

CONCEPT PAPER

ON

**KERALA SECONDARY
HEALTH SYSTEM PROJECT**



**Department of Health & Family Welfare
GOVERNMENT OF KERALA**

This Concept Paper is the outcome of the deliberations of the two-day workshop held on 6-7 August, 2003, in which members of the Kerala Task Force on Health & Family Welfare prioritized the areas to be focused on during the next five years. This being a draft, kindly do not quote this as the official version.

I. Introduction.

1. Even though Kerala is known for better health care indicators in the Country, and its performance is comparable with some of the developed countries ,it has reached a stage, where we are finding it extremely difficult to sustain the development made during the last 200 years. More over, due to resource crunch, the State could not provide adequate resources for health care delivery and keeping in tune with the epidemiological and demographic transition that have swept the state since independence. In order to fill up the critical gaps in terms of personnel, infrastructure, equipment and capacity building, the State of Kerala is seeking financial assistance from the World Bank. The Project Implementation Plan of the Kerala Secondary Health System Project was submitted to the World Bank through Govt. of India in March 2003.
2. Dr. Peter Heywood, Lead Health Specialist, World Bank Country Office New Delhi visited Trivandrum on 7 April, 2003 and had a detailed discussion with the members of the Kerala Task Force. Taking into the suggestions/ observations made by Dr. Peter Heywood and based on the priorities identified by the task force this concept paper has been prepared.

II. Disease Burden of the State

1. As per the **52nd Round of National Sample Survey** (NSS 1995-96), in the State of Kerala, 110 persons per thousand population suffered from some ailment or other during 15 days preceding the date of interview. It was high in rural areas with 118 persons per thousand population and 88 in urban areas. Where as, the national averages were 55 and 54 for rural and urban respectively. Of the rural population, 88.3 per thousand and of the Urban population 89.2 per thousand sought treatment, while it was 82.7 and 93.5 for the entire country.
2. Those who were admitted as inpatients during the preceding 365 days of the survey accounted for 69 persons per thousand population. The outpatients accounted for 77 persons per thousand population. The persons, who received treatment as Out Patients was 104 per thousand in rural areas and 78 persons in urban areas. This clearly indicates the urgent need for pumping in more resources into the system so as to enhance the quality of life of the people of the State.
3. There was a time, when communicable diseases such Malaria, Typhoid, Cholera, Leptospirosis, and so on had been eliminated from the State. However, the recent phenomenon of mindless urbanization and resultant environmental degradation has led to re-emergence of Communicable Diseases.
4. To add injury to insult, the state is presently facing non-communicable diseases such as Diabetes, Hypertension, Cardio vascular diseases, renal disorders, arthritis, and malignancy. The non communicable diseases is becoming more and more pronounced in view of '**Graying Kerala**' with 11 % of the population under the category of the elderly.
5. The State is also a victim of HIV/ AIDS, substance abuse, suicides and mental illness due to migration and changing family environment and lack of family support system.

III. Project Justification and expected out comes

1. The state is facing acute lack of adequate infrastructure especially to provide curative services. Coupled with this, the state has not kept pace with the rapidly changing health management issues and has thus declined further in their preparedness and capacity to manage adequately the over all health system. The inadequate decision support systems has been affecting implementation and monitoring capabilities and this has often led to ad hoc policies.
2. The State now proposes to bringing about Health Sector Reforms through Health Systems Project with external assistance mainly to address the issues of secondary level health systems and thus over all health care delivery. The major

and precise issues that concern particularly the secondary health care is presented below :

- Policy Reforms
- Management Development
- Institutional Strengthening,
- Improving access to better health care
- Access to Quality Services
- Accessibility of health care to the under privileged such as fishermen, tribals, slum dwellers and street children
- Improving health outcomes such as reduction in neo natal, infant , under five mortality, maternal mortality,
- Risk reduction such as obesity, smoking, alcoholism, sexual behaviour

IV. Policy Reforms Underway

1. Define/Redefine the Job Responsibilities

Based on the study conducted by Achutha Menon Center for Health Science Studies, the job responsibilities of workforce in primary health care in Kerala are being redefined. The discussions are going on to rearrange the duty hours of the workforce and institutions to ensure better functioning.

