



**GOVERNMENT OF KERALA**

**TWELFTH FIVE YEAR PLAN**

**(2012-2017)**

**REPORT OF THE EXPERT COMMITTEE**

**ON**

**HEALTH**

**STATE PLANNING BOARD  
THIRUVANANTHAPURAM  
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## *Preface*

The Kerala State Planning Board constituted an expert committee to help the Board in formulating the optimal approach to implementing the 12<sup>th</sup> Five Year Plan proposals on health. Through six meetings, the committee finalised and unanimously approved a Concept Note on the direction in which the proposals may be implemented that would help to improve the health of the population of Kerala, not merely the management of diseases and disabilities alone. The Committee is pleased to present this Note for the consideration of the Board.

The Expert committee deliberated on the various challenges faced by the State's health system and the strategies to be adopted during the 12<sup>th</sup> Five Year Plan. It was decided that the overall thrust of the Plan should be on prevention of diseases and promotion of health. The Committee has identified 6 areas of priority, namely Ensuring Financial Risk Protection to the Population, Prevention of Communicable and Non-Communicable Diseases, Human Resource Planning in Health, Improving the Quality of Health Services, Improving Services for the Elderly, Mental Health and Disability, and Generating Evidence for Policy, with recommendations for the implementation strategy of the Plan Proposals. The Report points out that achieving the goal of disease prevention and health promotion is a complex task that requires a holistic approach involving many sectors and actors other than the health sector and health professionals alone. In fact the non-health sectors have a more significant role to play than the health sector in a number of areas. Even within the health sector, all disciplines, for example Modern Medicine, Ayurveda, Homeopathy, Nursing, Dental Sciences etc, need to work together to achieve best results. Since there are a number of programmes initiated by the Government of Kerala, it is necessary to ensure close coordination between the different departments and agencies entrusted with the task of their implementation in order to avoid potential overlapping and under-achieving of targets.

The Committee wishes to place on record its gratitude to Dr. Arun B Nair, Deputy Director, State Health Systems Resource Centre, Kerala and Smt. Shila Unnithan, Chief, Social Services Division, State Planning Board for their invaluable help. Thanks are also due to the members of the staff of the Board for their assistance. The Committee also thanks the Vice Chairman and members of the Board for according the privilege of taking part in the process of planning for the health of the people of Kerala.

*Thiruvananthapuram,  
9 October 2014.*

*Sd/-  
Chairman  
&  
Members of the Committee*

## Chapter -1

### **Introduction**

This report is the outcome of a series of six meetings to identify priority areas in health sector for the 12<sup>th</sup> Plan. The Expert committee deliberated on the various challenges faced by the State's health system and the strategies to be adopted during the 12<sup>th</sup> Five Year Plan. It was decided that the overall thrust of the Plan should be on prevention of diseases and promotion of health. While treatment of the sick is of overwhelming importance and sufficient allocation of financial and human resources are essential for this, the aim even on this score must be to nurse the ill back to robust health. Obviously speedy and complete recovery must become part of the process of ill health management. The 12<sup>th</sup> Plan implementation must therefore have its focus on paving the way towards a healthy nation and may be considered as a firm step in this ongoing process, which might straddle several Five-Year Plans.

The Committee realizes that achieving the goal of disease prevention and health promotion is a complex task that requires a holistic approach involving many sectors and actors over and beyond the health sector and health professionals. In fact the non-health sector has a more significant role to play than the health sector. Even within the health sector, all disciplines, for example Modern Medicine, Ayurveda, Homeopathy, Nursing, Dental Sciences etc, need to work together to achieve optimal results.

The Committee recommends that a 'group' consisting of health and non-health agencies and departments may be entrusted with formulating, implementing and monitoring a road map towards reaching the goal of good health. Participation of other stake-holders from among the public, mainly the users and intended beneficiaries, may also be considered for inclusion in this 'group'.

The Committee has identified areas and priorities for the implementation of the 12<sup>th</sup> Plan. They are, in order of priority:

1. Ensuring Financial Risk Protection to the Population
2. Prevention of Communicable and Non-Communicable Diseases
3. Human Resource Planning in Health

4. Improving the Quality of Health Services
5. Improving services for the Elderly, Mental Health and Disability
6. Generating Evidence for Policy

## Chapter -2

### **Ensuring Financial Risk Protection to the Population**

Kerala has one of the highest 'out of pocket' expenditures on health in the country. With the unique 'high-morbidity with low mortality' model, not only the health care infrastructure, but, also the finances of the common man have come under stress. The morbidity profile of the state is increasingly influenced by demographic transition, high health seeking behavior and prevalence of a wide range of non-communicable disease. The spectrum of diseases in Kerala has been changing from communicable to non-communicable diseases to chronic diseases, especially CVD and diabetes, cancer and hypertension. Due to all these changes in the health profile, the cost of health care in Kerala is very high.

As per the National Health Accounts (2004-05), of the total health expenditure in Kerala, the share of the private sector was the highest in the country with 90.27% and public sector accounted for only 9.73%. Table 1 shows the per capita public and private health expenditure across major states of India. Health expenditure in Kerala is highest in terms of both public (Rs.287) and private health expenditure (Rs.2663) in India.

