

Chhattisgarh Healthcare Summit

24-25th October, 2017

RAIPUR

Concept Note

Chhattisgarh is one of the younger states in the country. The state was formed in year 2000. It was one of the poorest states in the country with a third of its population belonging to the scheduled tribes. The state at the time of its birth was at the bottom amongst the states in India in terms of health indicators like the Malnutrition rates, Infant Mortality Rate (IMR) and Under-5 Mortality Rate. The state had inherited an under-developed health system with inadequate infrastructure and severe shortage of qualified human resources for healthcare.

Over the last 17 years since its formation, the state has made significant progress in developing its health system and healthcare services. The state is known for its innovative HR development and community processes. The state has now moved close to national average in terms of the health outcome indicators like IMR. In terms of service indicators also, the state has reached close to the national average for many of the essential services. There is a need to evolve strategies to meet the next set of challenges for the state. Government of India has unveiled the National Health Policy 2017. While it provides a very important reference for the states, there is a need to adopt a State Health Policy for Chhattisgarh in order to address the state-specific needs.

This Healthcare Summit is being organised to deliberate on the health issues important to public health in Chhattisgarh with a view to debate and evolve potential strategies. A set of eminent panelists is being invited to kick-start the discussions, to shed light on the issues involved and also to share some best-practices and innovative approaches. The summit will use a workshop format with a number of parallel sessions. Each session will involve a group discussion with around 15 participants drawn from experts, officials, field level functionaries and civil-society. For each session, a set of questions have been listed to facilitate a focused discussion.

The expected outcome of the workshop is to enable the state to make well-informed choices in terms of short term and long term strategies for meeting its key public health challenges.

About Chhattisgarh: Chhattisgarh currently has a population of around 28 million of which 77% is rural. Scheduled Tribes constitute 31% of the population whereas Scheduled Castes are 11% of the population.

44% of the state's geographical area is covered with forests. It has 27 districts which are divided into a total of 146 blocks. 85 of the 146 blocks are classified as Tribal blocks. In terms of poverty head-count and the per capita consumption expenditure, Chhattisgarh figures amongst the poorest states in India.

Key Public Health Challenges in Chhattisgarh: Although the state has made rapid progress in expanding coverage of basic healthcare services, the state faces several public health challenges. The key public health challenges include:

- a) Communicable diseases including Malaria, Leprosy, TB, Hepatitis E
- b) Maternal and perinatal conditions requiring emergency care
- c) Non-Communicable diseases including Hypertension, Diabetes, COPD

Key Health System Challenges in Chhattisgarh

In terms of health systems, the key challenge in the state relates to shortage of skilled human resources for healthcare, particularly at secondary and tertiary level. Ensuring access to services in remote areas is another major challenge in the state.

Chhattisgarh – Key Health Indicators

Vital Statistics (Source SRS)

| Indicator | Chhattisgarh Year 2000 | Chhattisgarh Year 2006 | Chhattisgarh Year 2016 | INDIA Year 2016 |
|------------------------------------|---------------------------|---------------------------|---------------------------|--------------------|
| Infant Mortality Rate (IMR) | 79 | 61 | 39 | 34 |
| MMR (combined with Madhya Pradesh) | 379 (SRS 2001-03) | 335 (SRS 2004-06) | 221 (SRS 2011-13) | 167 (SRS 2011-13) |
| Birth Rate | 26.7 | 26.9 | 22.8 | 20.4 |
| Crude Death Rate | 9.6 | 8.1 | 7.4 | 6.4 |

The Neonatal Mortality Rate as reported by SRS Statistical Report 2015 for Chhattisgarh was 27 per 1000 live births compared to 25 per 1000 for India. The Under-5 child Mortality Rate (U-5MR) as reported by SRS Statistical Report 2015 for Chhattisgarh was 48 per 1000 live births compared to 43 per 1000 for India.

The Maternal Mortality Ratio (MMR) has not been reported separately for Chhattisgarh. It is reported for Chhattisgarh and Madhya Pradesh together as one sample. The MMR for Chhattisgarh and Madhya Pradesh together was reported as 379 per 100000 births as per SRS for period 2001-03. It declined to 221 in SRS 2011-13 whereas the figure for India was 167 as per SRs 2011-13.

National Family Health Survey reports data on status of reproductive and child health along with indicators on provision of services.

