Chapter 8

Health

Introduction

This chapter opens with a brief summary of health planning in Himachal Pradesh, and analyses various issues, such as trends in outlays and expenditure during the different five year plans; availability of infrastructure facilities and other health services in Himachal Pradesh; morbidity and treatment pattern; health-seeking behaviour and utilisation patterns of available health care facilities and services including cost of treatment. The last section tries to present a vision of the state of health of the people of Himachal Pradesh and work out some operational strategies to achieve the same.

At the time of the formation of Himachal Pradesh on 15 April 1948, medical and health care facilities were virtually primitive. Since the First Five-Year Plan, the government of Himachal Pradesh has been making continuing efforts to provide medical care of a reasonable standard. During the initial years of planning, it attempted to provide access to health care services to the people by increasing the number of health care institutions and diagnostic facilities. The programme to control venereal diseases, implementation of the national programmes, providing quality education, and training programmes were assigned top priority. Later, measures were taken to strengthen rural health care and reduce the existing regional disparities in this area. The previous three plans had laid emphasis on strengthening the existing infrastructure, dental health care, food and drug laboratory, audit planning and legal cell besides implementation of different national health programmes. The Tenth Plan, for the first time, aims at improving the quality of the health services. In recent years, the state government has focused more on the development of the Indian system of medicines and Homoeopathy (ISM&H), particularly *Ayurveda*, involving members of the Panchayati Raj Institutions (PRIs), and ensuring greater community participation through hospital welfare societies, etc. However, providing tertiary health care services in the form of super specialised hospitals, both in the public and private sectors, establishing a strong health management information system (HMIS), proper referral linkages, management of lifestyle diseases, and involvement of the voluntary sector in different health programmes are some areas which are still lagging behind in the state.

Resource Allocation and Expenditure

There has been a massive increase in the outlay and expenditure on medical and public health services since the First Five-Year Plan (Table 8.1). At present, this sector comprises Allopathic, *Ayurveda* or other systems of medicine, medical education, dental department and Director, Medical Education and Research (DMER). Table 8.1 shows that during the First Five-Year Plan, the outlay and expenditure on social services was 3.1 times and 3.4 times as that on medical and public health. In the Ninth Plan, the proportions became 6.6 times and 5.6 times for outlay and expenditure respectively. This implies that even though the outlay and expenditure on medical and public health sector has risen in absolute terms, it has not kept pace with the rise in expenditure on social services as a whole.

Table 8.2 and Figure 8.1 shows that the percentage share of medical and public health (MPH) to the total outlay and total expenditure has fluctuated during various five year and annual plans. It has declined sharply from the Third Plan and fluctuated between two and four per cent of the total allocations up to the Seventh Plan. After the Eighth Plan, the share has started increasing but has remained less than the

TABLE 8.1

Plan-wise Outlay and Expenditure on Medical and Public Health, Social Services in Himachal Pradesh

(in Rs. lakh)

Name of the Plan	*Medical and Public Health*		*Social Services*[1]		*Total Plan*	
	Outlay	*Expenditure*	*Outlay*	*Expenditure*	*Outlay*	*Expenditure*
First Plan (1951-56)	35.96	30.86	112.66	104.85	564.40	527.25
Second Plan (1956-61)	79.65	81.78	341.05	308.36	1472.53	1602.60
Third Plan (1961-66)	171.00	116.23	632.00	716.27	2793.00	3384.47
Annual Plans						
1966-67	30.44	18.38	144.98	112.22	900.00	946.05
1967-68	55.00	24.91	219.24	157.33	1572.00	1443.94
1968-69	50.00	33.70	209.00	190.12	1550.00	1595.19
Fourth Plan (1969-74)	415.00	338.15	1692.00	2042.49	10140.00	11342.97
Fifth Plan (1974-78)**	750.00	414.24	4335.00	2709.78	23895.00	16714.10
Annual plans						
1978-79	190.47	189.76	1460.96	1477.09	7329.11	6810.17
1979-80	219.50	168.04	1297.00	1654.91	7877.00	7877.00
Sixth Plan (1980-85)	1608.00	2338.68	10750.00	15854.29	62217.00	66471.00
Seventh Plan (1985-90)	3721.00	4346.86	28162.75	30099.36	117800.00	132474.75
Annual plans						
1990-91	1265.00	1473.14	11265.00	11729.69	36000.00	37762.93
1991-92	1550.00	1962.00	11718.00	12546.00	41000.00	40482.00
Eighth Plan (1992-1997)	12100.00	16280.00	74815.00	121310.00	250200.00	349905.00
Ninth Plan (1997-2002)	31765.00	51885.12*	210644.00	293966.34*	570000.00	712117.67*
Tenth Plan (2002-07)	78772.28	N.A.	488248.04	N.A.	1252057.50	N.A.

Source: Five Year Plans and *Statistical Abstract of Himachal Pradesh* (different issues).

Notes: '*' includes anticipated expenditure for FY 2001-02.

'**' Plan was implemented only up to March 1978. As a result, expenditure figures are up to March 1978 only.

allocations made during the initial Five Year Plans. On the other hand, a review of expenditure patterns during the plans indicate that the expenditure on MPH was less than the allocations up to the Sixth Plan and started increasing thereafter. Less than five per cent of the total expenditure was incurred on MPH services during the Eighth Plan, while the estimates for the Ninth Plan projects this to be nearly seven per cent. From this, it can be inferred that health in Himachal Pradesh started getting priority after the Seventh Plan. One of the reasons for increased expenditure and allocations after the Seventh Plan is the increased expenditure on the Indian system of medicines and Homoeopathy (ISM&H), after a separate department of ISM&H was created in November 1984. There has been a steady increase in the budget outlay of the Department of ISM&H. The total budget outlay has increased to Rs. 5,348 lakh during 2002-03, which is 17.1 times of the outlay in 1983-84, when the department was not working as an independent entity. The Tenth Five Year Plan proposes a total outlay of Rs. 78,772.28 lakh for Health and Family Welfare. The distribution of this outlay among different departments is 21.3 per cent for *Ayurveda*, 60 per cent for Allopathy, 17.8 per cent for medical education, 0.6 per cent for dental department and 0.15 per cent for DMER.

However, a comparison of expenditure on MPH with the overall expenditure on social services during the different five-year and annual plans reveals an entirely different picture. Whereas the percentage expenditure on MPH remained around five per cent or less during the different plans, on social services other than MPH it rose rapidly during these plans, clearly indicating that medical and public health was accorded a lower priority among the social services (Table 8.2 and Figure 8.2). Figure 8.2 shows that up to the Eighth Plan, the percentage expenditure on MPH mostly remained less than five, on social services other than MPH it rose to 30 per cent of the total plan performance.

Health Services in Himachal Pradesh

It is well known that Himachal Pradesh, like most other states, has made significant progress in bringing

1. The 10th FYP classification of social services include education, sports, arts and culture; health and family welfare; water supply, sanitation, housing and urban development; information and publicity; welfare of SCs, STs and OBCs; labour and labour welfare; and social welfare and nutrition.

TABLE 8.2

Total Percentage Share in Outlay and Expenditure on MPH, Social Services including MPH and Social Services Excluding MPH

Name of the Plan	*Medical and Public Health*		*Social Services including MPH*		*Social Services excluding MPH*	
	Outlay	*Expenditure*	*Outlay*	*Expenditure*	*Outlay*	*Expenditure*
First Plan (1951-56)	6.37	5.85	19.96	19.89	13.59	14.03
Second Plan (1956-61)	5.41	5.10	23.16	19.24	17.75	14.14
Third Plan (1961-66)	6.12	3.43	22.63	21.16	16.51	17.73
Annual Plans						
1966-67	3.38	1.94	16.11	11.86	12.73	9.92
1967-68	3.50	1.73	13.95	10.90	10.45	9.17
1968-69	3.23	2.11	13.48	11.92	10.26	9.81
Fourth Plan (1969-74)	4.09	2.98	16.69	18.01	12.59	15.03
Fifth Plan (1974-78)**	3.14	2.48	18.14	16.21	15.00	13.73
Annual Plans						
1978-79	2.60	2.79	19.93	21.69	17.33	18.90
1979-80	2.79	2.13	16.47	21.01	13.68	18.88
Sixth Plan (1980-85)	2.58	3.52	17.28	23.85	14.69	20.33
Seventh Plan (1985-90)	3.16	3.28	23.91	22.72	20.75	19.44
Annual Plans						
1990-91	3.51	3.90	31.29	31.06	27.78	27.16
1991-92	3.78	4.85	28.58	30.99	24.80	26.14
Eighth Plan (1992-1997)	4.84	4.65	29.90	34.67	25.07	30.02
Ninth Plan (1997-2002)	5.57	7.29*	36.96	41.28	31.38	33.99
Tenth Plan (2002-2007)	6.29	N.A.	39.00	N.A.	32.70	N.A.

Source: Five Year Plans and *Statistical Abstract of Himachal Pradesh* (different issues).

Notes: * includes anticipated expenditure for FY 2001-02.

** Plan was implemented only up to March 1978. Therefore, the expenditure figures are up to March 1978 only.

FIGURE 8.1

Outlay and Expenditure during Five Year and Annual Plans (as per cent of total), (1951-56 to 2002-07)

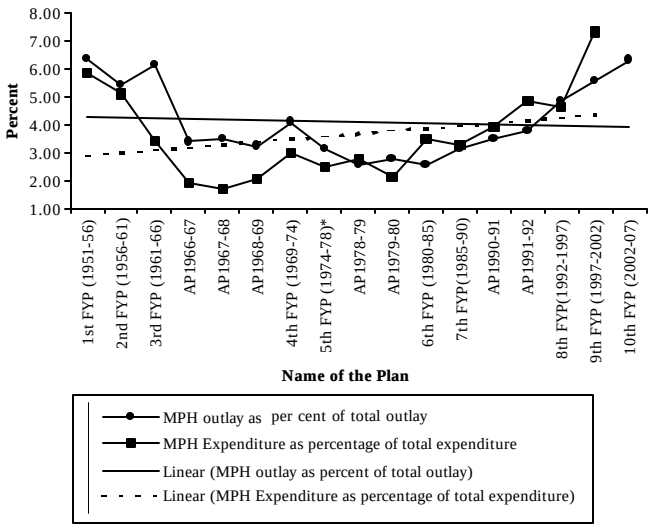
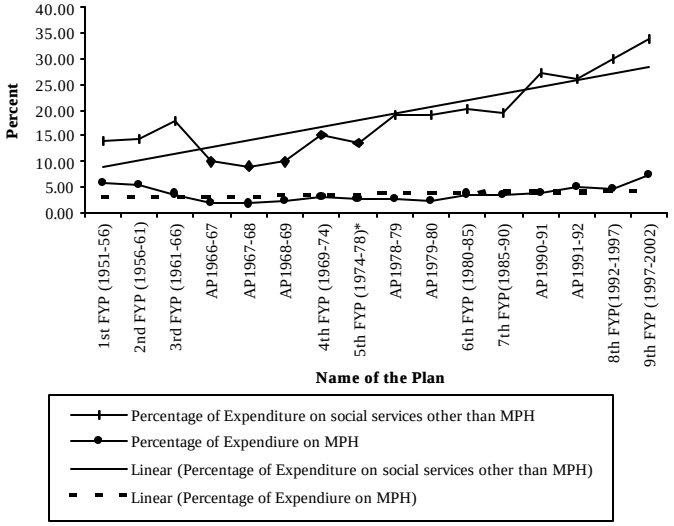


FIGURE 8.2

Variations in Expenditure on MPH and Social Services other than MPH during Different Plans (1951-56 to 1997-2002)



down the crude death rate (CDR), infant mortality rate (IMR), and in raising the standard of living and expectancy of life at birth. This is also true of the control of different communicable and non-communicable diseases, such as diphtheria, poliomyelitis, tetanus (both neonatal and others), whooping cough, measles, leprosy, malaria, goitre, blindness, etc. Although the state has made remarkable

achievements in controlling the spread of venereal diseases through family health awareness campaigns, tuberculosis remains the major killer in the state.

