1.8)</td>
<td>1387.0 (1.3)</td>
<td>-</td>
<td>3412.2 (3.1)</td>
</tr>
<tr>
<td>9</td>
<td>Seventh Plan (1985-90)</td>
<td>218729.6</td>
<td></td>
<td>3688.6 (1.7)</td>
<td>3120.8 (1.4)</td>
<td>-</td>
<td>6809.4 (3.1)</td>
</tr>
<tr>
<td>10</td>
<td>Annual Plan (1990-91)</td>
<td>61518.1</td>
<td></td>
<td>960.9 (1.6)</td>
<td>784.9 (1.3)</td>
<td>-</td>
<td>1745.8 (2.9)</td>
</tr>
<tr>
<td>11</td>
<td>Annual Plan (1991-92)</td>
<td>65855.8</td>
<td></td>
<td>1042.2 (1.6)</td>
<td>856.6 (1.3)</td>
<td>-</td>
<td>1898.8 (2.9)</td>
</tr>
<tr>
<td>12</td>
<td>Eighth Plan (1992-97)</td>
<td>434100.0</td>
<td></td>
<td>7494.2 (1.7)</td>
<td>6500.0 (1.5)</td>
<td>108.0 (0.02)</td>
<td>14102.2 (3.2)</td>
</tr>
<tr>
<td>13</td>
<td>Ninth Plan (1997-02)</td>
<td>859200.0</td>
<td></td>
<td>19818.4 (2.31)</td>
<td>15120.2 (1.76)</td>
<td>266.35 (0.03)</td>
<td>35204.95 (4.09)</td>
</tr>
<tr>
<td>14</td>
<td>Tenth Plan (2002-07)</td>
<td>1484131.3</td>
<td></td>
<td>31020.3 (2.09)</td>
<td>27125.0 (1.83)</td>
<td>775.0 (0.05)</td>
<td>58920.3 (3.97)</td>
</tr>
<tr>
<td>15</td>
<td>Eleventh Plan (2007-12)</td>
<td>2456571.0</td>
<td></td>
<td>136147.0 (6.31)</td>
<td>3988.0 (0.18)</td>
<td>3928.0 (0.18)</td>
<td>140135.0 (6.49)</td>
</tr>
</tbody>
</table>

Source: Planning Commission of India.

Notes:

* Department of ISM & H (now AYUSH) was created during 8th Plan Period.

\[\text{Department of Health and Family Welfare merged from 2005 and Rs. 136,147.00 crores for newly created Health Research Department during 2008-09.}\]

\[\text{Figures in bracket indicate percent of total plan investment outlay.}\]
India after independence and since its First Five Year Plan has given special attention towards healthcare and it is noticed in Table No. 3.5 that the total allocation for health sector during First Five Year Plan was 3.4 percent which consists of two departments i.e., Health and Family Welfare, during the Second Plan the percent of allocation to health sector decreased by 0.3 percent with (3.1%), further in the Third Plan, Plan allocation again decreased by 0.2 percent and stood at 2.9 percent. During the Annual Plans from 1966-69 the Plan allocation rose by 0.3 percent (3.2%), further at the time of Fourth Plan allocation for health sector increased steadily to 3.9 percent, correspondingly during Fifth Plan, allocation was decreased by 0.8 percent (3.1%), further decreased by 0.3 percent (2.8%) during the Annual Plan of 1979-80. Allocation during Sixth Plan rose with 0.3 percent (3.1%) and remained constant during Seventh Plan, but during the two Annual Plans of 1990-91 and 1991-92, Plan Allocation came down by 0.2 percent and stood with 2.9 percent.

During Eighth Plan the allocation for health sector went up by 0.3 percent (3.2%) and AYUSH (Ayurveda, Yoga, Unani, Siddha and Homoeopathy) was added in health sector, so, the health sector consists of three departments i.e., 1)Health 2)Family Welfare 3)AYUSH. During Ninth Five Year Plan, a drastic change was noticed in the allocation of amount for health sector, which increased by 0.89 percent and rested at 4.09 percent, but this increased allocation was not continued in the next Plan, further it decreased by 0.12 percent and stood with 3.97 percent during Tenth Plan.

The highest allocation of amount in the era of Five Year Plan was viewed during Eleventh Plan, where the amount was increased by 2.52 percent and rested at 6.49 percent, during the same period, Health and Family Welfare Departments were merged.

According to the increasing trend of population, there is a need of increasing Plan allocation in the area of health sector in the upcoming Five Year Plans.
b. National Health Committees

Over the past decades, several Committees and Commissions have been appointed by the Government to examine issues and challenges facing the health sector. The purpose of these committees formed from time to time is to review the current situation regarding health status in the country and suggest further course of action in order to accord the best of healthcare to the people.\(^{137}\)

Health development is a continuous and dynamic process. Strategies for development of health services have to be reviewed, so various committees of experts have been appointed by the government from time to time to render advice about different health problems. The reports of these committees have formed an important basis of health planning in India which is enlightened in Table No. 3.6

<table>
<thead>
<tr>
<th>No.</th>
<th>Year</th>
<th>Name of the Committees</th>
<th>Major Policy Decisions Recommended</th>
</tr>
</thead>
</table>
| 1   | 1946 | Bhore Committee        | • Developing Proper Health Services easily available and accessible to people.  
                                  | (Report of this committee is relevant to the present situation and regarded as an authoritative document)  
                                  | • Establishing of Primary Health Centres.  
                                  | • Social Orientation of Doctors.  
                                  | • Small Units of Health Administration.  
                                  | • Integrated Preventative and Curative Services. |
| 2   | 1948 | Sokhey Committee       | • Free Healthcare Services.  
                                  | (Sub-Committee of National Planning Committee)  
                                  | • Integration of Preventive and Curative Functions. |
| 3   | 1961 | Mudaliar Committee     | • Expansion of Health Service Provisions. |
| 4   | 1963 | Chadah Committee       | • Malaria Eradication Programme with Vigilance Operation.  
                                  |                                 | • Basic Health Workers. |

\(^{137}\) 'Health Committee and Commission Reports, 1946-2005’, *National Health Profile 2011*, p. 221.