2. Standardization of Health Institutions

A committee was constituted to study the existing Medical Institutions in the state and recommend standards for service delivery, infrastructure, equipment and staff pattern of various levels of health care institutions under the health services department of the state.

The committee has recommended to standardize the service provision, infrastructure, manpower and equipment at various levels of institutions. The committee has recommended a hierarchy of Sub Centre (grass root level for every 5000 population in rural areas), Primary Health Centre (Grama Panchayat level), Community Health Centre (Block Panchayat level), Taluk Hospital/ Urban CHC (Taluk/sub district level) and District Hospitals (District Panchayat level). The recommendations of the committee are in the initial phase of implementation.

3. Private Public Mix

1. 35% of the hospitals in the state are in the Government Sector and the balance in private sector. There are about 4288 private hospitals in the state compared to 1317 in the Government sector (2001). There are 30318 registered medical practitioners in modern medicine in Kerala. Majority of the doctors are working in private sector and only 5692 doctors are working in Government sector. A survey conducted in 1995 by Department of Economics and statistics shows that the number of doctors working in private sector was 19963.

2. The private hospitals are involved in the implementation of many of the national health programmes. The “Kannur Model” being tried out in the implementation of Revised National TB Control Programme is one of the models quoted even by the WHO for private participation in Govt. programmes. Government servants are permitted to avail super specialty services from major private hospitals and the expenditure is reimbursed.
3. In the medical, Dental, Nursing, Pharmacy and Para medical education private participation is permitted as a result 4 Medical colleges, 3 Dental colleges, 4 Pharmacy colleges and 24 Nursing Colleges and 4 Ayurveda Colleges have been opened during the last two years.

4. State Health Policy

The Government of Kerala is now preparing a state health policy. A series of meetings were conducted and a draft of the policy was prepared. The final draft will be prepared within next few weeks and it will be posted in the web site of Government of Kerala soon. After getting suggestions from public and other organizations, the draft will be published.

5. State Population Policy

Govt. of Kerala has constituted a committee for the preparation of Population Policy for Kerala. The committee conducted a preliminary meeting on 25-11-2002 and a one-day workshop on 22nd April 2003. The committee also conducted a series of discussions and a draft Kerala population policy was prepared. A copy of the draft was hosted in the Government of Kerala Website. After obtaining suggestions from public and various organizations, the draft will become ready for final publication.

6. Modernization of Health Department in Govt. Secretariat

Modular arrangement and refurbishment work at the Health Department was done. Thirty computers were installed in the Office as a part of the e-governance Project.

7. Capacity enhancement of Technical Secretariat and Project Support Cell

The infrastructure of Technical Secretariat and Project Support Cell were improved at Directorate of Health Services. A Documentation, Library and Conference Hall were set up. Computerization was implemented in the office.

8. Health Vision Kerala 2025

The Government of Kerala has decided to prepare a document entitled “Health Vision Kerala 2025”. It has analyzed the present system, identified its strength and weakness, set a mid term and long term goal for the Health Sector. An Action Plan to achieve the goals is under preparation. This document will serve as the backdrop of all future plans in the Health Sector. For the preparation of Health Vision Kerala 2025 twenty-nine task groups have been formed. The Terms of Reference for each Task Group have been prepared. The final document will be ready by end 2004.

9. Tele Medicine

The Department of Health and Family Welfare introduced tele medicine in Kerala. The remote medical facility in Pampa in Pathanamthitta district and the District Hospital have been linked to Medical College Trivandrum, Regional Cancer Centre and Sri Chitra Tirunal Institute for Medical Sciences and Technology.

10. Specialty Cadre

Specialty Cadres were introduced in Health Services Department. Under this programme, specialty services are now being implemented all the CHCs/Taluk/ District Hospitals in the state. 375 specialists will be recruited shortly to fill up the gap.