**Table-1****Comparative Health & Social Indicators and Expenditure**

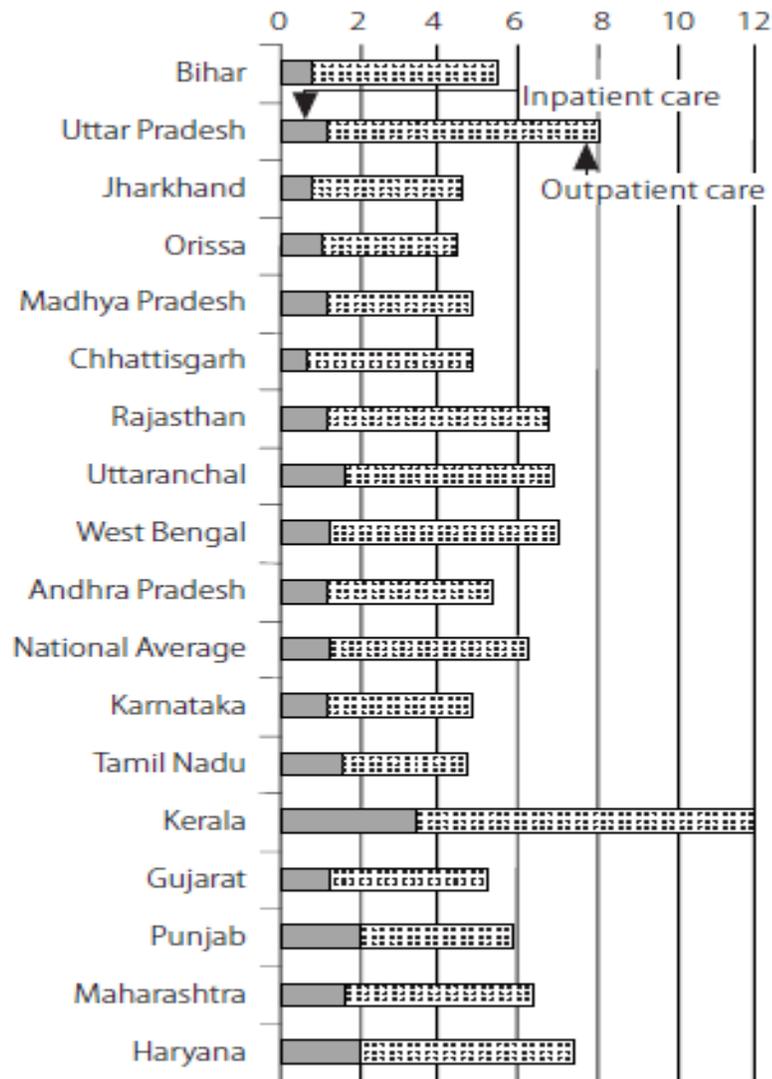
States	Per Capita Public Expenditure on Health - NHA (2004)	Per Capita Private Expenditure on Health – NHA <sup>§</sup> (2004)
Andhra Pradesh	191	870
Assam	162	612
Bihar	93	420
Gujarat	198	755
Haryana	203	875
Karnataka	233	597
Kerala	287	2,663
Madhya Pradesh	145	644
Maharashtra	204	1,008
Orissa	183	719
Punjab	247	1,112
Rajasthan	186	575
Tamil Nadu	223	1,033
Uttar Pradesh	128	846
West Bengal	173	1,086

<sup>§</sup> Source: National Health Accounts, published by the Ministry of Health & Family Welfare, Govt. of India

The latest study conducted in 2012 by KSSP shows that on an average, in Kerala, a person now spends almost Rs. 6,000 an year out of his own pocket to seek medical care. The average out-of-pocket expenditure of a person in visiting OP (out-patient) clinics in the government sector was Rs. 4,034 in a year and in private Rs. 4,739. The average out-of-pocket expenditure on IP care (in-patient), in government was Rs. 6,267 against the figure of Rs. 30,800 in the private sector. The study results show that the main reason for the high health expenditure is due to the increase in the number of people suffering with chronic diseases and the recurrent expenses of treating these diseases.

Various other research studies have also have shown that the high cost of treatment and out-of-pocket expenditure in Kerala has contributed to people falling below the poverty line. A recent study done by Peter Berman and Rajeev Ahuja using NSSO 2004 survey data has estimated that around 12 % of rural households and 8 % of urban household in Kerala were pushed below the poverty line (BPL) due to health care expenditure in 2004.

**Figure - 1**  
**Percentage of All Households Falling BPL Due to Healthcare Costs in Kerala**



*Source: Berman et al, 2010, The Impoverishing Effect of Healthcare Payments in India: New Methodology and Findings, Economic and Political Weekly*

## **Strategies to reduce OOP expenditure**

### **1. Strengthening Primary Care Service Delivery**

One of the most important strategies to reduce the out-of-pocket expenditure is to strengthen the primary health care system in the state. Health care systems build on a strong comprehensive primary care service acts as a platform which can reduce the health expenditure considerably. Currently the focus of primary care has remained on maternity and child care services and even in these areas there is scope for improvement. This can be achieved by increasing the services beyond maternal and child health and addressing 80% of the disease burden. Reprioritization of financial and human resources to the primary care settings can shift the focus of care from secondary and tertiary levels, back to the primary level. It is generally acknowledged that NCDs could be better managed in primary care settings and this itself can reduce the out-of-pocket expenditure. In Kerala there is a uniquely strong link with LSG institutions which could be further strengthened to benefit the health of the community especially through more effective interventions to address the wider environmental and social determinants of health in the community.