<table>
<thead>
<tr>
<th>Year</th>
<th>Committee</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| 1966 | Mukherjee Committee | • Basic Health Services.  
• Family Planning Activities to be separated with ANM (Auxiliary Nurse Midwife). |
| 1967 | Jungalwala Committee | • Integration of Health Services.  
• Ban on Private Practicing. |
| 1973 | Kartar Singh Committee | • Rural Orientation of Medical Education. |
| 1975 | Shriastav Committee | • Creation of National Referral Services Complex. |
| 1975 | Hathi Committee | • Promoting growth of Drug Industry. |
| 1981 | ICSSR and ICMR Study Group (This group was setup after India became a signatory) | • Health for All.  
• Integration of overall Development of Family Planning.  
• Improvement in Nutrition.  
• Environment and Health Education.  
• Provision of Adequate Health Services for all and especially for the poor and under-privileged. |
| 1983 | Mehta Committee | • To ensure the maintenance of high standard of Medical Education |
| 1987 | Bajaj Committee | • To improve Health Manpower Planning, Production and Management |
| 2003 | Mashelkar Committee | • A new structure for the Drug Regulatory System  
• Setting up of a National Drug Authority |

The earliest committees included, the Health Survey and Development Committee (Bhore Committee) and Sokhey Committee. Other main Committees in the Post-Independence period included Mudaliar Committee, Chadha Committee, Mukherjee Committee, Jungalwalla Committee, Kartar Singh Committee, Mehta Committee, Bajaj Committee amongst others. Some of the recent Committees include the Mashelkar Committee and the National Commission on Macroeconomics and Health. The Committees and Commissions have been headed by eminent public health experts, who have studied the issues in an in-depth manner and provided overarching recommendations for various aspects of the health care system in India. The areas covered by them related to organization, integration and development of health care services / delivery system across levels; health policy and planning; national programmers; public health; human resources; indigenous system of medicine; drugs and pharmaceuticals amongst others. An examination of these reports reveals the options, lessons and challenges for strengthening India’s health system.
c. Health Sector Reforms

Health Sector Reform is a sustained process of fundamental change in policy and institutional arrangements of the health sector usually guided by the Government. This process lays down a set of policy measures covering the four main functions of health system which includes governance, provision and financing and resource generation. It is designed to improve the performance of health sector and ultimately the health status of the people.

Health sector reform deals with equity, efficiency, quality, finance and also defines the priorities, refining the policies and reforming the institutions through which the policies are implemented.\textsuperscript{139}

Necessity of health sector reforms:

Many developing countries across the globe have been facing water-tied compartments of constraints to control disease burdens that are emerging day by day and to improve the health status and quality of life of their people. The major reasons for the health sector reforms are as follows:\textsuperscript{140}

i. Scarce resources.

ii. Inefficient use of resources.

iii. Inaccessible need based healthcare.

iv. Improper health planning for the needy people.

v. Health services not responding to the demands of the people.

Coherent approach to health sector reform

During Ninth Five Year Plan the health system reform at Primary Healthcare Level has faced the problem of sub-optimal functioning and difficulties in providing adequate investments for improving healthcare facilities in the public sector. Almost

\textsuperscript{139} "WHO", 1997.

all the state governments have initiated health system reforms with public sector playing lead role. It has been also observed that structural reforms related to reorganization and restructuring of all the elements of healthcare so that they function as integrated component of health system. so that the functional reforms are aimed at improving efficiency by creating a health system with well-defined hierarchy functional referral linkages in which the health personnel should work as multi-professional team and perform duties according to their positions, skill and level of care.

Thus the both governments’ central and state have outlined certain strategic frameworks of the reform.

a. The community based link workers who act as liaison between people and healthcare functionaries and ensure optimal utilization of available facilities and will provide the last link.

b. The PRIs should participate in planning programmes and assist an implementation and health promotion.

c. Almost all the states have attempted the introduction of user charges for diagnostic and therapeutic procedures in government hospitals from people above the poverty line and use the funds generated to improve the quality of care in the respective institutions.141

**Overview of five year plans**

To understand the health sector reforms we have to overview policy decisions and strategic plan of actions taken in different Five Year Plans in India. The major incentives undertaken for the changes in health service development in India can be viewed through Table No. 3.7.

