Public Health Care in India

State Institute of Health and Family Welfare, Jaipur
Infrastructure
H R &
Performance
Issues
Health?

State of complete physical mental and social and spiritual well-being and not merely the absence of disease or infirmity.
System?

A set of interrelated and independent parts designed to achieve a set goals.
Health System?

- Traditionally-based on capacity indicators & activities. (e.g. Programs, hospital beds, Physicians & Nurses)
Health System?

Structure & functions of a Country’s MoH having

- Resources,
- Management
- Organization
- Economic support and
- Service delivery as it’s main component
Public Health

• What is public health?

• Why does it matter?

• How is the public health system structured?

• What does the public health system do for people?

• How is it done?
Core functions of Public Health

- Monitoring health situation
- Disease surveillance
- Health promotion
- Regulations
- Partnerships
- Planning & Policies
- HRD
- Reducing impact of emergencies on health
Why study Health Systems

✓ Provides perspective to understand self
✓ Prompts and tutors
✓ Observe & examine strategies for achieving equity under different situations
✓ Draw generalizations
✓ System’s influence on health status
Determinants of Health System

• **Economic**-
  – Affordability?
  – Availability?

• **Political**
  – Priorities
  – Appropriateness?
  – Accessibility
  – Equity

• **Cultural**
  – Acceptability
  – Utilization
  – Participation
National Health Systems

Issues:

• Generalizations of performance & trend
• Political dimensions-Dynamism
• Forces deciding character
• Impact on Health
• Relevance to human rights
Forces asking for a change in System

a. New emerging diseases,
b. Changing disease profile,
c. Technical and diagnostic advances,
d. Longevity of life,
e. Expectations of people,
f. Subsidies and cross-subsidies

Longevity of life,
e. Expectations of people,
f. Subsidies and cross-subsidies

g. Increasing non-plan expenditure,
h. Competing priorities and

i. Improving awareness among people, and
J. Rising Cost of health care delivery
Problems:

• Indirectly related to health
  – Environment
  – Education
  – Empowerment

• Directly affecting Health
  – Diseases
    • Communicable
    • Non Communicable
    • New emerging
  – Fertility
    • Population
    • Growth rate
    • Total Fertility
  – Nutrition
    • Malnutrition
    • Obesity
Problems—Why

- Access
- Availability
- Utilization
Policies:

- NHP-1983……NHP-2002
- NPP-2000
NHP–1983

- Re-orientation of Medical education
- Re-structuring and Re-organizing the then existing health care services
- Population stabilization
- Re-orientation of existing health personnel
- Role of practitioners of ISM in Health care delivery
- Goals -
  - Achievement?
  - CDR & Life expectancy
NHP–2002

• Averages of health indices hide disparities
• large gap in facilities still persists
• shortfall in the number of SCs/PHCs/CHCs is of the order of 16 percent. (CHC-58%)  
• ‘Vertical’ implementation structure - extremely expensive
• the rural health staff has become a vertical structure exclusively for the implementation of family welfare activities
• Low utilization- 20 % seeking OPD services, <45 percent seeking indoor treatment, go to public hospitals.
• Integrated disease control network
• Increase in postgraduate seats in Public Health & Family Medicine
• Decentralization - Role of LSG/ NGO
• Medical Grants commission
• Legislation for regulating clinical establishments/medical institutions by 2003
<table>
<thead>
<tr>
<th>Goals to be achieved by 2000–2015</th>
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<tr>
<td>Eradicate Polio and Yaws</td>
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<td>Establish an integrated system of surveillance, National Health</td>
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Challenges