There is a need for paradigm shift in terms of expansion of provision of services at PHC level. Ensuring adequate infrastructure, human resources, medicines and equipments in primary health centers can transform the health system from a high cost to a low cost system and reduce out-of-pocket expenditure.

### **2. Ensuring Comprehensive Financial Risk Protection**

Development of comprehensive financial risk protection system is crucial to reduce out-of-pocket expenditure and increase access to health services. In the past five years, the government of Kerala has initiated various financial protection mechanisms which includes health insurance for inpatient care, illness assistance funds etc. The major schemes are as follows

- A. **Comprehensive Health Insurance Scheme (CHIS):** This scheme covers 1088 surgical procedures and also medical conditions and the reimbursement for a card holding family is up to Rs.30,000. CHIS/RSBY mainly caters to secondary level of care provision.

- B. **CHIS PLUS-** This scheme provides coverage up to Rs.70,000 for chronic diseases and caters to tertiary care to those who are enrolled in CHIS Scheme. This Scheme managed by Comprehensive Health Insurance Authority of Kerala (CHIAK) without an insurance company and service delivery is only through government health institutions
- C. **Arogya Kiranam.** This scheme provides comprehensive health package to all children in the State under the age of 18 at government hospitals regardless of their BPL/APL status, and provide them free medical care for all chronic diseases, including cancer, heart and renal disorders.
- D. **Karunya Benevolent Fund-** This scheme provides financial aid for poor people suffering from serious ailments, affecting heart, kidney, liver and brain; cancer and palliative care, mental illnesses, thalassemia, and sickle cell anaemia. Each patient is eligible for grants of up to Rs. 2 lakh. Service delivery through government hospitals and empanelled private providers
- E. **Thalolam-** This scheme under the Social Security Mission provides free treatment to children below the age of 18, who are suffering from Kidney diseases, Cardiovascular diseases, Cerebral palsy, Haemophilia, Thalassemia, Sickle cell anemia, Orthopedic deformities and other Neuro- Developmental Disabilities, Congenital anomalies (Endosulphan victims) and accident cases which needs surgery.
- F. **Cancer Protection Scheme-** The scheme under Social Security Mission provides free treatment to poor children below the age of 18.
- G. **The Chief Minister's Distress Relief Fund:** The fund provides financial assistance to the needy individuals for their treatment of major diseases like Cancer, Cardiac surgery, Kidney transplant, Brain Tumor, Liver and Multi Organ failure etc.

Presently there are around seven major schemes which provide various types of assistance to patients either through insurance or through financial assistance to beneficiaries. In terms of the insurance schemes, there exists integration between CHIS and CHIS plus as the implementing agency is the same. But there exists an overlap between CHIS plus and Karunya Scheme as both cater to chronic diseases even though benefit package is not the same. CHIS plus provides a

benefit package up to Rs, 70,000 whereas KBF provides up to Rs.200,000 but KBF is one time assistance whereas CHIS Plus is annual insurance scheme to family. Similar is the case with Thalolam Scheme where many of the diseases under the scheme are also part of CHIS, CHIS Plus and KBF Scheme.

Other than the overlaps in the benefit package, the schemes cater to different categories of the population. CHIS and CHIS plus caters to 35 lakh households which is primarily the BPL population, KBF provides assistance to those families whose annual income is below Rs.300,000 and Thalolam and Arogya Kiranam to children below the age of 18 to poor patients irrespective of BPL/APL status.

With regard to service delivery, most of the existing schemes are providing services through public hospitals. But each scheme is having a different benefit package and different guidelines for implementation which hampers effective service delivery. Even though the service delivery is through health department, the schemes are all under other departments which make convergence difficult.

An integrated approach which facilitates the convergence of various programs can be beneficial to the demand side and supply side of health care provision. For the patients it will ensure a continuum of care without having to incur out-of-pocket expenditure. This can also be the roadmap to provision of 'Universal Health Care' for the state. If we have an integrated approach for the various schemes which are complementary in nature, one scheme can build up on other and can help in provision of UHC in state.

On the supply side, this will help in increasing the risk pool and thereby enhance the financing of health care. The public hospitals can provide the complete range of services and they can be financed from various existing schemes. This can help in bringing efficiency and the funds from these schemes can be pooled and used for improving the quality and human resources at the facility level.

### **3. Strengthening the service delivery of public hospitals through innovative financing mechanisms**

One of the most important changes in financing of the secondary/tertiary care facilities in the last few years is the introduction of insurance scheme and channelization of insurance claims to public hospitals. Currently in Kerala, government Hospitals are the main care providers of Comprehensive Health Insurance Scheme (CHIS) and the additional top up scheme CHIS Plus scheme in Kerala. The scheme mandates that the claim amount received from the insurance company should be kept in a separate account with the HMC and this money should be used for improving the service delivery in public hospitals. Presently the claim amount received through RSBY insurance scheme is used for the following purposes (a) Infrastructure Modification (b) Hiring Human Resources (c) Reimbursement to outsourced diagnostic centers (d) Reimbursement to outsourced pharmacies (d) Incentives to HR (e) Miscellaneous Expenses at the facility level like call allowances.