11. Decentralization Of Health Institutions

The public health services institutions up to the level of District Hospitals stand transferred to the Local Self Government Institutions (LSGIs). All the hospitals under the Health Services Department with the exception of General Hospitals were transferred to Local Bodies. In the context of the Panchayati Raj, the Local Self Government Institutions are assigned more powers. Hospital Development Committees were established in all hospitals. These HDCs have financial and functional autonomy. These Committees levy user charges and use them for the development of the hospitals, procurement of essential drugs and equipment. They hire technicians and doctors wherever necessary.

12. State Drug Formulary

Kerala Government developed a State Drug Formulary for the State in 1999. Now, the Government is revising this document in accordance with the requirement of PHCs, CHCs, Taluk & District Hospitals and Medical College Hospitals.

13. Web Site

The activities of Health Departments of Kerala were posted in the Government of Kerala Website. www.kerala.gov.in

14. State Training Network

Two State Institutes of Health & Family Welfare were established to coordinate all the training activities in the State. A full-fledged computer lab was established in the Training Centre, Thycadu, Thiruvananthapuram.

15. Computerization

The Directorate of Health Services, Directorate of Medical Education, Directorate of Ayurveda, Directorate of Homoeopathy and the Directorate of Ayurveda Medical Education have been computerized in the first phase. Medical College Hospital, Trivandrum is under computerization. In the second phase, all the Medical Colleges, District Hospitals will be computerized.

V. Proposed Health Sector Initiatives

1. Local Self Governments And Secondary Health Centres

- For better functioning of the institutions, more powers are to be granted to the LSGs wherever necessary.
- Code of conduct governing relationship between elected representatives of the local governments and staff should be published.
- With respect to secondary health system institutions the transfer of funds should take into consideration the size of the hospital and the area.

2. Need for updated guidelines

- Guidelines also need to be revised and updated in terms of clear roles and responsibilities in addition to the powers granted to the elected representatives and the local bodies with respect to health sector
- Decentralization of planning should always occur within the context of a broad vision and strategy of the State. Therefore, broad sectoral allocations are to be made at the State level, so that sufficient allocation is made in sectors like women's component plan and public health and to ensure that decentralization does not end in financial independence for individual facilities and areas.
- Minimum infrastructural and service standards for health institutions should be evolved for better and cost effective health planning at individual facilities.

3. Capacity building

To operationalise the decentralized planning effectively, capacity building of elected representatives through a structured and continuing training program (incorporating the broad vision of health and development, managerial skills, field experiences and innovative experiments in the health sector) is necessary.

4. Monitoring and Evaluation

- Monitoring and evaluation of the functioning of the secondary health system institutions are to be strengthened by conducting periodic review and performance audit
- Methods to ensure that public grievances in relation to the health sector must be in place
- Publication of Citizen Charter for hospitals and annual reports of activities should be done to ensure transparency
- Independent evaluation of the activities of the expenditure and functioning of the institutions to be made once in three years in addition to regular internal auditing to maintain transparency

5. Intersectoral coordination and involvement in public health activities

- The decentralized planning process offers the best opportunity to bring the various sectors and departments for the best outcomes in health sector institutions. The periodic review and evaluation meetings of the health

institutions should include representatives from other concerned departments transferred to the LSGs.

- Enforcement of public health legislations should be also monitored and evaluated by the management committees.
- All the private institutions in the health care sector including private hospitals and paramedical institutions are at present mandated to register with the LSGs. Beyond just registration, they can be made part of a wider surveillance and reporting network and also to work with the public health system in disaster and crisis management.
- A crisis management set up should be operational at the local level under the auspices of the LSGs for prompt and efficient responses to crisis situations.

6. Innovative schemes to share health expenditure

Local self governments may be entrusted with the responsibility to collect user or services charges for institutional development and novel social insurance schemes

VI. Public - private Mix

Private sector is catering to a big chunk of population in their health care needs, especially in curative care. It is high time we brought them into the fold of health service system. The first step in doing so is creating an awareness among the care providers that they are not only running a profitable business but also ensuring the health of individual citizens and the nation in general.

1. Initiate dialogue with Private Hospitals and Professional Organizations

The medical officer in charge of the secondary level hospitals may create a data base, which would include enumeration of the private hospitals in his jurisdiction, the specialties and services available in each of these hospitals, so that it is possible to coordinate and integrate all the services, if need be.