• Manpower- Number & Norms
• Rural / Urban differential
• Geographical divide across States
• S-E groups –accessibility/ reach
• Gaps between Policy & Action
• Health sector expenditure
• Newer Infections
<table>
<thead>
<tr>
<th>Five year Plan</th>
<th>Period</th>
<th>Major areas addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1951-55</td>
<td>Infrastructure</td>
</tr>
<tr>
<td>II</td>
<td>1956-61</td>
<td>Industry</td>
</tr>
<tr>
<td>III</td>
<td>1961-66</td>
<td>Panchayat &amp; Green Revolution</td>
</tr>
<tr>
<td>IV</td>
<td>1969-74</td>
<td>Expenditure, Agriculture</td>
</tr>
<tr>
<td>V</td>
<td>1974-79</td>
<td>Agriculture</td>
</tr>
<tr>
<td>VI</td>
<td>1980-85</td>
<td>Health, Technology</td>
</tr>
<tr>
<td>VII</td>
<td>1985-89</td>
<td>Poverty, Agriculture &amp; Justice</td>
</tr>
<tr>
<td>VIII</td>
<td>1992-97</td>
<td>Pop., Agriculture, Poverty</td>
</tr>
<tr>
<td>IX</td>
<td>1997-02</td>
<td>Employment, Basic facilities</td>
</tr>
<tr>
<td>X</td>
<td>2002-07</td>
<td>HRD, Industry, Technology</td>
</tr>
<tr>
<td>XI</td>
<td>2007-12</td>
<td>Education, Health, Empowerment</td>
</tr>
</tbody>
</table>
Bhore Committee, 1946

PHCS: nodal points for Health care
Phased expansion
Prevention stressed
Population based
Constitutional commitment: 
Health: State subject

- Central List
  International Health, Port Health Research
  Technical & Scientific Education

- State List
  All other Health issues

- Concurrent list
  Epidemics
- Centralized planning, Decentralized implementation
- Fiscal control of central Govt.
- Dictates States for Objectives & Priorities

Health – State subject?
• NO Health Policy for 36 years
• Health left to Committees and Commissions
• Each Committee addressed to a single specific issue.
• Comprehension was missing
• Majority of recommendations of every committee were reiterations of Bhore Committee.
• Individual “Health” Programs developed in isolation based on situational exigency.
• Uni-purpose workers later baptized as Multi-purpose.
• Some Programs worked in complete isolation till 1980 (e.g. NTCP).
• Fragmented approach to Health
Health Care Infrastructure
Sub Center over FYP

There was no SC till III FYP

Source: CBHI NHP-2010
PHC over FYP

Source: CBHI, NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
There was no SC till IV FYP

Source: CBHI, NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Total Beds (India)

Source: CBHI, NHP-2010
Health Facilities 2011

Source: CBHI, NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Health Facilities 2011

Primary Health Centers
- India: 23458
- Rajasthan: 1517

PHCs owned building
- India: 19706
- Rajasthan: 1473

Sub Centers
- India: 146036
- Rajasthan: 11488

SCs owned building
- India: 78803
- Rajasthan: 9740

Source: CBHI, NHP-2010
Infrastructure Status

Source: DLHS-3

SIHFW: an ISO 9001:2008 certified Institution
Healthcare Delivery Status

Source: DLHS-3
Health Care Infrastructure: Rajasthan (March, 2011)

Source: CBHI,NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Medical Colleges, 2011

- India: 218 (97 Non Recognized, 121 Recognized)
- Rajasthan: 7 (3 Non Recognized, 4 Recognized)

Source: CBHI, NHP-2010
Dental Colleges, 2011

Source: CBHI, NHP-2010

India

- Recognized: 154
- Non Recognized: 136

Rajasthan

- Recognized: 8
- Non Recognized: 5

SIHFW: an ISO 9001:2008 certified Institution
Nursing Schools (India)

Source: Indian Nursing Council
CHCs: IPHS Vs PG seats
March 2008

Source: CBHI
Some Medical Statistics: Rajasthan

<table>
<thead>
<tr>
<th>Population: Medical College</th>
<th>6675000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate Intake</td>
<td>1150</td>
</tr>
<tr>
<td>Post Graduate seats</td>
<td>739</td>
</tr>
<tr>
<td>UG:PG Seats</td>
<td>1.56</td>
</tr>
<tr>
<td>No. of Specialties</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: CBHI
Health Expenditure
Share in health care spending
source: CBHI, NHP–2010

- Private Expenditure: 71%
- External flow: 2%
- Public Expenditure: 27%

SIHFW: an ISO 9001: 2008 certified Institution
Health Expenditure as % of total Plan Outlay
Source: CBHI, NHP, 2010
Who *really* pays?