This insurance claim fund along with the other funds coming to the Hospital Development Committees (HDC)'s can be effectively used to strengthen the infrastructure, service delivery and also implement quality assurance systems in public hospitals. A gap analysis can help in understanding the current situation as well as future requirement of infrastructure and equipments for OPD, IPD, Emergency services. The gap analysis can be benchmarked against the existing standards like the KASH or NABH. The gap analysis will be helpful in providing the data on existing infrastructure and what more needs to be done for improving services and this will also help in comprehensive facility planning.

### **4. Strengthening Drugs and Diagnostic Facilities in Primary, Secondary and Tertiary Facilities**

As detailed in the previous sections, the major component of out-of-pocket expenditure in the state is expenditure on drugs and laboratory tests and the strategy should aim at provision of these services in all three levels of service delivery. Presently the Kerala Medical Services Corporation (KMSCL) through centralized procurement system supplies essential medicines to all public health facilities. Further KMSCL also has retail chain outlets called “Karunya

Community Pharmacy” for branded generics and the cost of medicines in these outlets are significantly lower than the private chemist’s shops.

Expansion of Karunya Community Pharmacy model to all secondary and tertiary government facilities across the state can help in significantly reducing the out-of-pocket expenditure on drugs. Further, this scheme can be in coordination with the CHIS scheme. At present significant portion of the RSBY/CHIS fund in government hospitals is used for reimbursing outsourced pharmacy and diagnostic services. Karunya Community Pharmacy outlets can be initiated in all public hospitals where CHIS scheme is operational and this can ensure availability of drugs at lower costs.

Thus, structural changes in health care system should aim at reduction of OOP. The principal components of cost, medicines and laboratory investigations, should be made available free at the point of delivery. While the distribution of free generic drugs is being undertaken by the department now, the issue of providing free investigation can be accomplished by Kerala Medical Services Corporation, if necessary with adequate budgetary provisions. Similarly, in another model HLL operates partnership models with public institutions for running and managing diagnostic services in Government Medical Collage hospitals in Trivandrum, Alleppy, Kottayam and Thrissur. In this partnership model, the public hospitals provide space and HLL operates the laboratory and radio diagnostic centers for providing services to the public at low cost. Expansion of this partnership model to secondary and tertiary care hospitals can be another effective strategy in reducing out-of-pocket expenditure.

### Chapter -3

#### **Prevention of Communicable and Non-Communicable Diseases**

Kerala is witnessing an increasing burden of diseases, communicable & non-communicable diseases and road traffic accidents. Although the State has been successful in controlling the communicable diseases in the past, in recent years there is a resurgence of communicable diseases leading to considerable morbidity and mortality. Strategies should focus on broad basing the preparedness for communicable and non-communicable diseases and also bringing convergence between various departments like LSG, Water Supply and Sanitation etc. The introduction of Health Protection Agency (HPA) is a welcome step in this regard, but the Health Protection Agency is still not operational in implementing these tasks. One of the key strategies can be development of HPA as the apex agency for improving the the preparedness for communicable disease control with the coordination of various other departments. Another important aspect of communicable disease surveillance is strengthening the laboratory surveillance at the district and state level. This would involve the development of public health labs at the district levels. The labs presently located at the district hospitals can also be upgraded to accomplish this task.

Kerala, among the Indian states, has one of the highest prevalence of non-communicable disease and its associated risk factors. The huge burden of non-communicable diseases is due to epidemiological and demographic transition. While the state is ranked best in terms of reduction in infant mortality rate, maternal mortality rate and high life expectancy, the prevalence of non-communicable diseases is increasing. National data shows that among rural and urban areas Kerala reported high levels of morbidity with the major chunk attributable to non-communicable diseases. The spectrum of diseases in Kerala has been changing from communicable to non-communicable diseases to chronic diseases, especially CVD and diabetes, cancer and hypertension. Adding to this fact, non-communicable diseases by their very nature involve long-term care and consume significant household resources for treatment. Various studies have also have shown that the high cost of treating non-communicable diseases disproportionately affects the poor and the elderly. High treatment cost weans away a significant part of the household's resources, thereby making them more vulnerable to poverty.

The strategy to address the non-communicable disease burden should focus on improving the health services in the public sector, thereby reducing the cost of care. Screening for NCD's is presently being done at the primary care institutions and this needs to be strengthened across the state. Along with this availability of medicines for NCD's free of cost should be ensured at all levels of public health facilities especially at primary health institutions. Introducing laboratory facilities in PHC's and CHC's can also help in proper treatment and follow up for NCD's, and this along with supply of essential medicines can significantly reduce the cost of care.

Enforcement of regulatory mechanisms can also help in reducing the burden of NCD's. Regulatory measures would include implementation and monitoring of the existing acts such as Food Safety and Standards Act, 2006 and COTPA Act 2003 (Cigarettes and Other Tobacco Products-Prohibition of Advertisement and Regulation of Trade and Commerce, Production, Supply and Distribution).

The department of health is presently implementing the National Programme for Prevention of Non-Communicable Diseases (NPCDCS) and this is a centrally sponsored scheme through the National Health Mission (NHM). There are ten programmes under the National Programme for Prevention of Non-Communicable Diseases and the funding criteria of this program is based on the guidelines of National Health Mission. The fund allocation criteria of NHM gives importance to backward states and hence Kerala is not a high-focus- state based on this criteria. At present the state is not receiving adequate allocation for the National Programme for NCD prevention compared to the actual need of the state. Increase in fund allocation to Kerala for the NCD programme needs to be addressed in order to enhance the reach of the program.