In Himachal Pradesh, health services (preventive, promotive and curative) are provided through the Department of Health and Family Welfare and the Department of Indian System of Medicines and Homoeopathy (ISM&H). Since primary health care is the first and the nearest contact between the individual and the health care services, the state has made good provision for primary health care services through a network of sub-centres (SC), primary health centres (PHCs) and community health centres (CHCs). To support the primary health care services, provision has been made for secondary-level health care facilities through sub-divisional and zonal/district hospitals. Further, tertiary-level health care has been catered for through specialised hospitals and those attached to the state medical colleges. These institutions, besides extending support to the secondary-level health care systems, are expected to carry out research and manpower development for the health services of the state.

Health services under the Allopathic System of Medicines

The state has a number of medical, public health and Ayurvedic institutions (Table 8.3). The table shows that the state also has a number of specialised institutions for treating tuberculosis, leprosy, and sexually transmitted diseases (STDs). Besides these, there are adequate facilities of dental clinics, X-ray clinics, ENT clinics, and maternal and child welfare (MCW) centres. Further, the state receives World Bank assistance to the Reproductive and Child Health (RCH) sub-project in Kinnaur district, UNICEF assistance for Kangra and Chamba districts and World Bank assistance for prevention of gastrointestinal diseases and AIDS. The rural population covered is 2,738 per sub-centre, 12,832 per PHC and 85,745 per CHC against the stipulated norms of 3,000 per sub-centre, 20,000 per primary health centre and 80,000 per community health centre in the hilly and tribal areas[2]. For the tribal areas, comprising Kinnaur, Lahaul and Spiti, Pangi and Bharmour, there are three hospitals, nine CHCs, 36 PHCs, 100 SCs, 84 ayurvedic dispensaries, and two state special hospitals. There are 422 allopathic and 58 ayurvedic beds in the region.

As on 31 March 2003, the total number of beds available under the modern system of medicine is 8,872. Of these, 5,558 beds are in general hospitals, 1,202 in CHCs, and 966 in PHC grade-2 and 124 in PHC grade-1. In addition, 35 beds are reserved for cancer, 751 for tuberculosis, 232 for leprosy, four for sexually transmitted diseases.

Health Services under the Indian Systems of Medicines and Homeopathy

In recent years, the state has been attaching greater importance to institutions related to the Indian system of Medicines and Homoeopathy (ISM&H). A separate department of ISM&H was created on 7 November, 1984. As on 31 March, 2003, there were 724 beds under the ISM&H. There has been tremendous increase in the number of institutions and the amount of budget for Indian systems of medicines and homeopathy since then. Ever since its inception as a separate department, there has been an independent minister in-charge of the Department and senior I.A.S./H.A.S. officers have held the charge of Director. The department has a large network of primary and secondary level institutions. The basic primary unit is Ayurvedic Health Centre (AHC). It covers a population of 3000 to 5000 and caters to outdoor patients only. This centre also functions as a referring unit in case of any emergency after providing first aid treatment. Normally, medicines worth Rs. 15,000 to 20,000 are provided free of cost every year to each AHC. In addition, there are 22 district level/sub-divisional ayurvedic hospitals providing secondary services in the state besides two tertiary level hospitals (one each in Shimla and Kangra). They are providing indoor as well as outdoor services. Normally, these hospitals cover a population of 15,000 to 20,000. Medicines worth Rs. 1.25 lakh for 10-bedded hospitals and Rs. 250 lakh for 80/100-bedded hospitals are being provided free of cost every year. The department also started a Nature Cure Unit at Oel in Una district. It intends to upgrade the existing nature cure hospital to 10-50 bedded hospital besides establishing College of Naturopathy and Yoga to provide five and half year degree in Naturopathy and Yoga.

To conserve and enlarge the valuable herbal wealth of the state and to provide a sustainable supply of raw material to the pharmaceutical industry, the state has launched a programme for promotion and conservation of the herbal wealth by setting up herbal gardens in the different agro-climatic zones. Herbal gardens have already been established in Jogindernagar (district Mandi), Neri (District Hamirpur), Dhumrehra (Rohru,

2. Department of Health and Family Welfare, Government of Himachal Pradesh, *Health at a Glance (2002)*, pamphlet

TABLE 8.3

Number of Health Institutions as on 31.3.2003

S. No.	*Type of Hospital*	*Rural*	*Urban*	*Total*	*Remarks/Observations*
1.	General hospitals (GHs)	17	33	50	No GH in rural areas in Bilaspur, Kullu district
2.	Community health centres (CHCs)	56	10	66	No primary health care facilities to be set up in urban areas. The institutions shown in urban were earlier in rural areas
3.	Primary health centres (PHCs)	437	4	441	
4.	Civil dispensaries (CDs)	3	18	21	Available in rural areas of Solan, Sirmaur and Kangra district. No urban CD in Chamba, Hamirpur, Kullu, Mandi and Una district. **Maximum 8 Urban CDs in Shimla district**
5.	Sub-centres	2067	-	2067	
	Tuberculosis Institutions				
1.	Hospitals	2	0	2	One in Kangra and another in Solan
2.	District TB clinics/centres	2	10	12	
3.	TB sub-clinics	4	3	7	Two each in rural areas of Chamba and Kinnaur. All three urban Sub-Clinics in Shimla
	Leprosy Institutions				
1.	Hospitals/wards	4	2	6	Chamba, Kangra, Kullu and Solan in rural areas. Mandi and Sirmaur in urban areas
2.	District nucleus	2	10	12	One at each district
3.	State survey assessment units (SSAU)	-	1	1	At Shimla
4.	Leprosy training centers	2	4	6	Rural areas of Solan and Kangra district. Urban areas of Shimla, Sirmaur, Kullu and Chamba district
	STD Institutions				
1.	Clinics/sub-clinics	11	15	26	No STD clinic in rural areas of Bilaspur, Hamirpur, Kangra, Kullu and Una district
2.	Units	34	11	45	No STD unit in rural areas of Hamirpur, Kangra and Una districts. No STD unit in urban areas of Chamba, Hamirpur, Kangra, Solan and Una district
	Indian System of Medicines and Homoeopathy (ISM&H)				
1.	Ayurvedic college	1	0	1	Kangra district
2.	Ayurvedic hospitals	10	13	23	No rural ayurvedic hospital in Mandi, Shimla, Sirmaur and Solan districts. No urban ayurvedic hospital in Kullu district
3.	Ayurvedic dispensaries	1092	20	1112	No urban ayurvedic dispensary in Chamba, Hamirpur, Sirmaur and Una districts
4.	Unani dispensaries	2	1	3	Available only in Kangra, Shimla and Solan districts
5.	Homoeopathic dispensaries	4	10	14	Available at all district headquarters and two in rural areas of Bilaspur and Chamba districts
6.	Nature cure unit	1	0	1	Una district
7.	Ayurvedic pharmacy	1	1	2	Available in rural areas of Sirmaur and urban areas of Mandi district
8.	Ayurvedic research institute	0	1	1	Available in Mandi district
9	Panchkarma centres	1	1	2	One at Paprola in Kangra district, and another in Bilaspur district (urban)
10.	Amchi clinics	4	0	4	Two in each district (Kinnaur and Lahaul and Spiti)
	Other Clinics and Centres				
1.	Dental clinics	67	41	108	Maximum 20 in Kangra followed by 15 in Mandi
2.	X-ray clinics	98	44	142	Maximum 26 in Shimla followed by 20 in Mandi
3.	Eye-ENT clinics	0	11	11	None in rural areas
4.	Maternal and child welfare (M&CW) centres	19	27	46	None in rural areas of Hamirpur, Kullu and Una district. None in urban areas of Hamirpur district

Source: Information provided by the Department of Health and Family Welfare and the Department of ISM&H, Government of Himachal Pradesh.

Note: There is no urban area in Kinnaur and Lahaul and Spiti districts.

All SHCs were converted into PHCs in the year 1986-87.

district Shimla), and Jungal-Jhalera (district Bilaspur). In addition, proposals are to set up herbal gardens at Rakcham/Chitkul (district Kinnaur) and Paprola (district Kangra). Besides a Herbarium has been established at Jogindernagar to keep the specimens of medicinal plants systematically and scientifically. Separate counters are maintained for Root drugs, Bark drugs, Flower drugs, Fruit/Seed drugs, Leaf drugs and Whole plant drugs, etc. During the year 2002-03, the department also organised 33 farmers training camps and three department exhibitions in different districts to create awareness among the farmers/participants with respect to identification, conservation, propagation, cultivation and utilisation of the medicinal flora existing in the State of Himachal Pradesh. A total of 960 farmers were trained/participated. Tenth Plan (2002-07) proposes to strengthen the health care facilities of the ayurvedic system by strengthening the infrastructure and introducing specialised services like *Panchkaram* and *Kshar Sutra*. The Plan also lays stress on the conservation, development, cultivation and utilisation of medicinal plants to improve the quality of raw herbs, material for herbal medicines, and to develop Himachal Pradesh into a herbal state of India. It also recognises the need for modern facilities for drug testing, research, and development of drugs. It contemplates the introduction of modern technology and management techniques to improve the quality and competitiveness of medicines produced in government and private pharmacies of the state. The Plan also proposes to expand the Ayurveda tourism activities in close collaboration with public and private sector hotel industry/health institutions in all parts of the state. Two such centres (one in Joginder Nagar and another at Kullu) has already been started.