2. Participation of Private Hospitals in National Health Programs and Public Health Programs

- Private sector may share the responsibilities of implementing some or all of the national health programs.
- Continuing Medical Education for doctors and paramedics in the private sector will enable Govt. to provide for better health care

3. Sharing of services and goods

Investment in private sector is increasing day by day leading to the availability of better infrastructure. With reciprocity their value added services like CT scan and other lab test can be subsidized to the public sector leading to a win - win situation

VII. Reproductive and Child health

Women and children constitute around 60% of the population and they are the most vulnerable group. The ultimate objective should be utilization of the available funds and services to meet the felt needs of the beneficiaries.

PRESENT ISSUES OF FW IN KERALA

Declining quality of services in Govt. institution.

- ❖ Man power shortage
- ❖ Inadequate facilities
- ❖ Maintenance and modification required in hospital buildings, OTs, OPDs, LRs etc
- ❖ Increasing load of patients
- ❖ Growth of private sector –more attractive for doctors. Scarcity of Medical Officers in Health Department. Many are leaving for better job opportunities
- ❖ Atrocities against doctors and institutions etc. demoralize the enthusiastic doctors and discourages them from taking risk.
- ❖ Inadequacy of funds

RCH – ANTICIPATEED OUTCOME

Goals	2005	2015
MMR	60	40-60
IMR	10	7-9
Temporary Contraceptive	10	15
CPR	65-70	75
LBW	10-12	<10
Immunization FRU	Above 90% complete	Above 95%
Neonatology Units	50% FRUs	100%

Viii. Political Backing

For implementing the Secondary Health System Development Project in the State, political backing at various level is necessary. For reaching a consensus on various components of the project , for planning the administrative and managerial aspects of the projects and for seeking support on wider policy issues like user -fee , public – private mix, health insurance etc. political support is inevitable.

Following activities may be done:

1. An upgraded version of the document may be prepared and circulated to all MLAS, MPs etc,
2. A letter may be written to Legislative Assembly Speaker requesting to initiate a discussion in the Legislative Assembly.

3. Copy of the corrected version of the document may be circulated to the State level Office bears of the Political parties having elected representation in the Legislative Assembly and their opinion may be collected and support may be sought for .
4. At district Level workshop involving block/grama Panchayath Presidents, Municipal Chairpersons, Corporation Mayors may be convened in each district as well as at the State level. Aspects of Project management issues at district level may also be finalized in such workshops
5. A discussion on the project may be conducted through electronic media and print media
6. Involvement and support of the Political parties may be brought in to the implementation of the project through the Hospital Development Societies, in which all political parties having membership in the Legislative assembly is having a membership.

Ix Priorities From Vision Document

Tribal Costal and Slum Population

Although Kerala had made remarkable achievements is improving the health indices, it was not uniform for all section of the population. The condition of tribals, slum dwellers and people listing in coastal areas it is far below the Kerala average. These are 320,000 tribal population in Kerala constitutions more than of the Kerala Population, coming under 35 district tribal communities. They are having very poor living condition high maternity and mortality rate. Poor health awareness and low utilization of available health services.

Kerala is having a lengthy coastal area of 590 km convening district. Provision for safe drinking water and sanitation facilities are still a major problems in these area. Communicable diseases including waterborne disease and mosquito born disease like malaria, filariasis are more prevalent in many of these areas. According to the Official Statistics more than 8 lakhs population are living in the coastal area.

According to the 2001 census 25.97% of the Kerala Population is urban. Many of the municipal towns and corporation are having a sizable numbers of slum dwellers. Based up on the criteria set for 2001 census, slum enumeration blocks were identified in 9 town, consisting 45,337 slum population. There should be some special focus for meeting primary health care needs of the population.