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### Table No. 3.7

**Overview of Five Year Plans for Health Sector Reforms in India**

<table>
<thead>
<tr>
<th>Five Year Plans</th>
<th>Policy Decisions</th>
<th>Planning Strategies</th>
<th>Programmes for Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Plan (1951-1956)</td>
<td>• India Welfare State</td>
<td>• Rural Health Services</td>
<td>• 1952 National family Planning Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health Infrastructure Development</td>
<td>• 1953 National Malaria Control Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Dispensaries and Mobile Health Units</td>
<td>• 1954 National Water Supply and Sanitation Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 1955 National Malaria Control Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 1955 National Leprosy Control Programme</td>
</tr>
<tr>
<td>Second Plan (1956-61)</td>
<td>• Structural change in economy</td>
<td>• Establishment of PHC infrastructure</td>
<td>• 1956 National Venereal Disease Control Programme</td>
</tr>
<tr>
<td></td>
<td>• Primary Healthcare for entire rural population in India</td>
<td>• PHC in Community Development Block</td>
<td>• 600 Dispensaries and Mobile Health Units</td>
</tr>
<tr>
<td></td>
<td>• National Health Planning</td>
<td>• Guidelines for fresh Health Needs and Resources</td>
<td>• Training Nurses and Midwives from tribal population.</td>
</tr>
<tr>
<td>Third Plan (1961-66)</td>
<td>• Self-Reliant economy</td>
<td>• High priority in Family Planning</td>
<td>• Rural water supply scheme under community development</td>
</tr>
<tr>
<td></td>
<td>• To expand health services</td>
<td>• Supply good drinking water in rural areas</td>
<td>• National Water Supply and Sanitation Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Medical and health services in rural areas</td>
<td>• 1962 National Small Pox Eradication Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Efforts to eradicate other communicable diseases</td>
<td>• 1962 National Tuberculosis Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mid-day meal for school children</td>
<td>• 1962 National Goitre Control Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 1963 National Trachoma Control Programme</td>
</tr>
<tr>
<td>Annual Plan (1966-69)</td>
<td>• Continuing Economic Development</td>
<td>• Green Revolution</td>
<td>• Department of Family Planning in Ministry of Health (1966)</td>
</tr>
<tr>
<td></td>
<td>• Basic Health Services</td>
<td></td>
<td>• Centrally sponsored Family Planning Programme</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Concentration of ANM on Family Planning Programme</td>
</tr>
<tr>
<td>Fourth Plan (1969-74)</td>
<td>• Safeguards against Uncertain Economy</td>
<td>• More stressed on Family Planning including budgetary provision</td>
<td>• Multipurpose worker designation for ANM.</td>
</tr>
<tr>
<td></td>
<td>• Strengthening public health facilities</td>
<td>• Integration of Vertical programmes</td>
<td>• Allocation of Family Planning Targets</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Mass Vasectomy Camps.</td>
</tr>
</tbody>
</table>

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| Fifth Plan (1974-79) | Poverty eradication  
Social Justice and Economic Growth  
Rural Health Scheme | Integration of social and economic programmes  
Nutrition for Vulnerable Groups  
Reset of PHC establishment in rural areas  
National Health Policy  
Change in the concept of Family Planning | Minimum needs Programme  
20 Point Programme  
1975 Integrated Child Development Scheme  
One PHC per block  
One sub-center per 10,000 rural population  
Framed first National Health Policy (1976)  
1976 National Programme for Control of Blindness  
Renamed Ministry as Health and Family Welfare (1977)  
Health Guide Scheme (1977)  
Expanded Immunization Programme (1978)  
Midday Meal and Nutrition Programme |
| --- | --- | --- | --- |
| Sixth Plan | Health for All by 2000 AD through PHC  
Safe Drinking Water for All by 1990 | Priority on rural health, Communicable diseases  
Address to the felt Needs of the Community  
National Health Policy  
Under Minimum Needs Programme population norms revised  
Emphasis on tribal health, diseases and Contraceptive practice. | For PHC 30,000 in plains and 20,000 in tribal and hilly areas  
For Sub-centre 5,000 in plains and 3,000 in tribal and hills  
CHC with four specialists for 1,000,000 population  
1983 National Guinea-worm Eradication Programme  
NLCP redesigned as National Leprosy Eradication Programme |
| Seventh Plan (1985-90) | Elimination of Poverty and Illiteracy  
Basic needs of food, clothing, shelter and health | Comprehensive PHC  
Emphasis on MCH  
Integrated Rural Development  
Strengthening health services and infrastructure  
Overcome constraints of HFA and TSP areas: lack of health staff inadequate health institutions, lack of medicine, no encouragement for ISM practitioners and unsatisfactory PHCs and SCs | Priority on the revised 20 point programme  
Family Planning Programme as People’s Programme  
Universal Immunization Programme  
1987 National AIDS Control Programme  
Welfare and Nutrition Programme for women and children in hilly and tribal areas  
Village Health Guide for 1000 population |
| Eighth Plan (1992-97) | • Human Development  
• Quality Healthcare | • HFA for under-privileged segments  
• Promotion of Indian System of Medicines  
• Decentralized and Participatory Planning through PRIs.  
• Revised National Tuberculosis Programme  
• Reproductive Child Health  
• Pooling Funds for TSP from central and central sponsored schemes, State plan and Institution Finance  
• 37% share of total Plan Fund for Infrastructure  
• States not utilizing fund, not using for which it is meant, not placing the grant under Article 275(1). | • 1992 Child Survival and Safe Motherhood Programme (CSSM).  
• 1993 DOT Approach for Tuberculosis Control Programme  
• 1995 Separate department for ISM and H.  
• 1996 Target free Approach of FPP.  
• 1997 RCH Programme.  
• Coverage of 194 ITdPs 252 MADAs Pockets, 78 Clusters for TSP |
| --- | --- | --- | --- |
| Ninth Plan (1997-2002) | • Social Development  
• Improvement of Health Status  
• Increase coverage of Quality Healthcare.  
• Provide Need-based Demand-driven high quality integrated RCH care. | • Horizontal Integration of Vertical Programmes  
• Appropriate Health Management System.  
• Integrated Non-Communicable Disease Control  
• Tribal health  
• Urban Health and Family Welfare Services  
• Implementation of RCH.  
• National Population Policy (2000) | • National Cancer Control Programme  
• National Mental Health Programme  
• Programme against micro nutrient malnutrition  
• Diabetes Control Programme  
• Cardiovascular Disease Control Programme  
• Prevention of Deafness and Hearing Impairment  
• Oral Health Programme  
• Medical Rehabilitation  
• PRI for Planning and Monitoring Health Programmes.  
• Involvement of ISM and H. Practitioners and NGOs intersectoral Coordination  
• IEC Programme.  
• Comprehensive RCH Care and Services.  
• Private Sectors Participation in RCH |
| Tenth Plan (2002-07) | • Reforms focused on primary, secondary & tertiary healthcare level. | • Emphasis was on equity and financing healthcare Social Health Insurance for BPL population – Universal Health Insurance Scheme. | • Human resource development Capacity building Quality assurance PRI empowerment Focus on public private partnership. |
From Table No. 3.7 the following facts are noticed:

During First Five Year Plan, the healthcare policy decisions were made through the consideration of India as a Welfare State with major strategies of providing required rural health infrastructure with mobile health units and different health programmes like National Family Programme, Malaria & Leprosy Control Programme and National Water Supply and Sanitation Control Programme were undertaken to improve the Health Status of Independent India.