Regarding the homoeopathic systems of medicines, the state opened 12 homoeopathic dispensaries (one at each district headquarters) in 1995-96. During the Tenth Five Year Plan, provisions have been made for opening 10 more homoeopathic centres (two each year). There are only three Unani dispensaries in the State functioning since very long. No new unani institution was opened after bifurcation of the department since the department feels absence of public demand for this system of medicine from other parts of the state.

Himachal Health Vision 2020 lists some problems related to the infrastructure. Some of these are uneven distribution of primary health care facilities (400 *panchayats* are still without primary health care facilities, whereas a number of them have two primary health care institutions including ayurvedic health centres) and uneven distribution of health manpower (better staffing in comfortable areas than those in rural and remote areas). Further, the lack of well-defined service norms and standards (absence of hospital manual), poor referral system resulting in under-utilisation of health services and overburdening of the secondary and tertiary health care centres too make a negative contribution. Buildings are poorly maintained and there is absence of residential accommodation. Information, education and communication (IEC) and health management information system (HMIS) are lacking in many respects and are still at a rudimentary stage.[3]

Training Facilities

Adequate training facilities exist for different categories of staff in the state through various training centres and schools. For imparting in-service training to medical officers and para-medical staff, there are two health and family welfare training centres, one at Shimla and the other at Kangra. Further, there are five general nursing training schools with a total capacity of 230 per batch, seven female health workers' training schools with a total capacity of 420 per batch, and six male health workers training schools with a total capacity of 360 per batch. Moreover, Indira Gandhi Medical College, Shimla, and the Zonal Office at Dharamshala also train operation theatre assistants (20), lab technicians (75), radiographers (20) and para medical ophthalmic assistants (20). Training in these hospitals is given only when there is a need to fill departmental vacancies. In addition, there are six leprosy training centres in the state (Table 8.3).

For the ISM&H Department, there are two training institutions, Ayurvedic College at Paprola (Kangra) with an yearly intake of 50, for Bachelor of Ayurvedic Medicines and Surgery (BAMS), and an intake of 14 for M.S./M.D. (Ayurveda) course, and a pharmacy training school at Jogindernagar, which provides a two-year course for ayurvedic pharmacists to meet the needs of the department.

Private Sector, NGOs and Voluntary Health Institutions

The private sector is growing fast in the state with private clinics, nursing homes, and other diagnostic centres. However, with a total bed capacity of approximately 500, the private sector has grown mainly

3. Department of Health and Family Welfare, Himachal Pradesh, *Himachal Health Vision 2020*, p. 21-23.

at Shimla and other district towns.[4] NGOs and other voluntary sectors have not been providing curative services in the state so far. However, one free hospital is being set up in Hamirpur district by a charitable organisation.[5] It seems that NGOs/voluntary sector institutions are not inclined to venture into difficult and far-flung areas of the state, which need their services the most.

Availability of Staff

An examination of the staff position of the Department of Health and Family Welfare (as on 31 March 2003) shows that 21 per cent of its sanctioned 16,743 posts, are vacant. The major vacancies among the medical staff include doctors (9%), nursing superintendents (55%), staff nurses (28%), public health nurses (30%), ANMs designated as staff nurse (21%), female health workers (18%), dais (35%), pharmacists (13%), male health workers (28%), health supervisors (20%), health educators (28%) and computors (25%).[6] Vacancies among the support staff include drivers (14%), class IV servants (22%), sweepers (15%), and cleaners (77%). Besides, vacancies exist in such administrative posts as District Family Welfare Officer (NM), senior assistants, steno-typists, projectionists, housekeepers, etc.

The Department of ISM&H has a total staff strength of 6,359 as on 31.6.2003. They include *ayurveda* medical officers (18%), ayurvedic pharmacists (18%), ANMs (3%), trained *dais* (14%), junior assistants (2%), and Class IV (regular or otherwise) (39%). The department of homoeopathy and Unani system has less staff. For example, there are only 14 homoeopathic doctors and three unani medical officers who constitute an insignificant proportion of the staff strength of the Department of ISM&H. Regarding the vacancies, 26% of total sanctioned posts are vacant in the Department as on 31.6.2003. The major vacancies include teaching staff including professors, readers, lecturers (41%), senior *ayurvedic chikitsak* (56%), *ayurvedic* medical officers (13%), *ayurvedic* pharmacists (46%), staff nurses (33%), ANMs (17%), dais (39%), laboratory technicians (53%), and class IV staff including drivers (19%).

4. *Ibid,* p. 5

5. *Ibid,* p. 21-22.

6. The total sanctioned positions of medical staff include doctors (1498), nursing superintendents (9), staff nurses (1540), public health nurses (30), ANMs designated as staff nurse (258), female health workers (2210), dais (467), pharmacist (854), male health workers (2005), health supervisors (413), health educators (81) and computors (101). The total positions of support staff include drivers (363), class IV servants (2247), sweepers (915), and cleaners (30).

Recent Reforms in Health Sector

Re-classification of Health Institutions

Recently, the government of Himachal Pradesh re-classified the existing health institutions in the rural areas, and rationalised them as under:

TABLE 8.4

Re-classification of Institutions

Sr. No.	*Existing Institutions*	*New Classifications*
1.	Civil dispensaries (except urban) and all PHCs with no facility for indoor treatment	PHC-I
2.	All PHCs with 6 beds and above	PHC-II
3.	All CHCs having only 10 beds in Indoor patients	CHC-I
4.	All CHCs having 11-30 beds	CHC-II

Source: Vide notification No. Health-A-B(1)/5/98-II dated, Shimla-2, the 24th November 2001 by Government of Himachal Pradesh, Department of Health and Family Welfare.

It was further notified that all CDs and PHCs would have the same kind of staff. All PHC-II and CHC-I shall have the same kind of staff. The circular also fixed the staff norms for these institutions, which are as under:

TABLE 8.5

Staff Norms for Health Institutions

Post	*PHC-I*	*PHC-II*	*CHC-I*	*CHC-II*
Medical Officer	1	2	2	4
Ward Sister	-	-	-	1
Staff Nurse	-	1	1	4
Senior Lab Technician	-	-	-	1
Laboratory Technician	-	1	1	-
Radiographer	-	-	-	1
Ophthalmic Assistance	-	-	-	1
O.T. Assistant	-	-	-	1
Pharmacist	1	1	1	2
Clerk	-	1	1	1
Driver	-	1	1	1
Class-IV*	1	1	1	5
Sweeper*	1	1	1	3
Total	**4**	**9**	**9**	**25**

Source: Vide notification No. Health-A-B(1)/5/98-II dated, Shimla-2, the 24th November 2001 by Government of Himachal Pradesh, Department of Health and Family Welfare.

Note: *: It was decided that in future all posts of sweepers/cooks and cleaners would be contractual in nature and on vacation by existing incumbents, these posts will stand abolished and will not be a part of norms for calculating future staff requirements.

Hospital Welfare Societies

Himachal Pradesh is the only state in this region to have started a community financial management

TABLE 8.6

Composition of PARIKAS at Panchayat, Block and District Level

Composition/Level	*Panchayat Level*	*Block Level*	*District Level*
Adhyaksh or Chairman	Pradhan of the gram panchayat	Adhyaksh of panchayat samiti	Chairperson of zila parishad
Sachiv or Secretary	Either male or female health worker	Block Medical Officer	Chief Medical Officer
Sadasya or Members	Ward Panches (not more than four, at least one woman elected Panch); Representatives of NGOs; Social Workers; Opinion Builders: President and Secretary of Mahila Mandal; ayurvedic Chikitsa Adhikari (if an AHC in village); forest guard; One teacher from each of the school in the Panchayat; Anganwadi workers; Trained Traditional Birth Attendants; the other Health Workers. If there are two in the Panchayat shall be the co-opted members.	All the members of the Panchayat Samiti; Representative of the NGOs (if any), Opinion builders, social workers, known active female workers; Ayurvedic Chikitsa Adhikaris; Medical Officer incharge of PHC in the block; Male and Female Health supervisors; Block Primary and Secondary Education Officers; Assistant Engineer (Roads and Buildings); Representative of Social Welfare Department looking after the block.	All members of Zila Parishad; Active Female workers of the District; District Primary/ Secondary Officer; Executive Engineer (B& R); representatives of NGOs (if any); Social Workers; Representative of Deputy Commissioner to be nominated by DC; District Panchayat Officer, District Social Welfare Officer

Source: Vide notification no. HFW-B (F) 7-2/2001 dated 10.12.2001 of Department of Medical Education, Department of Health and Family Welfare, Government of Himachal Pradesh and orders of Commissioner-cum-Secretary (Health) to the Government of Himachal Pradesh.

programme. It has set up hospital welfare societies at zonal/district hospitals to collect user charges and utilise these for fulfilling the needs of these hospitals. Earlier these societies were known as *Rogi Kalyan Samitis* (patient welfare committees). These committees were autonomous in nature and were capable of improving the hospitals by collecting finances from the community and levying user charges. By 2001-2002, these were set up in all the 12 zonal/district hospitals and 21 sub-divisional hospitals. Since these committees were fixing user charges for diagnostic and other services differently in different parts of the state, there was resentment among the population. As a result, the state government recently changed the name of these committees to Hospital Welfare Societies and rationalised the user charges. Now uniform user charges (as prevailing before 1998) would be applicable throughout the state in all hospitals for diagnostic and other services.

c. Involvement of Panchayati Raj Institutions (PRIs)

Himachal Pradesh has set up health and family welfare advisory committees known as Parivar Kalyan Salahkar Samiti (PARIKAS) at the *panchayat*, block and district levels[7] for the involvement of the PRIs. The functions of the *panchayat* PARIKAS include supervision and monitoring; implementation of national health programmes; ensuring cleanliness of the villages; checking pollution of water, air and noise; making people aware of dog and snake bites and their first aid treatment; cleaning and using bleaching powder, etc., for traditional water sources; disseminating information about reproductive and child health (RCH) care; checking regular opening of sub-centres and ensuring that immunisation and other necessary facilities are being provided to the newborn by the health functionaries; helping in updating the records of births, deaths and marriages; and preparing health micro plans every year. The functions of the block and district PARIKAS are to provide effective leadership and able guidance; hold periodic inspection of health institutions through sub-committees (with each sub-committee having an elected representative and a medical officer nominated by PARIKAS); appropriate counselling, whenever required; and disseminating information, education and communication (IEC). It is also envisaged that the PARIKAS at the three levels will be broad based and shall function as interdepartmental co-ordination committees. The composition of the PARIKAS at the *panchayat* level will be as under:

Morbidity Patterns in Himachal Pradesh

Himachal Pradesh has a generally healthy population. The NSS 52nd round gives information on morbidity patterns in the state. It indicates that the state has a high morbidity rate compared to India and the neighbouring states of Haryana and Punjab (Table 8.7). The table further indicates that morbidity is high in the rural areas of Himachal Pradesh compared to Haryana and Punjab, and the all-India position. This is because Himachal is primarily a rural state. Morbidity is

7. Vide Notification No. HFW-B (F) 7-2/2001 dated 10.12.2001 of Department of Medical Education, Department of Health and Family Welfare, Government of Himachal Pradesh and orders of Commissioner-cum-Secretary (Health) to the Government of Himachal Pradesh.