Scheduled Caste

In Kerala as per 1991 census there was 78.87 lakhs Scheduled Caste Population constituting 9.94% of the total rate population in the State. Social indicators and heath parameters of S.C population are bad compared to the generation. Many of the Scheduled Caste

X CARE OF ELDERLY

In 1985, through out the world, there were 427 million persons aged 60 and above. These figures are projected to be 1,171 million by the year 2025. If the expected rise in developed countries is 77 percent by the year 2025, this is 207 percent in case of developing countries. With a population of 944.5 million, India is supporting 16 percent of world's population. Though India's age composition is typical of underdeveloped countries, the sheer size of the population brings India to the forefront of the countries with high proportion of aged persons. By the year 2001 one in seven elderly persons above age 60 would be from India . Kerala ranks first among the states in terms of highest proportion of elderly population (10%) (National policy on old people Government of India 1999).

XI Coordination And Evaluation

Periodic performance evaluation of the Secondary level institutions need to be more streamlined with proper coordination and evaluation of activities. For the effective implementation of activities and programmes according to citizen charters coordination of related depth are also required.

A separate evaluation committee can be formed or present HDC can be reconstituted and renamed as HDEC involving the representation of related depth like LSG,PWD, Water Authority, Electricity, Professional Groups, NGOs, representative of public with President of Panchayath as Chairperson and Superintendent of S L I as convenor.

The Committee need to meet once a month to discuss the problems, for corrective action and to monitor & evaluate the activities with certain criteria . Meetings of LSG can be attended by the Superintendent of S.L. Institution, concerned DMO once in 3 months so that the activities and achievements become more transparent.

Annual performance evaluation need to be done. Achievements, problems and problems solved can be evaluated and documented. A copy of the report will be communicated to DHS and Director of Panchayaths. Performance may be evaluated by an external agency once 5 years or in once in 10 years if necessary.

Once in 6 months or once in 12 months state level meetings of the DMOs and District Panchayath officers may be organized with the participation of state officials of selected departments for state level evaluation.

Monthly reporting from private institutions also need to be established. Reporting format may be modified for the collection and consolidation should be done at district medical officers level.

Xii Insurance

In the field of Health care demand is limitless and resources limited. Hence the Govt. cannot provide everything. So the role of Govt. as a welfare agency is more becoming a regulatory and coordinating agency. The cost sharing and risk pooling is usually undertaken through insurance system. The dominant private sector will inevitable be operated through insurance system for the affordable sections. Private insurance being commercial establishment may not cover all health events and hence the Govt. should support for the non covering events and other sections of APL group and the

marginalized BPL group. The specially vulnerable like tribals, coastals and urban street dwellers become a part of this BPL group.

The specific strategies for risk assessment contracting, risk sharing and prevention of malpractices should be clearly made. The existing practices of social insurance systems like ESI, CGHS and Medical Reimbursement should be integrated with this comprehensive insurance system.

Strategies for burden sharing and risk contracting through local resource generation and alternative means of fiscal mobilization should be charted out. The HDC is a replicable model in this regard. As there is scope for enough people's participation social insurance can be implemented through the HDS for the service delivery and income generation can be undertaken through any of the CBO groups like MSS, neighbor hood groups. Cooperative credit system operated through local credit banks. Alternate methods of resource generation like pay clinics, user fees for special support services, health cess can be considered and revenue generated can be used for maintenance cost.

Xiii Trauma Care

It is also important to provide basic trauma care facility at all District Hospitals. The basic trauma care units may also be established in selected secondary level Hospitals close to national highways with a high record of accidents. It is proposed to develop district blood banks along with facilities for district laboratories and surveillance units in each district.

Xiv Man Power

The proposed standardisation of health institutions, implementation of specialty services in secondary level hospital and super specialty services in district hospital may require more specialists in the health services.

In a district there is District Medical Officer (DMO), who is responsible for primary and secondary health care services provided by various health care centres inclusive of CHCs, PHCs, disease surveillance, National Programmes, food & drug control, etc in the district.

The proposed man power in different health institutions, by the committee on standardisation of health institutions are given below. The man power requirement for individual hospitals should be worked out depending on the OP patients, IP patients, presents of other hospitals in that area. The peoples demand and suggestions from the local self government should also be considered for this regard.