Health and Service Indicators (Source – NFHS)

| Indicator | NFHS-2 (1998-99) Chhattisgarh | NFHS-3 (2005-06) Chhattisgarh | NFHS-4 (2015-16) Chhattisgarh | NFHS-4 (2015-16) INDIA |
|---|-------------------------------------|-------------------------------------|-------------------------------------|------------------------------|
| Maternal Health | | | | |
| Mothers who had antenatal check-up in the first trimester (%) | | 46 | 70.8 | 58.6 |
| Mothers who had at least 4 antenatal care visits (%) | | 28.3 | 59.1 | 51.2 |
| Institutional births (%) | 13.8 | 14.3 | 70.2 | 78.9 |
| Institutional births in public facility (%) | 7.6 | 6.9 | 55.9 | 52.1 |
| Births delivered by caesarean section (%) | | 4.1 | 9.9 | 17.2 |
| Births in a public health facility delivered by caesarean section (%) | | 24.9 | 5.7 | 11.9 |
| Women age 20-24 years married before age 18 years (%) | 61.3 | 55 | 21.3 | 26.8 |
| Women whose Body Mass Index (BMI) is below normal (BMI < 18.5 kg/m ²) ¹⁴ (%) | 48.1 | 43.4 | 26.7 | 22.9 |
| Pregnant women age 15-49 years who are anemic (<11.0 g/dl) (%) | 68.3 | 63.1 | 41.5 | 50.3 |
| All women age 15-49 years who are anemic (%) | 68.7 | 57.5 | 47 | 53 |
| Child Health | | | | |
| Children age 12-23 months fully immunized (BCG, measles, and 3 doses each of polio and DPT) (%) | 21.8 | 48.7 | 76.4 | 62 |
| Children age 9-59 months who received a vitamin A dose in last 6 months (%) | | 8.9 | 70.2 | 60.2 |
| Children under age 3 years breastfed within one hour of birth (%) | 13.9 | 24.6 | 47.1 | 41.6 |
| Children under age 6 months exclusively breastfed (%) | - | 82 | 77.2 | 54.9 |
| Children with diarrhea in the last 2 weeks who received oral rehydration salts (ORS) (%) | 29.7 | 40 | 67.9 | 50.6 |
| Children under 5 years who are stunted (%) | 57.9 (Under 3) | 52.9 | 37.6 | 38.4 |
| Children under 5 years who are underweight (weight-for-age) (%) | 60.8 (Under 3) | 47.1 | 37.7 | 35.7 |
| Children age 6-59 months who are anemic (<11.0 g/dl) (%) | 87.7 (6-35 month) | 71.2 | 41.6 | 58.4 |
| Family Planning | | | | |
| Female sterilization (%) | 35.1 | 40.7 | 46.2 | 36 |
| Male sterilization (%) | 3.3 | 3.3 | 0.7 | 0.3 |
| IUCD/PPIUCD (%) | 1.0 | 0.8 | 1.6 | 1.5 |
| Couples using any modern method ⁴ (%) | 42.3 | 49.1 | 54.5 | 47.8 |
| Total unmet need (%) | 13.5 | 11 | 11.1 | 12.9 |
| Unmet need for spacing (%) | 8.0 | 5.4 | 5.3 | 5.7 |

Some Issues to Focus our Discussions on

Comprehensive Primary Health Care

It is a new area of focus. The population has diverse healthcare needs. What are the ways to meet these needs? How should the primary-care services be organised to provide easy access, wide range of services along with continuity of care? What kind of HR will be needed? How will the skills get created for Health and Wellness Centres? How will the public system be geared to cover a much larger share of primary healthcare load than what it is able to attract and serve today? How to strengthen a combination of curative and preventive care in tandem rather than imagining them in separate boxes? There are some models which have emerged from the state itself which need to be discussed and suitable ideas from other states need to be assimilated.

Free Drugs policy

Government of Chhattisgarh adopted Free generic drug policy in August, 2013. The state has a history of notifying its Essential Drug Lists for various levels of care from year 2002 onwards. It also set up its Medical Services Corporation which now manages to procure most of the required drugs for public health facilities in the state. The availability of free drugs has improved over the last few years. Assessments show that around 80% of the prescriptions written in government facilities are of generics and around 70% of those drugs are available in the facility stores. Thus around 60% of the drugs needed by patients accessing care in government facilities have been available to them free of cost. States like Tamil Nadu and Rajasthan have shown strong sustained performance in provision of drugs. In order to move to the next level of achievements, apart from learning from such states, there are a few gaps and questions which should be discussed.