Similarly during Second Five Year Plan emphasis was given to improve the healthcare facilities at rural level so many PHCs were established with required infrastructure, nurses and mid-wives and National Venereal Disease Control Programme was undertaken.

During Third Five Year Plan prominence was given to expand health services, Family Planning Measures, providing good drinking water and medical services in rural areas to eradicate communicable diseases and free Mid-day meal for school going children was introduced.

At the time of Fourth Five Year Plan special stress was given to control population through various Family Planning measures.

At the point of Fifth and Sixth Plan Rural Healthcare was focused and many related programmes were introduced it was because majority of the Indian population was residing in rural areas.

Whereas during Seventh Plan special emphasis was paved to Maternal and Child Health Programmes and efforts were made to control AIDS.
But during Eight and Ninth Plan more significance was given for Quality healthcare and RCH Programmes, during the same plan period many of the National Health Programmes were undertaken which are pointed in Table No. 3.7.

Tenth Plan focused on Universal Health Insurance Schemes especially for BPL population and the same objectives were continued by Eleventh Plan with addition of raising sex ratio, reducing IMR, MMR and TFR.

d. Current National Health Programmes

Health is the biggest asset of every individual so; to improve the health conditions of its population India has undertaken the timely programmes, they are discussed as under:

1. Reproductive And Child Health Programme

The International Conference on Population and Development (ICPD) were established in 1994 to achieve population stabilization with essential components like:

i. Prevention and management of unwanted pregnancy.
ii. Maternal care that includes antenatal, delivery and postpartum services.
iii. Child survival services for newborns and infants.
iv. Management of Reproductive Tract Infection (TRIs) and Sexually Transmitted Infections (STIs).

2. Revised National Tuberculosis Control Programme (RNTCP)Dots Strategy

RNTCP was introduced in 1962 with the following strategies:

i. Early detection and treatment thereby converting infectious cases to noninfectious and preventing noninfectious cases from becoming infectious with treatment.
ii. Diagnosis through radiology and sputum microscopy.
iii. Free domiciliary treatment through Primary Healthcare Services.
iv. Establishing District Tuberculosis Centre in every district.
v. Extend coverage under Short Course Chemotherapy (SCC).
vi. Strengthen state TB training and Demonstration centres.

3. National Aids Control Programme

Acquired Immuno Deficiency Syndrome (AIDS) was emerged as one of the most serious public health problem in the country after reporting of the first case in 1986. The programme was divided into two phases as under:

National AIDS Control Programme Phase I (1992-99)

During the phase, the National AIDS Control Project was developed for prevention and control of AIDS in the country. The ultimate objective of the project was to slow the spread of HIV to reduce future morbidity, mortality, and the impact of AIDS by initiating a major effort in the prevention of HIV transmission.


Key Objectives were to reduce the spread of HIV infection in India; and Strengthen India’s capacity to respond to HIV/AIDS on a long-term basis.

4. Vector Borne Diseases Control Programme

To reduce and to control Vector Borne Diseases list of Legislative Programmes were as under:

a. National Anti-Malaria Programme

In April 1953, Government of India launched a National Malaria Control Programme (NMCP) with the following objectives:

i. To bring down malaria transmission to a level at which it would cease to be a major public health problem; and

ii. Thereafter an achievement was to be maintained by each state to hold down the malaria transmission at low level indefinitely.

Kala-Azar Control Programme

The budgetary provision for kala-azar was the part of National Malaria Eradication Programme budget until 1990-91. National Health Policy 2002 aims
“Elimination of Kala Azar by 2010” The strategy for kala-azar control broadly included three main activities.

i. Interruption of transmission by reducing vector population through indoor residual insecticides.

ii. Early diagnosis and complete treatment of Kala-azar cases; and

iii. Health education programme for community awareness.

b. National Filaria Control Programme

The National Filaria Control Programme was launched in 1955. The activities were mainly confined to urban areas. However, the programme has been extended to rural areas since 1994 and its objectives were:

i. Reduction of the problem in un-surveyed areas; and

ii. Control in urban areas through recurrent anti-larval and anti-parasitic measures.

c. Japanese Encephalitis Control Programme

This disease caused many epidemics and become a major public health problem and it was reported from 26 states and UTs since 1978 but only 15 states were reporting JE regularly. Government of India has constituted a Task Force at National Level which is in operation and reviews the JE situations and its control strategies from time to time. Though Directorate of National Anti-Malaria Programme is monitoring JE situation in the country, there is no separate funds are allocated for JE control. State should manage the situation/programme and may divert resources of NAMP (National Air Quality Programme) in case of outbreaks.

d. Dengue & Dengue Hemorrhagic Fever

The World Health Assembly passed a resolution in 1994 which urged Member states to strengthen their national and local programme for the control of DF/DHF and its major objectives were:

i. Surveillance for disease and outbreaks
ii. Early diagnosis and prompt case management

iii. Vector control through community participation and social mobilization

iv. Capacity building

5. National Iodine Deficiency Disorders Control Programme

In 1962, India launched 100% centrally sponsored the National Goiter Control Programme. In 1992, the National Goiter Control Programme (NGCP) was renamed as National Iodine Deficiency Disorder Control Programme (NIDDCP), with specific objectives like:

i. Initial survey to identify magnitude of problem in the country.

ii. Production and supply of iodized salt to the endemic regions.

iii. Health Education & Publicity.

iv. Re-survey in goiter endemic regions after five years continuous supply of iodized salt to assess the impact of the control programme. The result of re-survey in some areas has revealed that the prevalence of goiter has not been controlled as desired.