XV Quality Assurance

1. Treatment and referral Protocols

Effective health care requires a judicious balance of prescriptions and adequate supply of essential drugs at appropriate places and at the right time. Treatment can be successfully given if there is a good and scientifically sound referral strategy. Guidelines and protocols will enhance the utility of such referrals. A comprehensive referral strategy needs extensive human resource development and capacity building and the prime point is successful implementation of standard treatment guidelines to be used at

the primary, secondary and tertiary levels of care. The referral should be undertaken when the prescriber (doctor) is not able to manage the patient due to inadequate experience or expertise or non-availability of appropriate facilities. Emergency treatment should be given prior to referral and a detailed note indicating the reasons for referral and the treatment given till date with details of tests. Most National Programs insist on timely referral and establishment of linkages and connections.

Outcomes Expected

- ❖ Appropriate treatment in 80% of the cases treated
- ❖ Early referral and appropriate treatment in 80% of instances

Outputs Expected

- ❖ Standard treatment Guidelines prepared and distributed
- ❖ Training imparted to the doctors

2. Standard Operating Manuals

SOP is needed to implement a quality assurance program for effective health care delivery . Currently, there is no such manual in our state. We envisage to develop a guide with detailed instructions and standards for operating in the secondary health care institutions. This will cover the Medical, paramedical, pharmacy, nursing, operating rooms, laboratories and radiology set up.

Outcomes

- ❖ Adherence to the SOP in 90% of the institutions over 90% of the time

Outputs Expected

- ❖ Draft a SOP
- ❖ Circulate
- ❖ Revise
- ❖ Final SOP
- ❖ Train the staff to use SOP
- ❖ Disseminate

3. Drug Policy : Rational Use of Drugs

Over the past two decades there have been remarkable changes both qualitative and quantitative in the scenario of the Health Care system in this country. A hospital formulary has been in operation from 1997 which contain a list of essential drugs and priority items. Kerala state has already introduced Kerala State Drug Formulary in April 1999 and this needs revision and dissemination

Outcomes

- ❖ Proportion of physicians adhering to Rational Use of drugs will be 80-90% over the next 5 Years

Outputs Expected

- ❖ Preparation of the revised Formulary in consultation with the professionals
- ❖ Instructions issued to doctors in the public health system to adhere to prescribing generic brands and not advocate brand sales through their prescriptions.
- ❖ Prescribe drugs as per the formulary and in tune with rational use

4 Minimising barriers for appropriate care

Access to health is an important issue and there are geographical, economic, cultural barriers in the utilisation of services. A good quality care ensures that all population has opportunity to access. Barriers for appropriate care need to be addressed in the health provision. A monitoring and evaluation system has to be built to reduce the barrier and to assess the determinants for such barriers

XVI Continuing Medical Education

Kerala has a wide network of health care Institutions in Government, Cooperative and Private Sectors. Capacity building is needed for sustainable development so as to ensure quality in training and patient care. Demand for health care has increased drastically in Kerala. Exposure to Mass Media is high in Kerala. Morbidity pattern with burden of chronic diseases is highest in the State. Demographic transition has been rapid. Care Seeking behavior for high quality health care is on the increase. Optimising the delivery of health care is an area of concern in the transitional society. The quality of medical care expected and demanded by the public is of a very high level. Demand for quality care increases day by day. Physicians and paramedical staff need continuous up-gradation of skills and knowledge. Continuing medical education of high quality is mandatory.

The areas to be covered are:

- Induction training in the various aspects of teaching, service and research in Medical and paramedical disciplines
- In service continuing education at periodic intervals for all categories of faculty and non faculty personnel
- In service training for the practising doctors at other sectors such as Health Services, Insurance Medical Services
- To impart focussed training programs in clinical care for the Private Sector Physicians in collaboration with professional bodies

XVII DISASTER MANAGEMENT

Disasters

Important disasters occurred in the recent past includes epidemics, floods, earthquake, land slides and draught. Each district should have a team of experts and equipments to manage the disasters.

The situation in each district should be assessed based on the previous few years occurrence of disasters. In each district the period, number of individuals affected by each type of disaster should be collected.

Disaster management protocol

A disaster management protocol should be prepared and the team to be trained for management of disaster situation. The team may be constituted by district panchayat, which should contain trained persons from different department. The health should be constituted in the district hospitals.

The team should be trained for detection, reporting, immediate action and containment of the situation. This may be archived with the co ordination of other departments.