3.1. Progress of Ongoing Schemes and Proposed Interventions

There are several schemes introduced by the Government of Karnataka that address the health concerns specifically to maternal and child health and nutrition. There are alos schemes ongoing funded by the Government of India. Here, specifically the ones managed by the state have been presented.

- **Thayi Bhagya:** This Programme envisages, totally free Maternal & Child Health Care of all categories of Pregnant Women and Mothers in the State, with the core intention of zero Out of Pocket Expenditure to all women for MCH Services. The goals and objectives of this programme are achieved with main focus on equity, and ensuring quality MCH services which are available, accessible and affordable to all sections of the society. In addition to the said services, BPL, SC and ST category Pregnant Women and Mothers are provided incentives in cash and kind to motivate them to avail MCH Services in Government and Private Hospitals, with the sole intention of reducing Maternal & Infant Morbidity and Mortality.

    - **Madilu:** This is one of the four components of Samagra Mathru Aarogya Palane (ThayiBhagya) Scheme, it is being implemented since 2007-08, with 50 % of the budget coming from GoI, through National Health Mission and the remaining 50 % of the budget is being provided by the State Government. In this programme, a kit containing 19 items which are useful to the post-natal women and her infant is being provided to BPL, SC & ST beneficiaries, who deliver in any Government Hospital in the State. This benefit is provided to all deliveries of BPL, SC & ST women in HPD districts and for only two live births in the remaining districts of the State.

    - **Prasooti Araike:** This is one of the four components of Samagra Mathru Aarogya Palane (Thayi Bhagya) Scheme, out of which, the three components, Viz., Prasoothi Araike, Thayi Bhagya and Thayi Bhagya Plus are 100 % Government of Karnataka funded schemes. Prasoothi Araike scheme is being implemented from 2007-08 with the objective of providing cash benefits to BPL, SC and ST communities Pregnant Women, to enable them to take nutritious diet during pregnancy and post-natal period to reduce maternal and infant morbidity and mortality. This scheme is implemented in all the districts of the State, except Kolar and Dharwad. 28 Beneficiaries of this scheme receive cash incentives of Rs.1000 in two instalments, the 1st instalment is provided to the Pregnant Women during her 4-6 months' pregnancy and the 2nd instalment of Rs. 1000 is provided immediately after delivery, if the beneficiary delivers in any Government Hospital in the State. The 2nd instalment will include the JSY cash component. From 2014-15, the cash incentives, for the Pregnant Women and Post-natal mothers has been enhanced for SC & ST beneficiaries to Rs. 2000 each.

- **Extended Thayi Bhagya (Plus):** A cash assistance of Rs. 1000/- for a private hospital delivery is paid to rural SC, ST and BPL women for the first 2 live births in all other districts other than 10 High Priority Districts in accredited private hospitals.

- **Danta Bhagya Yojane:** Danta Bhagya Yojane was rolled out by the Government of Karnataka in 2015 which is first of its kind in India. The program includes delivery of complete dentures to total edentulous patients who are above 60 years of age and fall in the below poverty line. It is a state government programme with a PPP model. It is currently executed through 43 private dental colleges and 2 district hospitals. In 2015-16, 1606 dentures were given and in 2016-17, 3300 dentures were given. In the first quarter of 2017, 1018 dentures are already delivered. There are

suggestions to decrease the age from 60 to 45 years, also to include removable partial dentures, incentive of 750 rupees per complete denture and 300 per removable denture, to establish dental labs in 10 more districts, dental treatment camps at taluka and sub taluka level with a budget of Rs 10,000 per camp and to increase the delivery of 500 dentures per month. Other suggestions included to add dental caries treatment, pit and fissure sealants and oral cancer screening in the *Rashtriya Bala Swasthya* Programme and restorative procedures, endodontic treatment, scaling for people with special abilities. (Basapathy 2017)

Table 35. Beneficiaries of Health Schemes initiated by the state as on 31.03.2017

Sl. No.	Programmes	2013-14	2014-15	2015-16	2016-17*
1	Prasuti Araike	485,795	246,219	45,940	66,587
2	Madilu	323,155	271,815	334,189	339,365
3	Thayi Bhagya	42,471	37,194	17,871	16,225
4	Janani Suraksha Yojane	383,251	411,423	425,711	396,840
5	Extended Thaayi Bhagya	15,081	6,772	1,993	11,739

(Source: Directorate of Health and Family Welfare Services, Annual Report 2016-17)

3.2. Good Practices and Emerging Trends in Health and Nutrition

Across the world, there are many new emerging trends that could be modelled in the state as well. Out of the many, the following few have been mentioned as they can be the way forward for Karnataka to be a pioneer in.