Along with communicable and non communicable diseases, trauma care also needs immediate attention in Kerala as Road Traffic Accidents (RTA) in Kerala have reached a crisis proportion and addressing this issue is a great challenge for health system of the state. The mortality and morbidity due to road traffic accidents in the state is very high and trauma care and emergency management system in the state currently is not fully equipped to handle this situation. According to statistics from the crime records bureau, in 2013 there were 35,215 road accidents from which 4,258 persons died and 40,346 persons were injured in accidents. In 2012, the number of persons killed in road accidents was 4,286 and the total number of accidents was 36,174. The data shows

that in 2013 out of the 39524 injuries due to road traffic accidents, 24810 persons suffered grievous injuries and this accounts for around 63% of the total reported injuries. The state has one of highest number of trauma injury victims and most of these cases are breadwinners of the family leading to financial catastrophe for the family.

The RTA's have significant impact on the demand and supply side of the health system. The health system is not well equipped with adequate level of physical or human resources for essential trauma care. This brings us to the necessity of having an effective trauma care management system in the state. Currently the trauma care and emergency management system is not equipped to handle the large number of accident cases in the state. The emergency management services (EMS) is operational only in two districts of the state. A well networked trauma care management system with emergency medical services can help reduce deaths and disabilities due to RTA's to a considerable extent. In light of this, it is imperative for the state to have an effective trauma care management system which will include infrastructure strengthening for managing trauma care, emergency transport system, pre and post hospital care and management protocols and clinical pathways for handling trauma cases.

## Chapter -4

### **Human Resource Planning in Health**

Improved work force management and manpower planning for human resources is necessary for effective delivery of health services. This would involve increasing the availability of skilled professionals, measures for recruiting and retaining staff in the rural/difficult areas, skill development and training of existing staff, and changes in the workforce management in public health system including a re-look at the existing staff pattern so as to render the service delivery more effective.

So far no systematic/ scientific HRH planning has been made in our State in any health care delivery system. The Department of Health Services of Kerala relies on a staff pattern that was designed as far back as 1961. We have not been able to revise it suitably to keep it abreast with the changing needs of the time. This is the very same case with the AYUSH systems of medicine too. As part of Indian Public Health Standards (IPHS) Govt. of India prescribed a Staff Pattern of medical, paramedical, and perimedical from Sub Centers to Tertiary Care Dist. Hospitals based on nature of work and bed strength in the year 2007. It was subsequently revised in the years 2010 and 2012. Our State should either adopt or follow the IPHS pattern or develop Kerala Public Health Standards (KPHS) taking into consideration the requirements of the State. It should be done on the line of the former in all departments of health care delivery system in the State. While formulating the staff pattern or KPHS it would be highly desirable to integrate the health care facilities in a location (same building or compound) since the medical pluralism in the country provides people with options to avail treatments of their choice to help bridging the gaps in health care.

When a comprehensive planning in HRH is mooted, it should embrace adequate and effective human resources providing care at primary, secondary and tertiary levels in both public and private sectors. A scientific study should be made in the spheres of HRH production in each cadre of health care in all the prevailing systems of medicine. Accordingly an attempt should be made to assess the minimum density of HRH in all sectors so as to achieve it at the latest by 2030. It should be examined whether the existing number of passed out persons will suffice the requirement. If not, the deficiency should be detected to rectify it at the earliest.

Necessary steps should be taken to increase the admission strength in the sectors concerned either by enhancing the existing admission strength or by establishing new institutions .

The curriculums in medical colleges should keep pace with the changing dynamics of public health, health policy and health demographics. Health professional education should be directed towards population based primary and preventive health care instead of being driven by a curative treatment paradigm. The rural orientation design to understand and manage health problems of rural folk should also be included in the course curriculums in order to make the personnel prepared to do service in rural areas.

While integrated health care facilities as mentioned aforesaid are deployed, it is an imperative necessity to establish mutual understanding among the HRH working there in order to dispel ignorance and foster cross system referral. In order to create such a situation, orientation should be given to medical students and doctors about the salient features, scope and limitations of each system of medicine and other healthcare professions. Necessary modules for giving above orientation should be incorporated in the UG Curriculum of all health professional courses. Similarly this should be incorporated in the CME (Continuing Medical Education) programmes too.

Continued medical education and continued skill improvement programmes for HRH in all systems of medicine are required for quality health service. All service persons shall be given such training at the time of induction as well as for continuous upgrading of knowledge and skills. This in-service training should be made mandatory for their service benefits such as promotions etc. Corresponding changes should also be made in their Service Rules.

As prevalence of various types of cancer is increasing in the state, necessary training should be given to all concerned personnel in all the systems of medicine for early detection and management to stall this trend . Similarly it would be better to give such training to all concerned in the management of lifestyle diseases also, the incidence of which is also rising.

The persons in private sector of the HRH should also be subject to such CME programmes / orientation programmes etc. All required facilities towards the above end should be provided by the Govt. In the manner of State Institute of Health, district level institutes / centres should also be set up for imparting service induction and in service training to the incumbents of all systems of medicine. For the purpose of renewing registration once in 5 years, it should be insisted that the incumbent should have undergone a minimum of 50hrs CME programmes. On these lines, the statutory Registration Acts should also be amended.