6. National Mental Health Programme

The Government of India launched the National Mental Health Programme (NMHP) in 1982, keeping in view the heavy burden of mental illness in the community, and the absolute inadequacy of mental healthcare infrastructure in the country to deal with it with the following objectives:

i. To ensure availability and accessibility of minimum mental healthcare for all in the foreseeable future, particularly to the most vulnerable and underprivileged sections of population.

ii. To encourage application of mental health knowledge in general healthcare and in social development.

iii. To promote community participation in the mental health services development and to stimulate efforts towards self-help in the community.
7. **National Cancer Control Programme**

To control this problem the Government of India has launched a National Cancer Control Programme in 1975 and revised its strategies in 1984-85 stressing on primary prevention and early detection of cancer.

**Objectives**

i. To generate authentic data on the magnitude of cancer problem in India

ii. To undertake epidemiological investigations and advice control measures; and

iii. Promote human resource development in cancer epidemiology.

8. **National Diabetes Control Programme**

Government of India started National Diabetes Control Programme on pilot basis during 7th Five year plan in 1987 in some districts of Tamil Nadu, Jammu & Kashmir and Karnataka, but due to paucity of funds in subsequent years this programme has not been expanded further in remaining years. However, a sum of 12 lakh during 1995-96 was allocated for the programme. In 1997-98 an allocation of one crore was made.

**Objectives**

i. Prevention of diabetes through identification of high risk subjects and early intervention in the form of health education;

ii. Early diagnosis of disease and appropriate treatment morbidity and mortality with reference to high risk group;

iii. Prevention of acute and chronic metabolic, cardiovascular, renal and ocular complication of the disease;

iv. Provision of equal opportunity for physical attainment and scholastic achievement for the diabetic patients; and

v. Rehabilitation of those partially or totally handicapped diabetes people.
9. Yaws Eradication Programme

The programme was started in 1996-97 in Koraput districts of Orissa then extended to endemic states as a centrally sponsored health scheme with the objectives like:

i. Interrupting the transmission of yaws infection (no case) in the country; and

ii. Eradication of Yaws (i.e. no-sero reactivity to RPR/VDRL in children below 5 years of age) from the country.

The Government of Andhra Pradesh, Gujarat, Madhya Pradesh and Orissa have taken several initiatives for interruption of infection by mass administration of single dose of penicillin in the affected areas. “Yaws Cells” have been established in Division of Epidemiology to coordinate all activities.

10. National Leprosy Eradication Programme

This Programme was started in 1955 with the objective of early detection of cases and treatment. It was made a centrally sponsored programme in 1980 with the advent of Multi Drug Therapy (MDT) for leprosy the cure rates increased again it was changed into eradication programme in 1983 with the objective of eradicating the disease by the end of year 2000.

The ‘elimination’ was defined as attaining a Prevalence Rate (PR) of less than 1 case per 10,000 population.

11. Guinea Worm Eradication Programme (GWEP)

India is the first country in the world to establish the National Guinea Worm Eradication Programme in 1983-84 as a centrally sponsored scheme on 50-50 sharing between Centre and States with the objective of eradicating guinea worm disease from the country. The National Institute of Communicable Diseases (NICD), Delhi worked as the nodal agency for planning, coordination, guidance and evaluation of NGWEP in the country.
At the beginning of the programme i.e. in 1984, there were around 40,000 GW cases in 12,840 villages in 89 districts of 7 endemic states. During 1996 only 9 guinea worm cases have been recorded in three villages from Jodhpur (Rajasthan), rest of the country continued to remain free from G.W. Banwari Lal, 25 years old from Jodhpur in Rajasthan was the last case in India in 1996 (Lancet 2000). “Zero” incidence has been maintained since August 1996 through active surveillance and intensified field monitoring in the endemic areas.

In the Meeting of WHO in February 2000 the India has been certified for the elimination of Guinea Worm Disease and on 15th February 2001 declared India as “Guinea Worm Disease Free”. This is one of the greatest achievements of India in the area of Health Sector.

12. National Surveillance Programme For Communicable Diseases

A systematic process of reporting of various diseases of public health importance, as and when, and where, they occur, to a designated agency responsible for taking effective interventional steps, is known as disease surveillance. Its success will depend upon 3R i.e., the quality of diagnosis (Recognition), the timeliness and completeness of Reporting, and analysis and effectiveness feedback Response.

Major objectives:

1. Capacity building at the state and district for early identification of outbreaks of communicable diseases, and

2. Appropriate and timely response to the outbreaks of communicable diseases.

13. National Programme For Control & Treatment Of Occupational Diseases

Occupational health was one of the components of the National Health Policy 1983 and also included in National Health Policy 2002 but very little attention has been paid to mitigate the effect of occupational disease through proper programme. Ministry of Health & Family Welfare, Government of India has launched a scheme entitled “National Programme for Control & Treatment of Occupational Diseases” in 1998-99. The National Institute of Occupational Health, Ahmadabad (ICMR) has been identified as the nodal agency for the same.
14. Nutritional Programmes

In India during first and Second Five Year Plan achieving self-sufficiency in food grains was the major objective but during Third Plan (1962) applied nutrition and Mid-day Meal Programme was launched, during Fourth Plan “The Special Nutrition Programme(1970) and Integrated Child Development Scheme (1975) was started. Again during Sixth and Seventh Plan steps were taken to convert the special nutrition Programme centers on the pattern of ICDS schemes with linking the other inputs like: health, sanitation, hygiene, water supply and education.

i. Integrated Child Development Service (ICDS) Scheme

ii. Mid-Day Meal Programme

iii. Special Nutrition Programme (SNP)

iv. Balwadi Nutrition Programme

v. Wheat Based Supplementary Nutrition Programme

vi. Applied Nutrition Programme

vii. Tamil Nadu Integrated Nutrition Programme

viii. National Nutrition Anemia Prophylaxis Programme

ix. World Food Programme (WFP)

15. National Programme for Control of Blindness

The National Programme for Control of Visual Impairment and Blindness was launched in 1976 as a 100% centrally sponsored and incorporates the earlier Trachoma Control Programme that was started in 1963. With the following major objectives:

1. To establish eye care facilities for every 5 lakh population,

2. To develop human resources for eye care services at all levels the primary health centres, CHCs, sub-district levels,

3. To improve quality of service delivery and
4. To secure participation of civil society and the private sector.

3.2.3 Public Health Care System in Karnataka

Karnataka state is one of the pioneer states in the country in providing comprehensive public health services to its people. Even before the concept of Primary Health Centers was conceived by the government of India, the state had already made a beginning in establishing a number of PHU's for providing comprehensive Healthcare, and a delivery system consisting of curative, preventive, promotive and rehabilitation healthcare, to the people of the state. "HEALTH" is an asset to every person.\(^{143}\)

The major health related programmes implemented by Government of Karnataka through Department of Health and Family Welfare are as under:

1. NRHM
2. Thayi Bhagya
   a. Janani Suraksha Yojana (JSY)
   b. Prasooti Araike
   c. Madilu - Caring For the mother and the child
   d. Thayi Bhagya
3. Child Health
   a. Immunization
   b. IMNCI (Integrated Management of Neonatal and Childhood Illnesses)
4. Population Stabilization
5. 24x7 PHCs
6. Other Programmes
   a. Quality Assurance programme
   b. Suvarna Arogya Chaitanya School Health Programme

\(^{143}\) “Department of Health and Family Welfare”, online available at <http://stg2.kar.nic.in/healthnew/> accessed on 27/03/2013
c. Reaching the Poor

d. Main Streaming of Ayush

7. KHSDRP

8. KSAPS

9. KSDLWHS

10. Arogya Kavcha

11. IDSP (Integrated Disease Surveillance Project)

Out of these following Health Programmes, Thayi Bhagya, Janani Suraksha Yojana, Arogya Kavcha and IDSP are also running in the networking Private Hospitals so these programmes can also be termed as Public Private Partnership Programmes.

1. NRHM

Launched by Honorable Prime Minister Manmohan Singh in April 2005, National Rural Health Mission has strived to achieve progress in providing universal access to equitable, affordable and quality healthcare which is responsive to the needs of the people. The initiatives for reducing child and maternal mortality, stabilizing population along with gender and demographic balance have been taken.

The key features of the implementation of NRHM in Karnataka includes making public health delivery system fully functional and accountable to the community, working in a mission mode, decentralized planning, delegation of powers, human resource management, community involvement, rigorous monitoring and evaluation against standards, convergence of health related programmes and flexible financing.

A state specific programme implementation plan for NRHM was developed by integrating district health action plan from all the 27 districts in the state for the year 2008-09. It is based on the district specific health needs and comprises of most of the components of NRHM.

The National Rural Health Mission is dreams come true for millions of people in the country, especially for the country's poor, underprivileged, the women and the children.
2. Thayi Bhagya

a. Janani Suraksha Yojana (JSY)

Janani Suraksha Yojana is meant for helping the poor pregnant women after delivery. Janani Suraksha scheme is continuation of the previous delivery allowance scheme of the Central Government. The objective is to give financial assistance to the poor pregnant women during delivery. Under this scheme pregnant women belonging to below poverty line families and SC, ST families will get an assistance of Rs. 500 if delivered at home, Rs. 600 for urban institutional delivery, Rs. 700 for delivery in health centres in rural areas, and Rs. 1500 for caesarian delivery. This benefit is available if delivered in recognized private health institutions other than government hospitals also.

The eligibility conditions for the beneficiaries are as follows:

- The woman delivering at home or admitted to sub-centre/government hospital/registered private hospital (general ward), must belong to BPL family.
- Current delivery must be the first or second live delivery.
- She should be above 19 years of age and must have got Ante Natal checkup at-least 3 times.
- Must have taken Iron and Folic acid tablets and TT injection
- SC/ST Women not belonging to BPL families are also entitled for this benefit if they are admitted to general ward of Government or Registered Private Hospital.

Whether a woman is eligible under JSY scheme or not, ANC (Ante Natal Checkup) card is filled once it is known that the woman is pregnant. The Junior Female Health Assistant will identify the JSY eligible pregnant women during the routine visits. When it is confirmed that the woman is eligible under JSY, the information is filled in the card and attested by the Medical Officer. The card also contains the details of her address, BPL card number, expected date of delivery etc. Her eligibility for JSY is also recorded in the ANC register.
In case a woman is eligible for the scheme but does not possess a BPL card, she is guided through ASHA or Anganwadi worker, to obtain a certificate to the effect that her annual income is below Rs. 17,000, from the concerned revenue authority of Gram Panchayat.

b. Prasooti Araike (Care for the pregnant women)

Prasooti Araike scheme was introduced in six “C” Category districts of Gulbarga, Bidar, Raichur, Koppal, Bijapur and Bagalkot for the benefit of pregnant women belonging to below poverty line SC and ST families. This has now been extended to all below poverty line pregnant women of all the districts.

The benefits and conditions of the scheme are as follows:

- The pregnant women have to register their names with the Junior Female Health Assistant of the area. The beneficiaries will get Rs. 1000 during the second trimester ante natal checkup (i.e. between 4th and 6th month) and Rs. 1000 during the third trimester ante natal checkup (i.e., between 7th and 9th month), totaling Rs. 2000 paid through bearer cheque.
- During every ANC checkup, the Medical Officer of the Health Centre/Hospital puts the signature, date and seal on the ANC card.
- An information booklet on the dietary requirements for the pregnant woman has to be provided by IEC wing, to each of them.
- This facility is extended to all pregnant women belonging to below poverty line families
- The benefit is limited to the first two deliveries. The Junior Female Health Assistant has to record the ANC registration number along with noting whether it is first or second delivery.

c. Madilu - Caring for the mother and the child

Madilu scheme is started by the government to provide post natal care for the mother and the child. The objective of this scheme is to encourage poor pregnant
women to deliver in health centres and hospitals in order to considerably reduce maternal and infant mortality in the state.