While drugs are being procured as per EDL, how do we ensure that the quantities to be procured for each item are decided rationally? The state managed to procure many of the necessary drugs in large quantities but still there were a few crucial items missed. How to procure enough to avoid shortages while avoiding wastage at the same time? While the state has become more efficient in procurement, how can it decide and create optimum systems of storage and distribution? What kind of checks and balances are needed to avoid indenting of excessive quantities?

How does the state further promote the prescription and use of generics.

There is a Jan Aushidhi scheme also in the state. It provides drugs at economical prices. But if the policy of the state is to provide free drugs in its facilities then how do we reconcile the co-existence of Jan-Aushidhi with it?

Free diagnostics policy

It is another area which has attracted attention in recent times. There is a consensus that diagnostics is an integral part of providing healthcare. The state is yet to initiate a policy measure to provide free diagnostics to patients accessing government health facilities. The state has around

70% of the required HR and infrastructure. Though most of the Labs in government hospitals are found to be functional, the range and number of tests being done has been inadequate. In such situation, how does the state improve the performance of its Labs? Should the state notify a list of essential Diagnostics for each level of care? How should that list be arrived at? How the availability of necessary skills, consumables and management be improved to achieve this ambitious goal? Should all the tests be kept free of cost? Will the existing labs suffice for meeting the basic needs of testing? Should each district aspire to have a Central Lab? Has outsourcing for diagnostics worked well in other states? Which tests are better to be outsourced than being handled in-house? How do we promote rational use of diagnostics?

Human resource in health:

This has been one of the key challenges facing the state since its inception. The state has innovated at the primary level by bringing in Community Health Workers and a Three-year diploma course. The state also introduced Rural Medical Corps (CRMC) for incentivizing working in remote or difficult areas. The availability of HR in the market has improved in recent years with a large number of nurses and paramedics being produced annually. The number of medical colleges has gone up in the state but the state is yet to reap benefits in terms of being able to recruit or retain them in government service. Shortage is further severe for specialists in desired streams. There are also examples where very remote and difficult districts have successfully used innovative strategies to recruit doctors including specialists. Some of the questions which should be discussed in this context are:

- How to improve efficiency in ensuring recruitment by government for cadres for which there is enough market-availability of qualified HR? Are any changes needed in our procedures including norms of registration?
- How to attract doctors passing out of medical colleges of the state and outside?
- In a state which is short of specialists and doctors, what could be the alternative?
- How do we strengthen policy for human resource retention in remote areas?

Conflict-affected and other difficult areas:

Chhattisgarh has several areas affected by a situation of conflict due to left-wing extremism. Conflict poses additional challenges in provision of services and the necessary infrastructure, HR, mobility etc? The fact that most of such areas in Chhattisgarh also happen to be geographically remote and difficult compounds the challenges. Private sector option also does not exist there and government is the main provider of healthcare. There have been a few promising breakthroughs in the state where services have been made available despite multiple challenges. There is a need to discuss the solutions attempted. Is there a need to further specify the high-priority needs (malaria for example) for such areas rather than attempting everything? Also, it needs to be discussed what additional funds, facilities or flexibilities are needed for such areas? Should some of them be applicable to other remote tribal areas and populations, for example, the Particularly Vulnerable Tribal Groups (PVTGs)?

Raising resources

Are there enough resources available at the moment to build and sustain a strong public health system? If not, where are likely sources? While Government definitely needs to bring in more resources, can private sector be a reliable source of investment in healthcare infrastructure? Our past experience with outsourcing or PPPs for ancillary services (like referral transport) has been relatively more successful than outsourcing hospitals or their core clinical functions. The state had to cancel a PPP for a tertiary hospital after dissatisfactory experience of more than a decade and the Health Department is planning to run the concerned hospital itself. Even in the successful PPPs for ancillary services, bulk of the investment had to be made by Government and the private-sector partners provided the management function. In such a scenario, what are ways of raising more resources? Should better utilization of existing allocations be the focus first? Can funds like District Mineral fund (DMF) be mobilized towards healthcare?