TABLE 8.7

Number of Persons Reporting Ailments during the Last 15 Days Prior to Survey per 1000 Persons by Age and Sex (Type of Ailments: Any)

Characteristics	*Rural Areas*				*Urban Areas*			
	H.P.	*Punjab*	*Haryana*	*India*	*H.P.*	*Punjab*	*Haryana*	*India*
Males								
0-14	57	76	64	50	53	85	38	54
15-39	60	54	36	35	63	75	46	35
40-59	94	66	60	64	88	77	56	61
60 and above	295	171	139	178	241	194	101	148
All	84	71	57	54	71	84	47	51
Females								
0-14	45	50	47	45	41	64	47	49
15-39	79	69	51	45	46	72	66	45
40-59	136	126	123	75	80	120	117	73
60 and above	305	181	136	161	244	242	260	166
All	96	81	65	57	59	86	80	58

Source: 'NSS, 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments*, NSSO, Department of Statistics, Government of India, November 1998.

particularly high among elderly persons (aged 60 and above) in both the sexes. This may be due to the higher life expectancy in the state.

Table 8.8 compares prevalence of acute[8] and chronic[9] illnesses in respect of age, sex, caste, and residential status. In Himachal Pradesh, there is a higher prevalence of acute and chronic illnesses in rural as well as urban areas. Although chronic diseases among males appear usually after the age of 60 years (169 in rural areas and 90 in urban areas), the prevalence of such illnesses is also on the higher side among young males (age 40-59) in urban areas. Females show a similar trend except that chronic illness among the rural women starts at an early age compared to urban women. The prevalence level of acute illness has a direct relationship with increase in age. Higher the age, higher the prevalence of acute illness. In all, long duration illnesses are less prevalent than short duration illnesses at most ages, but for 60 plus. No substantial caste differentials in morbidity have been noticed.

Since mostly the elderly (Table 8.8) suffer from chronic or long duration illnesses, an attempt has been made to understand the types of diseases involved. Table 8.9 shows that major chronic illnesses suffered by rural elderly persons include problems of joints, cough, high/low BP while the major illnesses among the urban elderly persons include high/low BP and problem of joints. The table further reveals that urinary problems are more prevalent among males than females in both rural and urban areas. The incidence of high/low BP and heart diseases is much higher in urban areas. Prevalence of piles is relatively higher among males in the urban areas. Diabetes is more prevalent in urban areas.

Disease Prevalence (Based on Inpatient and Outpatient Records)

The Department of Health and Family Welfare maintains and compiles records of all inpatients and outpatients in the state. Examination of data for five years (1997-2001) surprisingly reveals that the department did not classify 67-70 per cent of outdoor patients, and 77-82 per cent of the indoor patients by the type of diseases they suffered from and simply marked them under other diseases. Among the classified diseases, acute respiratory infections (ARIs)

8. Acute or short duration ailments include diarrhoea and gastroenteritis dysentery (including cholera); tetanus; diphtheria; whooping cough; meningitis and viral encephalitis; fever of short duration; chicken pox; measles/German measles; mumps; disease of eye; acute disease of ear; heart failure; cerebral stroke; cough and acute bronchitis; acute respiratory infection (including pneumonia); diseases of mouth, teeth and gum; injury due to accident and violence; other diagnosed ailments (up to 30 days); and undiagnosed ailments (up to 30 days).

9. Chronic or long duration ailments include chronic amebiosis; pulmonary tuberculosis; STDs; leprosy; jaundice; guinea worm; filaria (elephantiasis); cancer; other tumours; (general debility) anaemia; goitre and thyroid disorders; diabetes; beri beri; ricket; other malnutrition diseases; mental and behavioural disorders; epilepsy; other diseases of nerves; cataract; other visual disabilities; other diseases of the eye; hearing disability; other diseases of the ear; diseases of the heart; high/low blood pressure; piles; speech disability; diseases of mouth, teeth and gum; gastritis hyper-acidity/gastric/peptic/duodenal ulcer; diseases of kidney/urinary system; prostrate disorders; pain in joints; other disorders of bones and joints; locomotor disability; other congenital deformities (excluding disability); other diagnosed diseases (more than 30 days); and undiagnosed ailments (more than 30 days). It is pertinent to mention here that chronic illnesses are long duration illnesses involving very slow change. It does not imply anything about the severity of the disease.

TABLE 8.8

Acute and Chronic Ailments Classified by Age, Sex, Caste, and Residential Status (per 1000 persons)

	Rural Areas				*Urban Areas*			
	H.P.		*All India*		*H.P.*		*All India*	
	Acute	*Chronic*	*Acute*	*Chronic*	*Acute*	*Chronic*	*Acute*	*Chronic*
Males classified by age								
0-14	52	4	46	3	49	4	51	3
15-39	49	12	27	8	49	14	28	7
40-59	80	14	42	22	67	31	36	24
60+	153	169	95	86	163	90	65	85
All	64	23	41	13	56	17	39	13
Females classified by age								
0-14	38	7	43	3	41	-	47	3
15-39	57	23	36	9	41	5	37	9
40-59	94	47	48	27	65	16	42	31
60+	132	186	90	73	104	140	73	94
All	63	35	44	14	48	11	43	15
Males classified by caste								
Scheduled Castes	75	13	41	12	50	6	39	10
Scheduled Tribes	19	10	37	5	-	-	35	7
Others	61	28	42	14	58	20	39	13
Females classified by caste								
Scheduled Castes	79	49	43	12	27	-	45	12
Scheduled Tribes	49	16	38	5	-	-	37	10
Others	56	29	45	16	52	13	43	16

Source: 'NSS, 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments*, NSSO, Department of Statistics, Government of India, November 1998.

including influenza but excluding pneumonia accounted for 21 per cent to 24 per cent of the outdoor patients during 1997-2001, followed by acute diarrhoreal diseases including gastroenteritis and cholera (7%). Pneumonia, pulmonary tuberculosis and enteric fever patients together constituted about one per cent of the outdoor patients. Very few patients were suffering from whooping cough and syphilis. The state reported almost complete absence of diphtheria, whooping cough, acute poliomyelitis, tetanus (neonatal or otherwise), Japanese encephalitis, meningococcal meningitis and rabies. On the other hand, classification of the records of indoor patients shows that ARIs accounted for seven to ten per cent of the indoor patients, followed by acute diarrhoreal diseases including gastroenteritis and cholera (5 to 7%). Pneumonia, enteric fever and pulmonary tuberculosis together accounted for about five per cent of the indoor patients in different hospitals. Among the indoor patients, the major causes of death were pulmonary tuberculosis, pneumonia, ARIs, and acute diarrhoreal diseases.

The Directorate of Health and Family Welfare, Government of Himachal Pradesh, entrusted a special study to the Department of Community Medicine, Post Graduate Institute of Medical Education and Research (PGIMER), Chandigarh, to assess the burden of disease in Himachal Pradesh. The findings of the draft estimation report are shown in Table 8.10. It shows the top ten causes of the burden of diseases (DALYs) in Himachal Pradesh classified by age and sex. According to it, the disease pattern vary with age and sex in

TABLE 8.9

Number of Elderly Population Reporting Chronic Diseases per 100,000 Aged Persons by Type of Chronic Disease Suffered, Sex and Residential Status

Name of Chronic Disease	*Rural Areas*		*Urban Areas*	
	Male	*Female*	*Male*	*Female*
Cough	14449	12139	17330	11814
Piles	1794	2764	5111	1789
Problem of joints	31169	38350	19124	50178
High/Low B.P.	10402	19838	39490	27250
Heart disease	2412	5908	14925	5252
Urinary problems	8186	1475	4820	2199
Diabetics	-	967	3172	2269
Cancer	764	1368	-	-
Any	43896	45882	54592	68914
Sample	391	374	50	46

Source: 'NSS 52nd round, July 1995-June 1996,' *Socio-economic Conditions of Ageing, Sarvekshana*, Vol. XXIII, No. 3, 82nd Issue, January-March 2000, p. S-414-416.

TABLE 8.10

Top 10 Causes of Burden of Diseases (DALYs) in Himachal Pradesh Classified by Age and Sex

Rank	Males					Females				
	0-4	5-14	15-44	45-59	60+	0-4	5-14	15-44	45-59	60+
1	Lower respiratory infections	Iron-deficiency anaemia	Road accidents	Chronic obstructive Pulmonary disease	Chronic obstructive Pulmonary disease	Lower respiratory infections	Iron-deficiency anaemia	Iron-deficiency anaemia	Chronic obstructive Pulmonary disease	Chronic obstructive Pulmonary disease
2	Diarrhoreal diseases	Asthma	Other unintentional injuries	Tuberculosis	Ischaemic heart disease	Diarrhoreal diseases	Diarrhoreal diseases	Other maternal conditions	Other maternal conditions	Asthma
3	Other maternal conditions[10]	Other unintentional injuries	Iron-deficiency Anaemia	Other unintentional injuries	Asthma	Other infectious diseases	Other unintentional injuries	Other unintentional injuries	Iron-deficiency anaemia	Ischaemic heart disease
4	Perinatal conditions	Diarrhoeal diseases	Chronic obstructive Pulmonary disease	Ischaemic heart disease	Tuberculosis	Other maternal conditions	Otitis Media	Maternal haemorrhage	Other unintentional injuries	Other infectious diseases
5	Other	Otitis media infectious diseases	Self-inflicted injury	Iron deficiency anaemia	Other unintentional injuries	Perinatal conditions	Asthma	Chronic obstructive Pulmonary disease	Tuberculosis	Tuberculosis
6	Road accidents	Dental caries	Ischaemic heart disease	Asthma	Other infectious diseases	Birth asphyxia and birth trauma	Dental caries	Asthma	Dental caries	Cataract
7	Iron deficiency anaemia	Lower respiratory infections	Asthma	Dental caries	Iron-deficiency anaemia	Iron deficiency anaemia	Lower respiratory infections	Road accidents	Ischaemic heart disease	Iron-deficiency anaemia
8	Birth asphyxia and birth trauma	Upper respiratory infections	Upper respiratory infections	Road accidents	Diarrhoeal diseases	Measles	Upper respiratory infections	Dental caries	Other cardiac diseases	Diarrhoeal diseases
9	Dental caries	Other infectious diseases	Dental caries	Peptic ulcer	Cataracts	Falls	Falls	Upper respiratory infections	Diarrhoeal diseases	Other unintentional injuries
10.	Falls	Falls	Diarrhoreal diseases	Cataracts	Dental caries	Low birth weight	Other infectious diseases	Abortion	Other infectious diseases	Dental caries

Source: Department of Community Medicine, Post Graduate Institute of Medical Education and Research, (2003) *Himachal Burden of Disease Study Draft Estimation Report 2003*.