Under this scheme a kit contains:

i. Mosquito curtain

ii. Medium sized carpet

iii. Medium sized bed sheet

iv. A thick blanket for mother

v. Bathing Soap

vi. Washing soap

vii. Cloth to tie abdomen of mother

viii. Sanitary pads

ix. Comb and coconut oil

x. Towel

xi. Tooth paste and brush

xii. Bed spread over rubber sheet for the baby

xiii. Bed sheet for baby

xiv. Bathing soap for baby

xv. Rubber sheet for baby

xvi. Diaper

xvii. Baby vest

xviii. Sweater, cap and socks for baby

xix. One plastic kit bag.

The beneficiaries must belong to below poverty line families, and delivered in government hospitals. The benefit is limited to only two live deliveries.
d. *Thayi Bhagya (Public-Private Partnership in maternal healthcare)*

This revolutionary scheme provides totally free service for the pregnant women belonging to BPL families, in registered private hospitals.

The background for working out this strategy is:

- Shortage of specialist doctors, especially the gynecologists, anesthetists and pediatricians Taluka hospitals and CHCs, The posts of these specialists are mostly vacant in Government Hospitals.

- Though there is very large number of government healthcare institutions in the state, the shortage of these specialists is a big draw back in providing proper maternal and child healthcare.

- There are considerable numbers of specialist doctors in urban private hospitals.

- By entering into Public-Private partnership with these hospitals, rural women can be provided with facilities for proper institutional deliveries.

The scheme has been designed so that women belonging to BPL families can avail totally cashless treatment in these private hospitals.

Under this scheme, the pregnant woman belonging to BPL family can avail delivery services free of cost in the registered private hospital near her house. She is not required to pay any charges right from the point of admission to discharge. The benefit is limited to the first two live deliveries.

The beneficiaries are identified through the ANC cards issued to them.

The scheme has been introduced in the six "C" category districts of Gulbarga, Bidar, Raichur, Koppal, Bijapur and Bagalkot and the backward district Chamarajnagar.

**Participation of Private Hospitals in Thayi Bhagya Scheme:**

The hospitals having requisite facilities will be registered under the programme with the approval of District Health Society. The Hospitals will then sign
an MOU with the Department. Government Hospitals can also participate in this scheme.

The eligibility for participation in the scheme is

- The hospital should have minimum 10 inpatient beds.
- Should have proper functional Operation Theatre and Delivery room
- 24 hrs availability of gynecologists, anesthetists and pediatricians
- Should have link with Blood banks
- The DHO has to identify such hospitals and invite them for partnership. Interested hospitals can sign the MOU.

Such registered hospitals will be paid Rs. 3.00 lakhs per 100 deliveries, which include normal delivery, complicated deliveries, caesarian, forceps deliveries etc. These hospitals will be paid 10% i.e., Rs.30, 000 advance on participation in the scheme. This is to encourage more and more private hospitals to participate in the programme.

The Government Hospitals will be paid Rs. 1.50 lakhs for every 100 deliveries, out of which 50 percent goes to the Healthcare Committee and the remaining is shared among the Hospital doctors, nurses and staff as per Yeshasvini guidelines.

3. Child Health
   
   a. Immunization

   Immunization programme is one of the key interventions for protecting children from life threatening conditions, which are preventable. Immunization programme in India was introduced in 1978. The following are the major objectives of Immunization programme:

- It is the most cost effective public health intervention to reduce mortality and vaccine preventable disease.
- Since 2005 “zero” polio drops has been introduced to give zero dose polio drops to new born children.
- Last case of polio was detected in 2007 who was a migrant from UP.
- The full immunization rate is 76.7 %, as per state DLHS -3 (2007-08).

**Hepatitis –B**

Hepatitis–B Program was launched in Jan 2008. All health workers are trained in Hepatitis –B vaccination.

**b. IMNCI (Integrated Management of Neonatal and Childhood Illnesses)**

This IMNCI approach is the main strategy for new born and child health. It was proposed for 5 districts of Kodagu, Koppal, Chamrajnagar, Bijapur and Gadag. Training is completed in the above districts. The program involves

- New Born Care facilities at PHCs
- New Born Corners for FRUs
- Procurement of New Born Resuscitation Kits

**4. Population Stabilization**

To control the burden of population, special attention was given towards population stabilization through sterilization programme.

- Sterilization: The sterilizations in the women increased from 3.7 lakh cases to 3.9 lakh cases during the year 2007-08.
- The male sterilization has improved from 576 cases in 2006-07 to 1804 cases during 2007-08
- Intra uterine device: The number of adoptees has decreased from 291134 in the year 2006-07 to 278894 in 2007-08.

**5. 24x7 PHCs**

Essential healthcare based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and
families in the community and which available on the basis of 24 hours and 7 days so these are called as 24x7.

6. Other Programme includes:

a. Quality Assurance programme

Tumkur District was taken up as pilot district for quality assurance programme in RCH services in SCs, PHCs and CHCs. This has improved quality service delivery.

b. Suvarna Arogya Chaitanya School Health Programme

Highlights of the Programme:

- Health checkup for all students studying in 1st standard to 10th standard.
- Detected cases of diseases to be treated free of cost in PHCs, Taluk Hospitals and District Hospitals.

c. Reaching the Poor

The State has strong commitment to improve the health status of its population, particularly the poor and vulnerable groups including women, children and those belonging to SC/ST and nomadic groups. Karnataka has 4.55% STs and 16.20% SCs of the total population. ANM (Auxiliary Nurse Midwife) in tribal areas are given special allowance and expense of ANMs appointed in tribal areas by an NGO is reimbursed.

d. Main Streaming of AYUSH

AYUSH and traditional healers would be brought into the purview of the healthcare delivery system.

- AYUSH doctors are appointed in single doctor PHCs of most backward Talukas (39), and more backward Talukas (40)
- Co-location of AYUSH dispensaries -91
- Rs. 45 lakhs worth of AYUSH drugs have been supplied to AYUSH doctors during 2007-08.