Hospital Strengthening

Improving functioning of government Hospitals involves improving in a number of areas from availability of infrastructure, skilled HR, availability of drugs or consumables and how the processes essential for the hospitals' functioning operate. The questions relate to how to build a stake for the officials, healthcare staff and public at large in improving government hospitals? How to improve quality? How to deal with complaints regarding rude behaviour by staff in public hospitals? How to create a sense of pride in the hospital staff? How to develop Clinical skills required in hospitals? Is separation of a Clinical cadre the answer? What kind of governance is most suitable for revitalizing our public hospitals?

Publically-funded Health Insurance

Government of Chhattisgarh has implemented a universal scheme of health insurance under which all families in the state are eligible to get covered. It provides annual coverage up to Rs.50,000 per family for hospitalizations. Chhattisgarh has the highest rate of enrolment (67%) under health-insurance amongst all Indian states as per NFHS-4 in 2015-16. The scheme has achieved significant milestones but faces certain challenges like occurrence of Out of Pocket Expenditure by families despite insurance use, imbalance in availability of services in remote areas due to concentration of services in urban areas and some concerns of irrational care and unnecessary procedures. The questions therefore, which need to be deliberated are:

Question 1- How do we ensure that the hospitalization is completely cashless for the covered families? How do we make sure that the services are regulated and there are no informal payments or Out of Pocket Expenditure?

Question 2- How do we ensure that the treatment provided under insurance is rational? How do we insure quality and dignity in treatment and minimize chances of denial of any of the designated services.

Question 3- How do we address the limited availability of empanelled private facilities in remote areas?

Use of Information Technology for Health Services:

Information Technology represents a very significant area of technology that has advanced in recent years and holds promise for sectors like healthcare too. Chhattisgarh used a mobile based system for name-wise tracking of mothers and children (e-mahtari). Government of India has institutionalized MCTS. There are packages available for e-hospitals. A few hundred ANMs in the state were given Computer Tablets for health related reporting and information sharing. Have all these measures helped in providing better services to more number of people? Has it really shown results? Have they reduced the burden of data-entry on key service providing staff like ANMs or increased it? Is the data getting generated being analysed and used for action? What are the lessons from attempts made in the state and elsewhere so far? What kind of design principles need to be observed.

- How to make rational use of IT to reduce effort of staff and improve services to people?
- How to use IT for better continuity of care?
- How to use IT for better disease surveillance?

AYUSH:

Chhattisgarh has a large tradition of herbal remedies and traditional healers. Large part of its geography is forests and a third of its population is of tribes. The state made a strong effort for AYUSH mainstreaming. There is further scope to promote AYUSH. NCDs offer new areas of expansion of AYUSH.

- How to promote greater use of AYUSH based care in government facilities?
- How to ensure the availability of Ayurvedic drugs? Should ASHA drug-kits have Ayurvedic drugs too?
- Should AYUSH Officers be used as Mid Level Care Providers for Health and Wellness centres? If yes, what kind of training be given to them?

Medical Education: The state was born with one medical college. It has since expanded to six colleges. There has been a boom in production of nurses in private schools. Many tribal areas still suffer from health HR shortages. Maintaining quality in education is another challenge.

- Should rural internships be made mandatory during medical education for both medical graduates and post graduates?
- How to achieve better enforcement of bonds after MBBS and PG?
- How do we encourage the entry of youth from tribal areas into medical education in Chhattisgarh?
- What strategies can be practiced to ensure standards in Medical education in Chhattisgarh?
- Should ethics be introduced into medical curriculum?

Role of private sector in its regulation

The state passed its Act on Regulation of Clinical Establishments and Nursing Homes in 2010. It has resulted in registration of a large number of clinical establishments. Private sector caters to a large chunk of ambulatory care and is a big partner with government for hospitalization care under health insurance programme. A few questions that need to be discussed are:

- Should cost control and quality of care be part of regulation? Is there a need to expand the provisions of the 2010 Act to include these aspects? How can its implementation be strengthened to ensure rights of the patients?
- Beyond the legal measures, are there other ways of regulation?
- A related issue is of informal providers who operated in parts of the state. Though they lack formal qualifications, they were providing curative services at primary level close to the people. At the same time, there is a need to apply regulation and standards and to protect the population from irrational care or out of pocket expenditure. High Court has directed for shutting down their practice. Should they be allocated a legitimate space in the health-system or be completely discouraged?