Himachal Pradesh. Lower respiratory infections and diarrhoreal diseases are the most frequent causes of the disease burden among children aged 0-4 years irrespective of sex. While iron-deficiency anaemia is the most frequent among the children in the age group of 5-14, diarrhoreal diseases, asthma and other unintentional injuries are also widely prevalent in this age group. Whereas road accidents and other unintentional injuries are most common among males in the age group of 15-44, it is iron-deficiency anaemia and other maternal conditions that account for most of the burden of disease among females in this age group. From the age 45 and above, chronic obstructive pulmonary disease constitute the largest burden of disease among both sexes. Further, tuberculosis, ischaemic heart disease, other unintentional injuries and asthma are widely prevalent among the males aged 45 and above, while other maternal conditions, asthma, iron-deficiency anaemia and ischaemic heart disease are prevalent among the females of the same age group.

Status of Maternal, Child and Reproductive Health

Two recent surveys, namely, National Family Health Survey (NFHS-II, 1998-99) and Multiple Indicator Survey (MICS 2000), collected information on the status of maternal and child health (comprising antenatal, natal and postnatal care), management of reproductive track infections and nutritional deficiencies

10. Includes maternal sepsis, maternal haemorrhage, hypertensive disorders of pregnancy and abortions.

in the state. A few findings where immediate intervention is required are listed below:

Deficiencies: Anaemia[11] is widely prevalent among women (41%) and children (70%) in Himachal Pradesh with nine per cent of women and 41 per cent of children being severely anaemic[12]. 41 per cent of the children are chronically undernourished (stunted), 17 per cent wasted and 44 per cent underweight.[13] In Himachal Pradesh, 68 per cent of the babies (31% in urban areas and 71% in rural areas), born in the three years preceding the survey, were not weighed at birth.[14]

Antenatal care: NFHS-2 points out that 13 per cent women (mostly rural) had no antenatal check-up at the time of first child birth, 6 per cent had only one antenatal checkup and 19 per cent (10% in urban areas and 20% in rural areas) had only two antenatal check-ups, against the Ministry of Health and Family Welfare (MOHFW), Government of India's guidelines of having at least three antenatal care visits for pregnant women. Among those who received at least one antenatal check-up, only 55 per cent received it during the first trimester, 40 per cent during the second trimester and five per cent during the third trimester. Moreover, among them, 67 per cent received antenatal check-up from a medical officer outside their homes and 33 per cent from other health professionals at home or outside. Regarding the administration of tetanus toxoid injection to prevent neonatal deaths, 34 per cent of the women did not receive the two desired doses of TT injections during their recent pregnancy, 23 per cent received only one injection and 11 per cent none. Fourteen per cent of the women did not receive any iron and folic acid tablets or syrup to provide additional nutrient requirements of foetal growth.[15] The *Multiple Indicator Survey* (MICS-2000) also points out that in Himachal Pradesh only 81 per cent of the women (80% in rural areas and 89% in urban areas), who delivered during the year preceeding the survey, received antenatal check-up. The position with regard to TT doses was much worse. For instance, only 54 per cent of the women received two or more doses. Similarly, only 57 per cent women (55% in rural areas and 79% in urban areas) had their blood pressure checked.

Natal care: The place of delivery and assistance during delivery constitute two essential ingredients of natal care. NFHS-2 indicates that most (71%) of the births in the state are home deliveries, and only 29 per cent are institutional deliveries, out of which 80 per cent are in the public sector. Mostly people with a high standard of living visit private institutions for delivery. Women who received more than three antenatal check-ups constitute the major chunk of institutional deliveries (49%). The survey points out that 57 per cent of the births in the three years preceding the survey were attended by traditional birth attendants (TBAs), three per cent by friends, relatives and other persons, and only 40 per cent by a health professional, including 31 per cent by a doctor and nine per cent by an ANM, nurse, midwife or LHV. According to MICS-2000, only 32.5 per cent of the deliveries (30% in rural areas and 61% in urban areas) were institutional deliveries. But, deliveries assisted by a health professional were 44 per cent (41% in rural areas and 71% in urban areas). Some of the reasons for fewer institutional deliveries in Himachal Pradesh are absence of health workers from the place of posting, and poor connectivity (road transport) particularly in rural areas.

Postnatal care: Postnatal care requires a minimum three postpartum visits by the field worker according to the RCH manual. During these visits, abdominal examination, advice on breast-feeding, baby care and family planning is provided. According to NFHS-II, only 21 per cent of the women received a postpartum check-up within two months of childbirth. One of the reasons for less post-natal care is the lesser number of home visits by health workers. NFHS-II indicates that only 3.7 per cent of the women received at least one visit by a health or family planning worker in the 12 months preceding the survey.[16] Further, the proportion of non-institutional births that receive post-partum check-up is very low (4-14%) largely depending upon whether the woman has received the antenatal check-up and the standard of living of the household.[17] During the check-up, abdominal examination was carried out on 50 per cent of the women, and advice on breastfeeding, baby care and family planning was given to 60 per cent, 53 per cent and 27 per cent of the women respectively. According to MICS-2000, only 16 per cent of the women (15% in the rural areas and 30% in the urban areas) received postnatal care.

Immunisation: People in Himachal Pradesh are aware of child immunisation. NFHS-II figures for the state

11. With haemoglobin level < 11.0 grams/decilitre for children and pregnant women, and < 12 grams for non-pregnant women.
12. With haemoglobin level < 10.0 grams/decilitre.
13. Stunting assessed by height-for-age, wasting assessed by weight for height, underweight assessed weight-for-age.
14. *National Family Health Survey-II, Himachal Pradesh,* p. 184.
15. *National Family Health Survey –II, Himachal Pradesh,* p. 176-179.
16. National Family Health Survey-II, (NFHS-II), Himachal Pradesh, p. 198.
17. *Ibid.,* p. 185.

show that 83 per cent of the children aged 12-23 received all vaccinations. The vaccination coverage rates are higher for the boys (87%) than the girls (79%). Literacy of the mother is important for the immunisation drive to be successful since the coverage rates ranged from 67 per cent for illiterate women to more than 90 per cent for women who were educated at least up to middle school level.

Reproductive Health: NFHS-II points out that reproductive health problems are widely prevalent in Himachal Pradesh with 34 per cent of the currently married women reporting some such problem. Among them, 27 per cent related to vaginal discharge, 14 per cent symptoms of urinary track infection, nine per cent complained of painful intercourse and one per cent reported bleeding after intercourse. These reproductive health problems are indicative of some serious reproductive track infection (RTI). The worrisome factor is that 47 per cent of these women have not sought advice or treatment for these infections.

HIV/AIDS: HIV/AIDS emerged in the state only in the early 90s, when the first AIDS case was detected in 1992. During the period March 2000-March 2003, the number of HIV-positive persons have increased from 201 to 531, and the number of AIDS patients from 72 to 143[18]. By 2001, HIV/AIDS cases were reported from every district except the tribal district of Lahaul and Spiti. HIV-positive cases are concentrated in the five districts of Shimla, Bilaspur, Hamirpur, Mandi and Kangra.[19] Thus, a majority of the HIV/AIDS infections are reported along the national highways, i.e., from Shimla to Kangra and from Anandpur Sahib to Manali. MICS-2000 focuses on awareness about HIV/AIDS. Sixty-four per cent of the women aged 15-49 in Himachal Pradesh (61% in rural areas and 85% in the urban areas) have heard about HIV/AIDS. Awareness about AIDS was higher among the never married women (78%) than among the ever-married women (59%). Given the socio-economic status of the state, and the recent spurt in HIV-positive/AIDS cases, the problem needs thorough investigation. Voluntary counselling and testing facilities should be extended to all zonal/district hospitals with immediate effect.

Health-Seeking Behaviour/ Utilisation of Health Care Services

Health-seeking behaviour or utilisation of health care services is influenced largely by access to health facilities, individual and family beliefs and attitudes related to illness and the system of medicine, cost of treatment and individual capacity to pay. The following section is an attempt to analyse the health-seeking behaviour of the population for preventive and curative health care services during non-hospitalised (outdoor) and hospitalised (indoor) illnesses. An attempt has also been made to find out the influence of socio-economic, and other behavioral factors such as the type of treatment preferred, choice of public/private or voluntary sector and the cost of treatment.

Preventive and Curative Services by Source of Treatment

Table 8.11 gives a picture of the role of the public and the private sectors in providing contraceptives, preventive and curative services in Himachal Pradesh, as pointed out by NFHS-II. The table shows that the public sector plays a crucial role in all spheres of health including preventive, contraceptive, immunisation, and curative services in the state. The public sector caters more to the rural population than to the urban. The table shows that 98 per cent of all children received vaccination from the public sector. Ninety-four per cent of the contraceptive users in rural areas and 68 per cent in urban areas obtain contraceptives from the public medical sector. The survey has revealed that the share of the private health sector in immunisation has a direct relationship with urbanisation, mother's education (at least high school), and households with a

TABLE 8.11

Share of Public and Private Sector in Contraceptive, Preventive, Curative Services

Type of Service	*Share of Public Sector*			*Share of Private Sector Including Shops*		
	Rural	*Urban*	*Total*	*Rural*	*Urban*	*Total*
All modern contraception	94.2	68.4	91.7	4.8	29.3	7.1
Male sterilisation	100.0	(100.0)	100.0	0.0	0.0	0.0
Female sterilisation	99.2	97.8	99.1	0.7	1.8	0.8
IUD	(85.3)	56.0	77.2	(14.7)	44.0	22.8
Oral Pills	(59.3)	*	(53.1)	(37.0)	*	(42.6)
Condoms	36.1	14.8	29.2	48.2	78.3	57.9
Childhood vaccination	98.3	94.9	98.0	1.0	4.6	1.3
Per cent share in institutional delivery	20.6	55.6	23.2	4.8	16.4	5.7
Usual source of health care	58.6	60.5	58.8	41.3	39.5	41.1

Source: *National Family Health Survey (NFHS)-II, Himachal Pradesh,* India 1998-99.