In this context, it is a pity to note that there has not been a comprehensive State Medical Practitioners Act despite the elapse of 58 years. since the formation of Kerala State. Even now what is prevalent in the State is the good old T. C. Medical Practitioners Act 1953. This has resulted in the emergence of quack medical practitioners and the inability of establishing properly elected medical councils in different systems of medicine. Immediate steps should be taken to formulate a comprehensive State Act on the basis of the Central Acts which are already in force in the State in respect of all systems of medicine. In this proposed new Act, necessary provisions should be brought in for renewal of registration as mentioned above.

It is highly recommended to introduce incentives either by cash or by preferment in service or awards or all these three or any one of them rolled into one with a view to extracting more attention and care to the patients, for carrying out the health care programmes more successfully and working in rural / difficult areas etc voluntarily.

The establishment of Public Health Cadre is another major step which is overdue. In order to establish this cadre, the two existing Public Health Acts viz. The Madras Public Health Act 1939 and the TC Public Health Act 1955 need to be unified for formulating a comprehensive State Act - The Kerala State Public Health Act. This has been referred to in the Working Group Report of the State Planning Board on Medical and Public Health for 12<sup>th</sup> Five Year Plan. It is understood that several discussions and deliberations have since been made towards this end. Steps may be taken to bring in the unified Act in the legislature at the earliest.

The above State Act should contain the concept and establishment of a State Public Health Cadre with the following **objectives**.

- i. To focus and co-ordinate all activities and factors related to health promotion and disease prevention - both 'medical' and 'non-biomedical'.
- ii. Epidemic surveillance
- iii. To be responsible for centrally sponsored programmes like MCH, RCH, ICDS, UIP as well as disease prevention / eradication / mitigation schemes.
- iv. To co-ordinate health related activities with depts. / agencies dealing with / responsible for sanitation, drinking water, waste management etc. under the aegis of the LSGs.
- v. Be responsible for health education of the public, starting at the level of schools, and even beyond.

This cadre should be an integrated one with members drawn from all the disciplines of the 'healing' sciences (Ayurveda, Homoeopathy, Modern Medicine etc.) as well as those from nursing and dentistry.

The question of giving special / additional qualification to the personnel can also be considered according to cadre wise necessity. The Health Science University should be entrusted with the conduct of such courses.

Career Progression in the State Public Health Cadre should be stream-lined from Public Health Officer at PHC, CHC to Taluk PHO, Dist. PHO, Divisional and then State PHO. State PHO should function in close co-ordination/co-operation with the Directorates of Health Services, Indigenous Systems of Medicine and Homoeopathy.

## Chapter -5

### **Improving the Quality of Health Services**

One of the major challenges faced by the public hospitals is ensuring the quality of care in service provision. The provision of quality services requires in addition to infrastructure and human resources, proper equipment, drugs and supplies, an efficient organization of work and a high level of motivation and a consciousness about quality. Strategies should focus on assuring minimum services provision in public hospitals especially at the secondary level, how to ensure the availability of services and how to ensure inputs for assured service provision.

In this regard the first step will be to define standards for each level of care; i.e primary, secondary and tertiary and standardization of the existing public health facilities. The standards can be adopted from the prevailing standards like Indian Public Health Standards (IPHS) and modified according to the needs of the State. Along with the standards, the service delivery at each level and the entitlements of the citizens also needs to be specified at each level of care. The second step in improving the quality of health services shall be accreditation of service delivery in public hospitals. Currently some of the public health facilities have started the process of accreditation using the National Accreditation Board for Hospitals & Healthcare Providers (NABH) and Kerala Accreditation Standards for Hospitals (KASH). This could be extended to include all levels of public facilities in the state including the laboratory facilities. Along with this, it is also suggested to develop evidence based treatment protocols and clinical pathways which will help in improving the quality of care in public facilities.

One of the major lacunae of the public facilities, especially secondary and tertiary care health facilities, is lack of proper planning in the hospital infrastructure. The various components hospitals are constructed using different type of funds such as MLA fund, MP fund, LSG funding etc and hence many are stand alone buildings which hampers the effective service provision. In this regard, it is suggested to prepare hospital master plans for all the secondary and tertiary level facilities and this master plan would include the current gaps in infrastructure, infrastructure up gradation and renovation and the budget estimate for each of the facility. The master plan may also suggest the health human resources requirement based on the caseload

handled as well as the requirement of equipments for the facility. This would help in planned development of public facilities and effective use of various types of funding source.

Improvement of quality of health services provided by private sector is also important as they are the major providers of out-patient and in-patient services in the state. In this regard, implementation of the Clinical Establishments Bill is an important step and this will help in ensuring a monitoring mechanism for the private hospitals and laboratory facilities in the state. Along with this it is suggested to promote accreditation initiatives among private health facilities to improve quality and standards.

## Chapter -6

### **Improving services for the Elderly, Mental Health and Disability**

The proportion of the elderly population in the state has been increasing steadily over the last three decades. This has also raised the demand for medical care for the ageing population. Significant proportion of the elderly suffers from various types of chronic diseases such as heart diseases, diabetes, stroke, cancer, dementia and psychiatric illness. The elderly population also suffers from disabilities, emotional and financial issues in addition to the health issues. In fact, the proportion of elderly population without any of the chronic diseases is relatively small. Chronic diseases result in catastrophic health expenditure which becomes a burden for the entire family resulting in limited or no access to health care to the elderly. Loneliness and lack of financial and social support are other major concerns of the elderly.