- Opportunity cost - if we choose to do one thing, the cost of doing that is the value which would have been obtained from the best alternative choice

- Who pays - the person who does not receive treatment
Total Govt. Expenditure on Health as % of GDP
Source: CBHI, NHP, 2010
## Status of Expenditure in FYPs

Source: CBHI, NHP, 2010

<table>
<thead>
<tr>
<th>FYPs</th>
<th>Total Plan Investment</th>
<th>Health</th>
<th>Family Welfare</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1960</td>
<td>65.2</td>
<td>0.1</td>
</tr>
<tr>
<td>II</td>
<td>4672</td>
<td>140.8</td>
<td>2.2</td>
</tr>
<tr>
<td>III</td>
<td>8576</td>
<td>225</td>
<td>24.9</td>
</tr>
<tr>
<td>IV</td>
<td>15778.8</td>
<td>335.5</td>
<td>284.4</td>
</tr>
<tr>
<td>V</td>
<td>39322</td>
<td>682</td>
<td>497.4</td>
</tr>
<tr>
<td>VI</td>
<td>97500</td>
<td>1821</td>
<td>1010</td>
</tr>
<tr>
<td>VII</td>
<td>180000</td>
<td>3392</td>
<td>3256.2</td>
</tr>
<tr>
<td>VIII</td>
<td>798000</td>
<td>7575.9</td>
<td>6500</td>
</tr>
<tr>
<td>IX</td>
<td>859200</td>
<td>10818</td>
<td>15120.2</td>
</tr>
<tr>
<td>X</td>
<td>1484131.3</td>
<td>31020.3</td>
<td>27125</td>
</tr>
<tr>
<td>XI</td>
<td>2156571</td>
<td>136147.0</td>
<td></td>
</tr>
</tbody>
</table>
Total Outlay – Plan and Health (including AYUSH & FW)

Source: CBHI, NHP, 2010
% of **total** budget allocated to health

Source: CBHI, NHP, 2010

SIHFW: an ISO 9001:2008 certified Institution
Budget Rajasthan

<table>
<thead>
<tr>
<th>Five Year plans</th>
<th>Amount in lakhs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>167.21</td>
</tr>
<tr>
<td>2</td>
<td>383.99</td>
</tr>
<tr>
<td>3</td>
<td>664.53</td>
</tr>
<tr>
<td>4</td>
<td>1775.68</td>
</tr>
<tr>
<td>5</td>
<td>3336.79</td>
</tr>
<tr>
<td>6</td>
<td>4939.06</td>
</tr>
<tr>
<td>7</td>
<td>20228.12</td>
</tr>
<tr>
<td>8</td>
<td>62870.95</td>
</tr>
<tr>
<td>9</td>
<td>102230.7</td>
</tr>
<tr>
<td>10</td>
<td>877171.14</td>
</tr>
<tr>
<td>11</td>
<td>147762.07</td>
</tr>
</tbody>
</table>

SIHFW: an ISO 9001:2008 certified Institution
Health Care Spending (2004–05)

- **Per capita expenditure**
  - India: 1377
  - Rajasthan: 808

- **Household**
  - India: 73.570
  - Rajasthan: 73.570

- **Public**
  - India: 22.245
  - Rajasthan: 22.245

- **Other**
  - India: 4.5
  - Rajasthan: 5.5

Source: NCMH, 2005

SIHFW: an ISO 9001:2008 certified Institution
Out of pocket expenditure on Health (2004–05)

Based on NHA-2000-01, extrapolated for 2004-05

SIHFW: an ISO 9001:2008 certified Institution
Health Spending: Facts

• Public Domain
  – Center: Rs. 35 bi (0.13% GDP)
  – State: Rs. 186 bi (0.72% GDP)
  – Local: Rs. 25 bi estimated (0.10% GDP)
  – Social Insurance: Rs. 12 bi (0.05% GDP)

• Private Domain
  – Out-of-pocket: Rs. 1200 bi (4.62% GDP)
  – Insurance (public sector): Rs. 8 bi (0.03% GDP)
  – Pharma Industry: Rs. 250 bi (0.96% GDP)
Human Resource in Health
People are resource
But
To maintain this resource
We need Resources
Doctors (Allopathic in India)