Maternal Health

At the time of its inception, the state was one of the poorest performers in maternal care. From that background, the state has made very significant progress over the last decade. The state now has good coverage under ANC care and institutional deliveries are around 70%. Providing adequate c-section and emergency care services in public facilities has been the key challenge. Some of the questions to be deliberated are:

- How to increase institutional deliveries from 70% to past 90%?
- How to manage complications detected during ANC check-ups?
- How to reduce maternal deaths in institutional deliveries? How to improve availability of blood and c-section facilities in government centres?
- How can the nutrition of girls and women be improved for better maternal outcomes?

Child Health

The state has made important progress in improving immunization. It has rolled out new national initiatives like RBSK, NRCs etc. Diarrheal deaths amongst children have reduced. Even child malnutrition has reduced fast and has come close to national figures.

- What strategies can increase the full immunization rate of children from 75% to 95%? Should it be Campaign approach or Strengthening Routine immunization?
- How to improve labour room practices for better peri-natal outcomes? What strategies can be adopted to reduce deaths due to birth asphyxia in institutional deliveries?
- How can mortality due to Acute Respiratory Infections in under-five children in Chhattisgarh be reduced?

- What can be the strategies for community based management of severe or acute malnutrition for children in Chhattisgarh?

Malaria:

Chhattisgarh has high incidence of malaria and most of its tribal areas are endemic. The Annual Parasite Index in more than 70 blocks is above 5 per 1000. Falciparum forms a big share of it. The state implemented a malaria control strategy from November 2014 onwards. It improved early detection and prompt treatment by equipping ASHAs with Rapid diagnostic tests. The state has also distributed bednets in tribal areas and is planning to scale it up. Along with the successful interventions, there are challenges which need to be met by the state. Some of the relevant questions are:

- How to strengthen prevention where efficacy of Indoor Residual Spray has come under doubt – should the state persist with IRS, what are the alternatives?
- How can we improve the management of severe cases of malaria in CHCs or PHCs?
- How to improve Surveillance and use it better for planning and for quicker response to outbreaks?
- How to rationalize the use of Rapid diagnostic testing versus Microscopic testing across different levels of health care?
- There are reports of asymptomatic malaria. How should the state deal with it.
- Malaria in Pregnancy – the state initiated intermittent screening two years ago. Should the state persist with it?

Non communicable diseases (NCDs):

The state has a large burden of NCDs like most parts of the country. Tobacco chewing remains a big threat on the risk factors side. Are NCDs mainly a lifestyle related set of diseases? A large number of non-obese people from poor socio-economic conditions are also suffering from NCDs like Hypertension, Diabetes etc. Very limited availability of primary treatment may be leading to lack of secondary prevention and resulting in large number of strokes or heart-disease cases. Air-pollution related diseases are also becoming more common. Sickle Cell Disease is another widespread health problem in the state for which availability of services has been inadequate. How does the state avoid the trap of large-scale screening for NCDs without preparing adequately to provide long-term medical care to the sick? Non-communicable diseases (NCDs) were not a traditional area of work for public healthcare services. It has come into prominence over the last few years and the availability of services is beginning to improve. The key questions are:

- How to ensure universal availability of detection and primary treatment of NCDs at primary level in Chhattisgarh?
- What can be the ways to reduce oral tobacco usage?
- How to improve management of sickle cell disease for better life expectancy with quality

Tuberculosis:

Despite carrying out adequate number of smear examinations, the state has struggled to improve detection rates particularly for smear-negative cases? Pediatric TB poses another challenge. Adherence to treatment has also scope for improvement. The state has been a pioneer introducing a statewide government programme for nutrition supplementation for TB patients.

- What can be the strategies to improve detection of TB (particularly, pediatric and smear negative) when there is already adequate number of referrals of presumptive cases and smear examinations?
- How can the adherence rate of TB patients for anti-tubercular treatment be improved?
- What can be the ideal package for nutrition of TB patients (in terms of daily supplements like calories and proteins etc) in Chhattisgarh? What kind of distribution systems can work better for the delivery of TB nutrition packages?

Leprosy:

In recent years, Chhattisgarh has been able to achieve increased detection of Leprosy cases. Thus while detection and treatment seem to be happening adequately, there are still large number of disabilities observed in Leprosy cases.

- How can the disability prevention among Leprosy patients be improved?
- How the social stigma be reduced?
- How to improve contact-tracing?