Note: The totals will not add up to 100 due to the presence of other categories such as missing and source unknown.

( ) Based on 25-49 unweighted cases.

* Percentage not shown: based on fewer than 25 unweighted cases.

18. Director, State AIDS Control Society, Himachal Pradesh.

19. Government of Himachal Pradesh (2002), *Himachal Pradesh Human Development Report 2002*, p. 139

high standard of living. As for the curative services, the table shows that 59 per cent of the households in Himachal Pradesh normally visit the public medical sector. In fact, the utilisation of public health services is much higher in Himachal Pradesh than in the country as a whole (29%). Overall, three types of health providers are generally used as a source of treatment by almost all the households. Thirty per cent of the households prefer treatment from private doctors, 55 per cent from the government/municipal hospital, government dispensary, CHC/PHC, and 10 per cent from private hospitals. Moreover, the pattern of service utilisation is almost similar in rural and urban areas. As for institutional deliveries, more people visit public health institutions than private nursing homes (23.2% as against 5.7% of the total deliveries).

Type of Treatment Preferred for Non-hospitalised Illnesses Episodes

Different household sample surveys (NSSO 1986-87 and NCAER 1993) conducted in the state point out that the allopathic treatment remains the most preferred form of treatment among the households. For instance, Table 8.12 (based on the sample survey conducted by NSSO through 42nd round) shows that a large majority of the state's population (93% in rural areas and 97% in urban areas) relies on allopathic medicines for treatment of non-hospitalised illnesses.

Likewise, the household survey of health care utilisation and expenditure (NCAER, 1993) reaffirms that allopathic treatment remains the most preferred form in both rural and urban areas of Himachal Pradesh for non-hospitalised illnesses. Despite the tremendous efforts made by the state government to promote the Indian system of medicines and Homoeopathy, nine out of ten households still prefer treatment by allopathic sources. According to the survey, no household in Himachal Pradesh received treatment from Unani or Homoeopathic sources. Ironically, more households in Haryana preferred treatment from sources other than allopathic (Table 8.13).

TABLE 8.12

Non-hospitalised Illness Episodes by Type of Treatment

System of Medicines	*Rural Areas*				*Urban Areas*			
	H.P.	*Punjab*	*Haryana*	*India*	*H.P.*	*Punjab*	*Haryana*	*India*
Allopathic	93.0	97.8	97.4	95.9	97.4	97.8	98.2	96.3
Homoeopathic	1.9	0.2	0.0	1.8	0.4	0.9	0.7	2.1
Ayurvedic	4.3	1.1	1.9	1.5	0.4	0.6	0.6	1.0
Unani/Hakimi	0.1	0.4	0.4	0.3	1.4	0.4	0.1	0.3
Any combination	0.4	0.1	0.0	0.1	0.0	0.0	0.3	0.1
Others	0.3	0.4	0.3	0.4	0.4	0.2	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: 'NSS 42nd round (July 1986-June 1987), *Morbidity and Utilisation of Medical Services, Sarvekshana, Vol.* XV, No. 4, Issue no. 51, April-June 1992, p. 71-72.

TABLE 8.13

Non-hospitalised Illness Episodes by Type of Treatment

System of Medicines	*Rural Areas*				*Urban Areas*			
	H.P.	*Punjab*	*Haryana*	*India*	*H.P.*	*Punjab*	*Haryana*	*India*
Allopathic	93.5	97.3	86.2	90.9	97.2	94.9	89.9	93.2
Homoeopathic	0.0	1.4	0.0	2.0	0.0	0.7	0.0	2.9
Ayurveda/Siddha	3.1	0.0	8.3	3.8	2.8	2.3	4.1	2.2
Unani	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.1
Any combination	3.4	1.4	5.2	2.0	0.0	2.	6.1	1.2
Rituals	0.0	0.0	0.3	0.6	0.0	0.0	0.0	0.3
Others	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: NCAER, *Household Survey of Health Care Utilisation and Expenditure,* March 1995.

Recent Trends

An examination of indoor and outdoor patients seeking treatment from the two departments (Department of Health and Family Welfare and the Department of ISM&H) indicates that ISM&H enjoys a share of 24 to 30 per cent among the total patients treated during the period 1994-95 to 1999-2000.[20] This state of affairs calls for introspection of the government.

Source of Treatment and Payment Mechanism for Non-hospitalised Illness Episodes

This section describes the findings of some all-India surveys on preferred source of treatment and payment mechanism in Himachal Pradesh. For a non-hospitalised illness episode, NSS 42nd round points out that more people have obtained no-payment treatment or free treatment in both rural and urban areas of Himachal Pradesh than in India (Table 8.14). Payment was made to government or private institutions by 30 per cent of the households in rural areas of Himachal Pradesh as compared to 46 per cent in India, and by 16 per cent households in urban areas of Himachal Pradesh compared to 44 per cent in India. Very few households (4%) in rural and urban areas made payment to private institutions in the state as compared to the rest of India (above 30%). From this, it can be inferred that in Himachal Pradesh very few people are willing to pay for the treatment received. This is different from the attitude in some of the neighbouring states of Punjab and Haryana, where more people are willing to pay for treatment, and also more people obtain health services from the private sector.

Another survey (NCAER 1993) reveals that the distribution of non-hospitalised illness-episodes by the type of treatment is slightly favourable to the private sector for males in rural areas. Otherwise a higher percentage prefer treatment from a public source. Only few females in rural areas of Himachal Pradesh reported receiving treatment from a medical shop or store, which is the usual practice in other parts of India. Moreover, households in Himachal Pradesh do not believe in going to faith healers or religious persons for treatment, according to this survey. Only three per cent of the women preferred home remedies, that too in rural areas.

The 52nd round (1995-96) of NSSO also collected data on the treatment of ailments. Table 8.16 shows that more households preferred treatment (including medicines and tests) from government sources in Himachal Pradesh than in the neighbouring states of Punjab and Haryana, and the rest of India.

TABLE 8.14

Percentage Distribution of Treatments (not as an in-patient) by Payment Category

Payment Category/ Institution	*Rural*		*Urban*	
	H.P.	*All-India*	*H.P.*	*All-India*
Payment category				
No payment	65.78	49.14	49.19	42.26
Under employer's medical welfare scheme	4.49	5.21	15.63	13.74
Per cent reportedly made payment to institutions				
Government institutions	25.91	12.42	31.62	12.65
Private institutions	3.82	33.23	3.56	31.35
All (Government and Private)	29.73	45.65	16.25	44.00
Total	100.0	100.0	100.0	100.0

Source: 'NSS 42nd round (July 1986-June 1987)', *Morbidity and Utilisation of Medical Services, Sarvekshana*, Vol. XV, No. 4, Issue no. 51, April-June 1992, p. 71-72.

TABLE 8.15

Percent Distribution of Non-hospitalised Illness Episodes by Type of Treatment

Type of Facility	*Rural Areas*				*Urban Areas*			
	H.P.		*India*		*H.P.*		*India*	
	Male	*Female*	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
Public facility	43.6	56.5	40.2	43.3	60.8	63.6	34.7	33.2
Private facility	56.4	40.0	54.5	50.8	39.2	36.5	58.9	60.9
Medical shop	0.0	0.8	2.6	3.7	0.0	0.0	5.5	5.0
Faith/healer/ religious person	0.0	0.0	0.7	0.3	0.0	0.0	0.3	0.2
Home remedies	0.0	2.7	2.0	2.0	0.0	0.0	0.7	0.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Source: NCAER, *Household Survey of Health Care Utilisation and Expenditure*, March 1995.

20. Government of Himachal Pradesh (1999), *Statistical Abstract of Himachal Pradesh.*

TABLE 8.16

Percentage of Ailments Receiving Non-hospitalised Treatment from Government Sources Classified by Type of Service

Type of Treatment	*H.P.*		*Punjab*		*Haryana*		*India*	
	Rural	*Urban*	*Rural*	*Urban*	*Rural*	*Urban*	*Rural*	*Urban*
Medicine	38.7	48.1	7.0	7.2	13.4	17.3	25.2	17.4
X-Ray, ECG, Scan etc.	33.2	(*)	6.7	26.8	(*)	22.5	18.5	24.7
Other diagnostic tests	10.1	(*)	6.3	10.8	51.5	23.1	20.2	21.1
Surgery	(*)	(-)	(*)	(*)	(-)	(*)	14.8	18.3
Other treatment	(*)	(-)	18.3	(*)	(*)	40.7	27.6	22.1

Source: 'NSS, 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments*, NSSO, Department of Statistics, Government of India, Report No. 441, November 1998.

Note: (-) indicates no sampled household.

(*) indicates the results were ignored since the sample size was too small (n = <20).

Table 8.17 illustrates the distribution of non-hospitalised cases by the type of treatment and type of medical service (medicines, X-ray, ECG, other diagnostic test, surgery and other treatment). It reveals that even though people utilised paid medical services in the private sector, yet the percentage of people visiting the private sector is much less in Himachal Pradesh than in the whole of India. 38 per cent of the rural population and 48 per cent of the urban population in Himachal Pradesh continue to visit the public sector services for medicines. The sample size is very small to arrive at conclusions with respect to other services comprising X-ray, ECG, diagnostic tests, surgery and other treatment.

TABLE 8.17

Per Thousand Distribution of Non-hospitalised Cases (not treated as in-patients of hospitals) During Last 15 Days by Type of Ward of Government and Other Hospital

Type of Medical Service	*Government*				*Other*				*No. of Cases Treated*
	Free	*Partly Free*	*Paying*	*All*	*Free*	*Partly Free*	*Paying*	*All*	
Medicines									
H.P. (rural)	42	56	289	387	3	6	606	615	757
India (rural)	60	26	96	182	17	6	796	819	15949
H.P. (urban)	32	23	426	481	36	-	483	519	109
India (urban)	73	20	81	174	20	7	799	826	11472
X-ray, ECG, Scan etc.									
H.P. (rural)	57	78	197	332	57	-	612	669	21
India (rural)	48	9	128	185	39	6	770	815	654
H.P. (urban)	312	-	623	935	-	28	36	64	8
India (urban)	137	11	99	247	42	11	699	752	777
Other diagnostic tests									
H.P. (rural)	32	13	56	101	278	-	621	899	20
India (rural)	129	7	66	202	56	38	705	799	1606
H.P. (urban)	362	-	354	716	-	-	284	284	11
India (urban)	138	7	66	211	55	4	731	790	1704
Surgery									
H.P. (rural)	180	-	-	180	12	-	808	820	9
India (rural)	75	1	72	148	77	3	772	852	225
H.P. (urban)	-	-	-	-	-	-	-	-	0
India (urban)	128	4	51	181	126	6	685	817	211
Other treatments									
H.P. (rural)	45	-	-	45	214	-	742	956	9
India (rural)	165	9	102	276	64	26	635	725	1237
H.P. (urban)	-	-	-	-	-	-	-	-	0
India (urban)	136	11	74	221	72	14	694	780	1041

Source: 'NSS, 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments*, NSSO, Department of Statistics, Government of India, November 1998.