3.2.1. Kaiser Permanente (KP)

It is one of the largest health maintenance organizations in USA, accounting for more than 9.6 million members in eight regions of the country. KP model of integrated care is based on stratification of the population and supply of different type of services according to needs. The Kaiser Permanente Medical Care Program comprises three separate yet interdependent entities: Kaiser Foundation Health Plan (KFHP), Kaiser Foundation Hospitals (KFH), and Permanente Medical Groups. In the KP model, the population receives promotion and prevention services with the aim to control exposure to risk factors. The core components to the KP model put emphasis on prevention, self-management support, disease management and case management for members with multiple conditions. A crucial component that has defined the success of the KP integrated care model is that all entities within the KP group are mutually accountable for a patient's outcomes and positive patient experience and provider incentives are linked to quality of care and patient satisfaction.

The idea is to implement this successful model of integrated healthcare across the state where overall integration happens of all the services ranging from Sub centre to Tertiary care. This can be an incentive based model which can focus mainly on prevention of diseases which has been proven to be more effective. Some of the achievements of the Kaiser Permanente model are reduction in heart disease mortality rate by 26%; increase in blood pressure control from 37 to 77 percent; The prevalence of adult smoking declined from 12.2 percent to 9.2 percent etc.

3.2.2. National Health Services (NHS) Model

The UK has a government-sponsored universal healthcare system called the National Health Service (NHS). The NHS was launched in 1948. It was born out of a long-held ideal that good healthcare should be available to all, regardless of wealth – one of the NHS's core principles. It covers everything, including antenatal screening, routine screenings (such as the NHS Health Check), treatments for long-term conditions, transplants, emergency treatment and end-of-life care. Citizens are entitled to healthcare under this system, but have the option to buy private health insurance as well. The NHS Plan promises more power and information for patients, more hospitals and beds, more doctors and nurses, significantly shorter waiting times for appointments, improved healthcare for older patients, and tougher standards for NHS organizations. The NHS consists of a series of publicly funded healthcare systems in the UK. The NHS was rated as the best system in terms of efficiency, effective care, safe care, co-ordinated care, patient-centred care and cost-related problems. It was also ranked second for equity.

This model can be implemented within the state specifically for PHC where the public and private health providers are combined under one umbrella. This can be implemented at the district level where the health providers can be paid accordingly. Currently, 80% of the patients go to the private providers so we need to integrate them at our PHC level to help improve accessibility and affordability for the people of the state.

3.2.3. Thailand Healthcare Model

Thailand's healthcare system incorporates the private and public sectors. The government regulates health care through a system of capping, which protects its interests while providing a climate for competition. The private sector operates 50% of hospitals which receive US$ 26/year/patient from the government. The government assumes about 100,000 patients for each private hospital. The government and third party providers are developing a range of insurance plans. Private providers offer insurance plans based on public insurance plans. The private providers voluntarily work within government-regulated insurance caps. Private providers are considering delivering of services to non-paying patients to increase revenue. Thailand scores higher than its neighbors in life expectancy and infant mortality. The private sector treats more publicly funded patients than they did in the past which is improving accessibility. Some private hospitals have streamlined their operations by setting up neighborhood clinics for non-hospital-based day services, mobile clinics, an extramural hospital, and home care services.

This is another example of a successful healthcare model which has partly been implemented in the state under SAST. This model can be upscaled across the state as it has been a success in addressing the secondary and tertiary care services fee.

3.2.4. Universal Health Care:

Countries should give a high priority to achieving full population coverage of an affordable package of services, rather than covering selected population groups with more generous packages of services and leaving some people relatively uncovered. UHC can only be achieved through publicly governed, mandatory financing mechanisms (general taxation and social health insurance contributions) that compel wealthier and healthier members of society to subsidize the poor and the vulnerable. Financing systems dominated by private voluntary financing (user fees and private voluntary insurance) will never achieve UHC. The transition towards UHC, in redistributing health benefits and financial burdens, is a highly political process that is likely to face opposition from powerful interest groups. Sustained political commitment from the highest level of government, including the head of state, is therefore essential in implementing successful UHC reforms.