Strategies should be evolved to focus on multidimensional approach to elderly care involving all systems of medicine and social welfare agencies/department. It would be highly desirable to establish an inter-disciplinary centre for the study of ageing with focus on both basic and translational research. The strategy shall also focus to strengthen the palliative and geriatric care services in the state. These services especially palliative care services are currently provided by Community Based Organisations (CBO's) and there are various best practice models available in the State. These initiatives can be strengthened and an integrated palliative care model which includes the participation of CBO's, Local Self Governments (LSG's), Department of Health and Department of Social Justice can help in improving these services to the elderly population.

Due to chronic diseases, elderly also incur very high out-of-pocket expenditure for medicines and diagnostic tests. In view of this ensuring the availability of essential medicines and diagnostic tests for NCD's free of cost to the elderly population shall help in improving the service delivery. Excellent social security measures are available for the elderly in the west. Similar measures, including total free health care and involving all systems of healthcare, should be planned and implemented in Kerala also.

A comprehensive study to assess the health and morbidity of the elderly population which would also cover the mental health, disability and social security concerns should be undertaken as part of the 12<sup>th</sup> plan.

It is recommended that the Planning Board should provide major support to the plan of the Kerala University of Health Sciences to set up an Interdisciplinary Centre for the Study of Ageing to research into all the aspects of the phenomenon of ageing, including basic science studies, the management of the health of the aged, as well as the socio-economic issues affecting the senior citizens.

The state also suffers from an increasing burden of mental illness precipitated by social causes such as suicides, homicides, road-traffic accidents, and alcohol & drug abuse. Strategies may focus on an interdisciplinary approach to mental health with emphasis on holistic management involving not only treatment, but also prevention and social inclusion. Currently the Department of Health has a District Mental Health Programme in selected Districts and also Community Mental Health Programs through NRHM in selected districts. Under these programs mental health services are provided at Taluk and District Hospitals. This needs to be enhanced to the primary care level and training/capacity building of the health staff which includes doctors, para-medical staff and field workers needs to be undertaken. Along with this the IEC/BCC activities needs to be strengthened and community should also be sensitized about the mental health issues with the support of LSG.

The census 2001 and NSSO 2002 estimates reveal that the state has a very high prevalence of the disabled in the total population. Around 2.7 per cent of the population of Kerala is disabled. The disabilities include chronic fits, difficulty in moving around, seeing, hearing, learning and feeling. Strategy should focus on bringing out a comprehensive policy for tackling the disability with an integrated approach with other departments like the social welfare department. This strategy will also focus on overall management involving prevention, rehabilitation and improving physical access to services and places.

## Chapter -7

### **Generating Evidence for Policy**

Evidence based research and policy making is necessary to facilitate realistic policy planning and implementation of various approaches in the state health system. Strategies will aim to promote evidence based policy making, a closer interaction and sharing of knowledge between different actors of the health system, and building capacities within the department. Strategies should focus on strengthening knowledge exchange and research activities to support policy making and Kerala University of Health Sciences in coordination with Achutha Menon Centre for Health Science Studies (AMCHSS) and Centre for Development Studies (CDS) can help in coordinating the research and knowledge dissemination activities within the health sector. In order to improve the evidence based research and policy making, a task force shall be formulated with members from government and non- government institutions working in the area of health systems and public health for developing the road map.

**PROCEEDINGS OF THE MEMBER SECRETARY, STATE PLANNING BOARD  
(Present: Shri. V.S. Senthil IAS)**

Sub: 12<sup>th</sup> Five Year Plan (2012-17) - Constitution of Expert Committees -  
Orders issued - reg.

Ref: 1. Minutes of the Planning Board Meeting held on 20-12-2012.  
2. Minutes of the Core Group Meeting held on 14-02-2013.

**ORDER NO. 9508/12/PCD/SPB DATED: 09.04.2013**

As per the reference first cited, State Planning Board in its meeting held on 20-12-2012 resolved to constitute Expert Committees on major sectors to examine in detail various programmes and policies proposed in the draft Central 12<sup>th</sup> Plan document so as to take maximum advantage of Central Schemes during the 12<sup>th</sup> Plan period, by the State.

2. The Core Group in its Meeting held on 14-02-2013, vide reference 2<sup>nd</sup> cited, decided to constitute 9 Expert Committees for the following sectors.

**Expert Committees**

- I. Resources and Plan Implementation
- II. Agriculture and Allied Activities
- III. Industry
- IV. Infrastructural Development including Water Supply and Sanitation
- V. Energy
- VI. Health
- VII. SC/ST Development and Social Welfare
- VIII. Education
- IX. Employment and Skill Development

3. In the above circumstances, 9 Expert Committees are hereby constituted as detailed at Annexure I to IX. The terms of reference are given below.

**Terms of Reference**

- (i) To review 12<sup>th</sup> Plan (2012-17) of Government of India with a view to maximise the State's access to Central Schemes during the Plan period.
- (ii) To examine how the State's Plan programmes (and the flexi-funds available under CSS) can be enhanced through access to Central Plan resources, external funding (including RIDF, Bank finance and PPP).
- (iii) To function as a continuing mechanism throughout the plan period to review how different sectors are able to act up on its recommendations regarding accessing outside resources.
- (iv) To identify road blocks in accessing resources and difficulties in implementation and suggest measures to overcome them.