TABLE 8.18

Per Thousand Distribution of Hospitalised Cases During Last 365 Days Classified by Type of Ward of Government and Other Hospitals and Residential Status of the Household

Area	*Government*				*Other*				*No. of Cases Treated*
	Free	*Paying General*	*Paying Special*	*All*	*Free*	*Paying General*	*Paying Special*	*All*	
H.P. (rural)	772	79	14	865	18	56	40	115	393
Punjab (rural)	235	135	7	377	33	529	17	579	542
India (rural)	388	41	8	438	28	411	91	529	14029
H.P. (urban)	705	175	33	913	5	23	53	80	107
Punjab (urban)	159	102	5	265	28	608	61	696	504
India (urban)	347	55	16	419	35	372	146	553	12497

Source: 'NSS, 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments*, NSSO, Department of Statistics, Government of India, November 1998.

Source of Treatment and Payment Mechanism for Hospitalised Illness Episodes

Table 8.18 shows the division of hospitalised cases by the type of treatment and payment category. It is evident that Himachal Pradesh is one state where more people (86% in rural areas and 91% in urban areas) visit a public sector facility for indoor treatment. The respective figures for the neighbouring state of Punjab and all-India are 38 per cent and 44 per cent for rural areas and 26 per cent and 42 per cent for urban areas respectively.

Cost of Treatment

It is well established that the cost of treatment is an important factor in the choice of health care. The following section is an attempt to highlight the differences in the cost of treatment considering the type of illness (non-hospitalised or hospitalised), system of treatment (modern or Indian) and the socio-economic characteristics of the households.

For Non-hospitalised Illness Episodes

NSSO 42nd round (1986-87) points out that the cost of treatment of non-hospitalised illnesses is much less in the private sector than in the public sector in the rural areas of Himachal Pradesh, Punjab and all-India and the urban areas of Punjab and India. Similarly, the cost of treatment and average duration of the illness is much higher in Himachal Pradesh than in Punjab and India (Table 8.19). Outdoor treatment being cheaper and the average duration being higher in the private sector than in the public sector in the rural areas of Himachal Pradesh, one is inclined to conclude that the private sector in these areas is not sufficiently qualified and therefore competing with the public sector by providing services at a lower cost. Elsewhere, for example, in Punjab the private sector is competing with the public sector to provide services on a par.

TABLE 8.19

Average Total Expenditure/Duration of Sickness Per Illness Episode by Source of Treatment

Expenditure/Duration	*Rural Areas*			*Urban Areas*		
	H.P.	*Punjab*	*India*	*H.P.*	*Punjab*	*India*
Average Total Expenditure (in rupees)						
Government	162.89	99.09	114.75	116.25	92.90	103.39
Private	113.80	83.05	84.93	132.37	76.61	91.30
Average Duration of Sickness (in days)						
Government	15.0	11.9	13.2	15.0	11.8	13.3
Private	16.4	10.1	12.2	14.2	9.3	11.5

Source: 'NSS 42nd Round (July 1986-June 1987)', *Morbidity and Utilisation of Medical Services*, July 1986-June 1987

NCAER (1990) has pointed out that the cost of medical treatment in Himachal Pradesh is much higher for homoeopathic treatment (Rs. 247 per episode in rural areas and Rs. 175 in urban areas), and a little higher for ayurvedic treatment (Rs. 69 per episode in the rural areas) than for allopathic treatment (Rs. 68 per episode in the rural areas and Rs. 45 in urban areas). The all-India picture shows a reverse trend with higher medical cost for allopathic treatment. In case of Himachal Pradesh, the cost of treatment is much lower than in Punjab and at the all-India level. The cost of treatment usually has a direct relationship with the distance covered by the patient from home to the health facility. Approximately 75 per cent of the total cost in the rural areas and 80 per cent of the total cost in the

urban areas goes into fees and medicines (NCAER 1990 & 1993). NCAER (1993) further reveals that the average expenditure per non-hospitalised illness episode is less for female adults compared to male adults, and female children compared to male children in the rural areas of Himachal Pradesh. On the other hand, in urban Himachal Pradesh, the expenditure per illness episode for female adults is twice as much as for male adults. For children in the urban areas, the trend is similar to the rural areas. The cost of treatment is slightly higher in a private facility in the urban areas and in a public facility in the rural areas. The survey has also pointed out that transportation is a major factor in the high cost of medical treatment.

Table 8.20 shows the average total medical expenditure required for treatment of one non-hospitalised illness episode according to NSS 52nd round. The table shows that the treatment cost per illness episode, particularly in the rural areas of Himachal Pradesh, is definitely less than the cost of treatment in Punjab, Haryana and the rest of India. The table also shows that the cost of treatment per episode of non-hospitalised illness is higher for females than for males in Himachal Pradesh, irrespective of their residential status. The treatment is expensive for the Scheduled Castes than the non-Scheduled Castes. Contrary to the findings of the previous surveys, the table shows that treatment is less expensive in Himachal Pradesh compared to all-India and neighbouring states of Haryana and Punjab.

For Hospitalised Illness Episodes

Table 8.21 indicates that the share of the private sector among hospitalized cases in both rural and urban areas of Himachal Pradesh is much less than in India (9% as against 32% in the rural areas and 19% as against 30% in the urban areas). 88 per cent and 81 per cent of the hospitalised cases in Himachal Pradesh are treated by the government sector. Charitable institutions, nursing homes and other non-specified institutions provide treatment to a very small section of the population. Fewer people are willing to pay for the treatment of hospitalised illness episodes in Himachal Pradesh than in India. Even among those who are willing to pay, fewer households prefer to pay special rates. A large majority of the population (98% in the rural areas and 99% in the urban areas) receive allopathic treatment for hospitalised illnesses. This points to the need for further strengthening the awareness of people about alternative systems of medical treatment, namely, ISM&H.

TABLE 8.20

Average Total Medical Expenditure (for treatment) Per Ailment (not treated as inpatient of hospital) During Last 15 Days Classified by Age, Sex, Caste and Residential Status

(in Rupees)

Sex/Caste	*H.P.*		*Punjab*		*Haryana*		*All India*	
	Rural	*Urban*	*Rural*	*Urban*	*Rural*	*Urban*	*Rural*	*Urban*
Males	**79**	**139**	**160**	**143**	**189**	**487**	**151**	**187**
0-14	51	63	93	112	117	483	97	146
15-39	142	163	143	140	194	676	196	203
40-59	92	138	312	172	424	189	180	220
60+	51	202	189	206	168	355	163	198
Females	**112**	**148**	**187**	**169**	**177**	**345**	**137**	**164**
0-14	62	124	151	94	122	119	101	113
15-39	124	270	221	220	296	332	170	193
40-59	188	117	178	162	153	523	166	187
60+	55	34	339	168	78	367	101	153
Persons	**97**	**143**	**173**	**155**	**183**	**402**	**144**	**175**
0-14	56	83	114	105	119	303	99	131
15-39	131	207	186	176	251	480	181	198
40-59	154	132	226	167	247	403	173	203
60+	53	99	179	185	123	364	133	174
Castes								
Scheduled Castes	96	176	160	138	160	107	117	137
Scheduled Tribes	85	-	12	198	-	-	68	108
Others	83	127	165	151	171	437	138	166

Source: 'NSS 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments*, Department of Statistics, NSSO, Government of India, November 1998.

TABLE 8.21

Percentage Distribution of Hospitalised Cases by Type of Hospital, Type of Ward for Himachal Pradesh, All-India

Characteristics	*Rural*		*Urban*	
	H.P.	*All-India*	*H.P.*	*All-India*
Type of Hospital				
Public hospital	80.09	55.40	77.13	59.51
PHC	7.84	4.34	3.85	0.75
Private hospital	8.89	31.99	19.02	29.55
Charitable institutions run by public trusts	—	1.71	—	1.91
Nursing home	1.20	4.86	—	7.04
Others	1.98	1.70	—	1.24
Type of Ward				
Free	83.56	60.71	76.76	55.22
Paying general	10.40	32.46	13.09	31.79
Paying special	3.06	6.83	10.15	12.99
System of Medicine				
Allopathic	97.70	98.50	99.32	98.52
Homoeopathic	0.43	0.30	—	0.25
Ayurvedic	0.77	0.51	0.68	0.42
Unani/Hakimi	0.09	0.22	—	0.28
Any combination of these	—	0.11	—	0.10
Others	1.01	0.36	—	0.43
Payment Category				
No payment	45.80	23.16	16.85	19.61
Employer's medical welfare scheme	10.62	6.18	18.48	12.95
Reporting payment to institutions	43.58	70.66	64.66	67.44
Total	**100.0**	**100.0**		**100.0**

Source: 'NSS 42nd round (July 1986-June 1987)', *Morbidity and Utilisation of Medical Services, Sarvekshana,* Vol. XV, No. 4, Issue no. 51, April-June 1992, p. 53-58.

Table 8.22 indicates that more hospitalised illness episodes occurred in H.P. (12 per thousand in rural areas and 22 per thousand in urban areas) than in the rest of India (seven per thousand in the rural areas and nine per thousand in urban areas). In fact, according to this survey, the urban areas of Himachal Pradesh have reported the largest number of hospitalised illness episodes per thousand population among all other states and union territories in India (Table 8.21). While all rural hospitalised illness episodes were treated in a public facility, only 70 per cent of the urban illness episodes were so treated. Distance covered for seeking hospitalised treatment is much longer in the rural areas of Himachal Pradesh than in most of the neighbouring states and the rest of India.

According to the above survey, the average expenditure on hospitalised illness episode is higher in Himachal Pradesh than in Punjab and at all-India in public sector in both the rural and urban areas. The hospitalisation expenditure in private facility in urban areas is higher than Punjab, but lower than in Haryana and all-India level (Table 8.23). The cost of treatment in the private facility in urban areas is higher by 3.7 times in Himachal Pradesh as compared to 3.6, 4.1 and 5.1 times in Punjab, Haryana and all-India levels respectively compared to public facility.