7. **Karnataka Health System Development and Reforms Project (KHSDRP)**

Karnataka Health System Development and Reforms Project is a World Bank funded project with the main objective of increasing utilization of curative and public health services of adequate quality by providing better healthcare services to the poor and vulnerable people in the state, so that the deprived and the vulnerable groups can access quality healthcare.

8. **Karnataka State Aids Prevention Society (KSAPS)**

Karnataka State Aids Prevention Society (KSAPS) gets Rs. 39 crore from National Aids Control Organisation (NACO) for undertaking HIV/AIDS prevention measures in the State in 2007-08. The society will support the Government efforts to prevent the spread and mitigate the impact of HIV/AIDS in the State, by assisting in improving prevention programmes, and amplifying care, support, and treatment of people living with HIV/AIDS in various districts.

9. **Karnataka State Drugs Logistics & Warehousing Society (KSDLWHS)**

Karnataka State Drugs Logistics & Warehousing Society is established in the Karnataka State to realize the following objectives:

1) To implement the logistical drugs and warehouse management through professionalize and IT interview management to ensure the drugs of assured quantity are made available at all levels, up to the sub-center and used rationally with due monitoring.

2) To implement the system for purchase and distribution of drugs in the department of Health & Family welfare.

3) To implement stakeholder friendly system to meet the qualitative and quantitative needs of the end users obviating scarcity and loss.

4) To economize expenditure on drugs through pooled procurement system

5) To optimize accountability at all levels.

6) Human Resource Development through training of functionaries in computer skill, warehouse management and Logistics management & through periodical bulletin.

7) Establishment of District warehouses in the districts and equipping them with the required infrastructure.

8) Total computerization for e-governance and management.

9) To conduct various studies and research as envisaged in the PIP and such other incidental studies found necessary.

10) To provide quality assured atmosphere both in material management and in system operation up to the end user.

11) To monitor various drug and therapy-related information and to take necessary follow up action.

12) To maintain the accounts for all expenditure under the project and ensure total transparency and accountability.

13) To formulate, promote, implement, develop, maintain, operate, construct, erect, build, remodel, repair, execute, improve, administer, control and manage drug warehouses, office building of the Drug logistics management center, quarters for staff, etc., and other related schemes of new constructions, up gradation, repair, renewal and renovation of the existing structures and buildings out of the funds made available to the society by State/central government and foreign funding agencies, for efficient implementation of Drugs logistics and warehousing project.

To realize the above objectives, the Karnataka State Government has already built 14 warehouses with all the infrastructures. These 14 warehouses are catering the drugs need of all the 27 districts of the state.145

10. Arogya Kavcha

Karnataka launched Arogya Kavcha, the free ambulance service for the common man on 01 Nov 2008, the Rajyotsava day, 66 state of the art ambulances were flagged off service by Sri. B S Yadiyurappa, Honorable Chief Minister of Karnataka and former President of India Dr. Abdul Kalam, in an impressive ceremony held at Vidhana Soudha, Bangalore.

The services will be run on Public-Private-Partnership modal. Government of Karnataka has signed an MOU with Emergency Management Research Institute (EMRI), Hyderabad, as a partner to run the service in the state. EMRI will be the sole Nodal Agency providing management, research, and technology along with bearing 5% of the opening costs, whereas the Government will meet 95% of the operating expenditure with full capital investment. The Government has allocated Rs.10 crores for this programme in the current budget. Balance amount will be met out of NRHM funds.

The Government aims to introduce 517 ambulance units in stages, by March 2010 throughout the state.

Citizens need to call “108” from anywhere in Karnataka to utilize the service.

11. Integrated Disease Surveillance Project (IDSP)

Integrated Disease Surveillance Project is a World Bank assisted Government of India project, started in our country during November 2004. The Project was inaugurated in Karnataka State on 28-5-2005. The Project will be implemented in Karnataka State for five years (2004-2009). Under this Project 23 District Laboratories, State Laboratory (PHI) and 249 CHC Laboratories will be upgraded and integrated under the State Surveillance Unit at Bangalore. The following are the objectives of Integrated Disease Surveillance Project:

- For Surveillance for action of 13 core Diseases and 5 State Priority Diseases.
- Up gradation of Laboratories at all levels.
- To establish a decentralized state based system of surveillance for communicable and non-communicable diseases, so that timely and effective
public health actions can be initiated in response to health challenges in the
country, at the state and national level.

- To improve the efficiency of the existing surveillance activities of disease
  control programmes and facilitate sharing of relevant information with the
  health administration, community and other stakeholders so as to detect
disease trends overtime and evaluate control strategies.
- To establish systems for data collection, reporting, analysts and feedback
  using Information Technology.
- To develop human resources for disease surveillance and action.
- To involve all stakeholders including private sector and communities in
  surveillance.
- To involve all stakeholders including private sector and communities in
  surveillance.

3.2.4 Conclusion

Health development is a continuous and dynamic process so, Government of
India has realized the importance of health in developmental process as a result since
independence, Government has given special attention towards the health of its
population through formulating various universal healthcare programmes in every
Five Year Plans with appointing different committees of experts to grasp the timely
demand in the area of healthcare. As the result of such efforts life expectancy and sex
ratio has been improved to 65.5 years and 940 females respectively in 2011, IMR has
been reduced to 44 per 1000 births and MMR is also declined to 212 per lakh
deliveries.

Similarly, Government of Karnataka has also undertaken various health
related programmes and schemes specially to improve the health condition of the poor
and underprivileged through various Healthcare schemes which are very popular and
successful such as: Janani Suraksha Yojana, Prasooti Araike, Madilu, Thayi Bhagya,
Arogya Kavcha etc., with the help of these effective healthcare schemes Karnataka
has achieved the Life Expectancy of 65.3 years and sex ratio 968. IMR and MMR are
also declined to 35 and 178 respectively.