- (v) To prepare a Plan of Action for each sectors incorporating the estimated resource availability both from Central as well as State and Financial and Physical Targets etc. during the Plan period.
- (vi) To assess the physical outcome of the efforts of each sector through the 12<sup>th</sup> Five Year Plan period.

4. The Chairperson is authorised to co-opt additional members, if necessary. The Chairperson can also modify terms of reference with the approval of the Board.

5. The Expert Committee may submit an interim report before 31<sup>st</sup> May 2013 and the final report by 30<sup>th</sup> September 2013. The interim report will cover all changes in guidelines required for Centrally Sponsored Schemes in the light of the proposed Government of India decision to introduce flexibility in these schemes. The interim report will also cover the immediate steps that are to be taken by the respective departments for submitting detailed proposals to various Central Ministers for availing financial assistance during the current financial year.

6. The non- official members of the Expert Committee will be entitled to travelling allowances as applicable to Class I Officers of the Govt. of Kerala. The local non official members will be eligible for TA/DA as per rules. The Class I Officers of GOI will be entitled to travelling allowances as per rules if reimbursement is not allowed from Departments. The expenditure towards TA, DA and the honorarium will be met from out of the outlay provided under the Head of Account “3451-00-101-93-Surveys and Studies” during 2013-14.

**(Sd/-)**  
**Member Secretary**

To

1. The Chairman / Members

Copy to

1. Chief Secretary, Government of Kerala (With C/L)
2. All Government Secretaries (With C/L)
3. PS to VC
4. CA to Members
5. PA to MS
6. CA to CEA
7. Sr. A.O.
8. SS, Accounts
9. Spare , S/F

Approved for issue

**(Sd/-)**  
**Chief, PCD**

**CENTRAL 12<sup>TH</sup> FIVE YEAR PLAN (2012-13) – CONSTITUTION OF EXPERT COMMITTEES**

**Expert Committee on Health**

**I. Health**

**Chairman:** Dr. K. Mohandas,  
Vice Chancellor  
Kerala University of Health & Allied Science  
Medical College.P.O,  
Mulankunnathukavu  
Thrissur. Pin – 680 596

**Members:**

1. Dr.M.S. Valiathan  
National Research Professor  
Manipal Academy of Higher Education  
Manipal, Karnataka
2. Dr.V. Ramankutty  
Achuthamenon Study Centre for Health Science & Studies  
Sree Chitra Tirunal Institute of Medical Science & Technology,  
Thiruvannathapuram- 695 011
3. Dr.T. Jacob John  
Christian Medical College, Vellore
4. Dr. Vasudevan Namboothiri,  
State Programme Manager,  
AYUSH, Programme Management Unit,  
NRHM Building, Thycaud, Thiruvananthapuram

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5. Dr. Ravi.M.Nair  
Aramam, HSRA E-25, Kalady, Karamana  
Thriuvananthapuram
6. Dr. Vinod Kumar  
President  
Ayurveda Medical Association of India  
Ayurveda Bhavan, Angamaly, Kerala

**Member Convenor:**

Smt. Shila Unnithan, Chief, SS Division, SPB

**PROCEEDINGS OF THE MEMBER SECRETARY, STATE PLANNING BOARD  
(Present: Ms. Rachna Shah IAS)**

Sub: 12<sup>th</sup> Five Year Plan (2012-17) - Constitution of Expert Committee on Health-  
Amendment- - reg.

Ref: 1. Order No. 9508/12/PCD/SPB Dated: 09/04/2013 and 30/05/2013.

2. Note No. 5529/2011/SS/SPB dated 24/05/2013 from the Chief, Social Services  
Division.

**ORDER NO. 9508/12/PCD/SPB DATED: 05.06.2013**

1. As per the reference first cited, 9 Expert Committees have been constituted on major sectors to examine in detail various programmes and policies proposed in the draft Central 12<sup>th</sup> Plan document so as to take maximum advantage of Central Schemes during the 12<sup>th</sup> Five Plan period, by the State.
2. As per the second reference, it was decided to co-opt four more members in the Expert Committee on Health.
3. In the above circumstances, the following members are also nominated to the Expert Committee on Health.

**Expert Committees on Helath**

1. Sri. Gopalakrishna Pillai IAS (Rtd.),  
K- 202, Plumeria Garden Estate,  
Senior Omicron III, Greter Noida,  
UP. Pin 201308
2. Sri. Rajeev Sadanandan,  
Principal Secretary to Govt.,  
Health & Family Welfare,  
3<sup>rd</sup> floor, South Block,  
Secretariat, Thiruvananthapuram
3. Dr. M. Beena IAS  
Mission Director (NRHM),  
Department of Health & Family Welfare,  
General Hospital Jn.,  
Thiruvananthapuram-35
4. Sri. Arun B. Nair,  
Faculty, Institute of Public Health, Bangalore,  
250, Masters Cottage,  
2<sup>nd</sup> C Main, 2<sup>nd</sup> C Cross,  
Giri Nagar I Phase,  
Bangalore- 560085

4. The proceedings first cited stands partially amended to the above extent

**(Sd/-)**  
**Member Secretary**

To

1. The Chairman / Members
2. Chief, Social Services Division

Copy to

1. PS to VC
2. CA to Members
3. PA to MS
4. CA to CEA
5. Sr. A.O.