NSSO 52nd round survey points out that the cost of treatment per episode of hospitalised illness in government hospitals is much higher in Punjab than in the rest of India. In Himachal Pradesh, the cost of private sector treatment is substantially higher in urban

TABLE 8.22

Per cent Distribution of Hospitalised Illness Episodes by Type of Treatment

Number of Cases, Type of Treatment and Distance	*Rural Areas*				*Urban Areas*			
	H.P.	*Punjab*	*Haryana*	*All-India*	*H.P.*	*Punjab*	*Haryana*	*All-India*
Reported Number of Hospitalised Cases by Sex (per '000 persons)								
Male	14.3	22.2	9.5	8.4	31.6	12.4	9.5	10.9
Female	9.8	5.7	2.1	5.5	11.5	16.6	10.5	8.4
Total	12.2	14.2	6.3	7.1	22.1	14.3	10.0	9.7
Distribution of Hospitalised Cases by Type of Treatment								
Public facility	100.0	95.3	73.5	62.0	69.7	68.7	65.9	60.1
Private facility	0.0	4.7	26.5	38.0	30.3	31.3	34.1	39.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Average Distance Travelled for Seeking In-patients (in kilometers)								
Public sector facility	35.0	9.0	15.2	18.6	3.3	3.5	2.7	5.7
Private sector facility	0.0	15.0	22.2	18.7	5.6	5.4	2.2	6.2
All	35.0	9.3	17.1	18.7	4.0	4.1	2.5	5.9

Source: NCAER, *Household Survey of Health Care Utilisation and Expenditure,* March 1995.

TABLE 8.23

Average Cost of Treatment Per Illness Episode for Hospitalised Illness Classified by Ownership of Service Provider

Type of Treatment	*Rural Areas*				*Urban Areas*			
	H.P.	*Punjab*	*Haryana*	*All India*	*H.P.*	*Punjab*	*Haryana*	*All India*
Public	659.01	434.21	690.31	535.20	460.64	372.81	579.34	452.55
Private	—	762.50	2257.55	1877.21	1730.38	1357.31	2392.14	2318.84
Total	**659.01**	**449.62**	**1105.86**	**1044.49**	**845.10**	**696.03**	**1197.70**	**1196.87**

Source: NCAER, *Household Survey of Health Care Utilisation and Expenditure,* March 1995.

areas. As a result, more people prefer to visit government hospitals in Himachal Pradesh. (Table 8.24)

Vision and Strategies for the Future

Himachal Pradesh provides health services of a reasonable standard in the public sector, with an adequate choice of allopathic and ayurvedic treatment. The vision of the state of health in Himachal Pradesh for the immediate future includes the provision of primary, secondary and tertiary health care services, both in the public and private sectors on par with the neighbouring states of Punjab and Haryana. Such a vision looks forward to a picture of a generally healthy population, free from communicable and non-communicable diseases, and a client-friendly manpower in the health and family welfare centres. Besides the continuation of the usual preventive health care measures, the state must ensure the availability of quality health care services (including secondary and tertiary health care services) to everyone. The health care system of the future should be more scientific and technologically advanced. Better health care services in the future are envisaged, with the introduction of selected health sector reforms, such as integration of the public and private sectors, framing of rules to regulate the private sector, introduction of sustainable approaches towards treatment and cure of communicable diseases, particularly HIV/AIDS, and a viable health insurance policy. We also look forward to immediate state interventions, such as setting up special clinics for the vulnerable sections (children, adolescents, women, and the elderly), and also bringing about an attitudinal and behavioural change in the removal of existing socio-cultural practices, particularly related to the reproductive health of women. Revitalising the existing health care institutions through reforms in governance (with greater involvement of the Panchayati Raj Institutions), and provision of additional funding on a self-sustainable basis (levying of user charges in consultation with the PRIs) would help the state come out of the administrative problems and resource crunch. We also foresee greater inter-sectoral and inter-departmental co-ordination, which would not only ensure effective and optimal utilisation of the existing and future health care programmes, but also result in increased public awareness towards healthy practices. Periodic assessment of health problems and needs of the state is an essential prerequisite for assessing the future requirements. To achieve the above, the following policy interventions are suggested:

1. For efficient and smooth functioning of health institutions, adequate monitoring and supervision

TABLE 8.24

Average Total Expenditure Per Hospitalised Illness Episode During Last 365 Days by Source of Treatment

(in Rupees)

Type of Treatment	*H.P.*		*Punjab*		*Haryana*		*All India*	
	Rural	*Urban*	*Rural*	*Urban*	*Rural*	*Urban*	*Rural*	*Urban*
Government hospitals	2542	2250	3645	5436	2667	8888	2080	2195
Other hospitals	2889	7293	6171	6130	3496	5087	4300	5344
Total	**2530**	**2643**	**4988**	**5712**	**3224**	**6537**	**3202**	**3921**

Source: 'NSS 52nd Round (July 1995-June 1996)', *Morbidity and Treatment of Ailments,* Department of Statistics, NSSO, Government of India, November 1998.

is necessary. The performance of various health indicators would improve to a large extent if there is regular monitoring and supervision. All officials of the Directorate, Chief Medical Officers (CMOs) and Block Medical Officers (BMOs) must make periodic field visits to different health institutions under their jurisdiction. Adequate POL expenses should be provided for regular monitoring and supervision work. Induction training and regular refresher courses are necessary for updating the knowledge of healthcare providers.

2. During the last few annual and five year plans, the government of Himachal Pradesh has advocated rapid expansion of ISM&H. It is time to integrate its functioning with the Department of Health and Family Welfare. To effectively achieve the national goals and objectives of health, both modern and Indian systems of medicine must work as harmonious units rather than in two separate compartments. Though some work has already been started in this direction and the necessary notification has been issued by the state government to implement various national health programmes jointly by the two departments, much needs to be done. Further, inter-departmental co-ordination between the Department of Health and Family Welfare and the Departments of Education, Public Health, Women and Social Welfare, Public Relations, etc., is needed for effective health intervention programmes.

3. The state has a *Health Vision 2020* document. Besides, some policy objectives have been highlighted in the Tenth Plan document. Considering the fact that, with the changing composition of the population, changing life-styles, urbanisation and industrialisation, Himachal Pradesh would have newer morbidity challenges in the future, it should work on a state health policy with a proper time schedule for the different activities. The policy should clearly spell out the future health care requirements of the state in the field of preventive, promotive, curative and rehabilitative health care. Adequate research through primary surveys should be conducted before fixing the goals and advocating policy prescriptions.

4. The primary health care facilities in the rural areas and the existing number of medical institutions in the state are sufficient to meet the needs of the people, but they have to be brought to a higher level of efficient functioning. Shortcomings, such as inadequate para-medical staff, buildings and equipment, must be overcome. The inconsistency in the distribution of primary health care facilities and health manpower (more staffing in comfortable areas than in the rural and remote areas) must be rectified immediately. The buildings of health institutions have to be maintained properly with adequate residential accommodation for the staff. Separate wings have to be established in each hospital in the urban areas for proper implementation of primary health care such as updating of records, undertaking survey work, etc. Further, implementation of service norms and standards (through hospital manual), and a proper referral system would contribute to reducing the burden of the secondary and tertiary health care services. The same applies to institutions under the ISM&H wherein all institutions require restructuring for delivering proper health care services and very often these institutions are lacking in proper infrastructure/ amenities. Sufficient funds are required to provide specialised treatments at these Centres.

5. Special emphasis needs to be given to preventive measures, such as vaccination against communicable diseases and identification of high-risk pregnancies to detect deformities and disabilities. Special clinics should also be established in each district to deal with problems related to infertility, reproductive health, and menopause.

6. Focused attention needs to be given to curative aspects of health care, particularly in a hilly state like Himachal Pradesh where the share of the private sector in the number of illness episodes treated is almost negligible. Strengthening the existing public health services and widening their network through the involvement of private practitioners, voluntary non-government organisations and research institutions will improve the health care services in the state.

7. It is important that professional medical bodies and the government of Himachal Pradesh evolve rules and regulations and develop appropriate strategies to regulate the private sector. It is important to have directives on the manufacture, sale and prescription of pharmaceutical drugs on the one hand, and medical and clinical practices,

including licence to practice, basic code of conduct, negligence and consumer complaints on the other. The rating of private clinics, nursing homes and hospitals based on physical facilities, manpower, equipment and technology will be useful.

8. Rising medical costs raises the question of available financing options. Hospitalised treatment in both the public and private sectors is very expensive and leads to loss of lifetime's savings, leaving no money for future social security. It is suggested that the state government should work out the modalities for a viable health insurance policy to meet the rising health costs in both public and private sectors. It is also an essential ingredient of social security measures.

9. Urbanisation brings with it mental stresses and strains. Efficient strategies need to be evolved to combat such stresses leading to accidents and other eventualities. More trauma wards need to be established to handle such cases.

10. In tune with the objectives of NHP-2002, convergence of all national programmes of health, such as malaria, tuberculosis, HIV/AIDS, RCH and universal immunisation programme, under the management of autonomous bodies for overall implementation, is desirable. Effective implementation by such bodies would not only reduce the incidence of communicable and non-communicable diseases in the state but also reduce the burden of the state government, enabling it to plan and implement alternative strategies for health care.

11. Special strategies need to be planned for HIV positive cases in the state. The present voluntary counselling and testing centres (VCTC) for HIV/ AIDS testing in Indira Gandhi Medical College, Shimla, is grossly inadequate. Such testing facilities should be made available at all zonal/ district hospitals.

12. Although the Panchayati Raj Institutions have been involved through the formation of health and family welfare advisory committees known as PARIKAS at the *panchayat*, block and district levels, yet effective decentralisation of powers, according to the 73rd Amendment of the Constitution is still to take place. Its implementation will help PRIs to identify their area-specific priorities, develop programmes and mobilise resources. Sensitisation and training of the elected PRI representatives on different health issues is important.

13. Introduction of telemedicine for appropriate consultation for the treatment of illnesses in the far-flung areas of the state through connectivity with the state headquarters would be useful in reducing people's hardship and the number of patients in specialised health institutions.

14. A number of primary studies should also be undertaken through autonomous research institutions, to assess the health needs of the state.

15. Last but not least, a proper computerised health-management information system should be developed from the block level to provide immediate access to information on health and other indicators. An effective Health Management Information System will help in planning area-specific and need-based policies and programmes in the future.

A few concerns which are outside the domain of this chapter, but constitute an integral part of the healthy growth of the human mind and body are environment and occupational health, adequate availability of drinking water, hygienic living conditions, nutritious food, removal of drug addiction and other health hazards. Excessive use of alcohol is a deterrent to growth. The state has to design the future of the next generation by ensuring minimisation of alcoholism and drug addiction. We visualise the need for extending the scope of interconnectivity and interdependence of the state within the region to ensure a disease-free, and an environmentally clean society.

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