Source: CBHI, NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Nurses (India)

Source: CBHI,NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Average Population Served in Rajasthan; 2010

Source: CBHI, NHP-2010
Manpower Status 2010

Source: CBHI, NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Manpower Status 2010

Source: CBHI

SIHFW: an ISO 9001:2008 certified Institution
Manpower Status 2010

Source: CBHI
Service Provider Status (2008)

Source: DLHS 3
Health system’s performance
### Goals to be achieved by 2000–2015

<table>
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<th>Goal</th>
<th>Year</th>
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<td>2005</td>
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<td>2005</td>
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<td>Eliminate Kalazar</td>
<td>2010</td>
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<td>2015</td>
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</table>
Population and Growth: India
Population Growth–India

Source: Census India, 2011
Crude Birth Rate (India)

Source: SRS 2011
Crude Death Rate (India)

Source: SRS 2011

SIHFW: an ISO 9001: 2008 certified Institution
Infant Mortality Rate (India)

Source: SRS, 2011
Maternal Mortality Ratio (India)

Source: SRS, July 2011
Total Fertility Rate (India)

<table>
<thead>
<tr>
<th>Year</th>
<th>Fertility Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1995</td>
<td>3.4</td>
</tr>
<tr>
<td>1997</td>
<td>3.3</td>
</tr>
<tr>
<td>2000</td>
<td>3.1</td>
</tr>
<tr>
<td>2008</td>
<td>3.4</td>
</tr>
<tr>
<td>2009</td>
<td>2.6</td>
</tr>
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Source: SRS, July 2011
How did Health system evolve
1947
Committees & Commissions
Committees & Commissions

- 1946: Bhore Committee
- 1959-62 Mudaliar committee (Health Survey And Planning Committee): Health services restructuring
- 1963: Chaddah committee: TOR-Malaria
- 1964: Mukherjee committee: Family planning
1964-67: Junglewala committee: Integration of Health Services

1972-73: Kartar Singh committee: MPW scheme

1974-75: Srivastav committee: Medical Education & Support Manpower
1959–62 Mudaliar committee (Health Survey And Planning Committee)

- Consolidate gains
- Strengthen district hospitals
- Regionalization of health services
- PHC for 40000 population
- Integration of medical & health
- Creation of all India health services cadre
1963: Chaddah committee

- TOR-Malaria
- NMEP
  - vigilance & maintenance by health services
  - Monthly home visits
  - 10000 population per worker
- Basic health worker
  - vital statistics &
  - family planning
1964: Mukherjee committee

• TOR-Family planning
• Exclusive family planning staff (uni-purpose worker)
1964–67: Junglewala committee (Integration Of Health Services)

- Unified cadre
- Common seniority
- Recognition of extra qualifications
- Equal pay
- Specialized pay
- No private practice
1972–73: Kartar Singh committee

- Conversion of ANM to MPHW (F)
- Uni-purpose to multi-purpose workers
- One PHC per 50000 population
  - 16 S/C per PHC
  - 3000-3500 population per S/C
  - One supervisor for 4 workers
1974–75: Srivastav committee (Medical Education & Support Man-Power Committee)

- Cadre of community health workers (CHW)
- Medical officer for maternal health at PHC
- Health assistant to be a link between health worker and PHC
Bajaj Committee, 1986

• An "Expert Committee for Health Manpower Planning, Production and Management" was constituted in 1985 under Dr. J.S. Bajaj.

• Recommendations:
  - Formulation of National Medical & Health Education Policy.
  - Formulation of National Health Manpower Policy.
- Establishment of Educational Commission for Health Sciences (ECHS) on the lines of UGC.
- Establishment of Health Science Universities in various states and union territories.
- Establishment of health manpower cells at centre and in the states.
4 Reasons based on 4 lesser known facts
• **Reason 1:**
  – Public doctors in India are among the most absent in the world
  – Absences are never below 30 percent!
• **Reason 2:**
  – When public doctors do show up for work, the exert very little effort
• **Reason 3:**
  – Public doctors in PHCs are not particularly competent to begin with
• **Reason 4:**
  – You still have to bribe public doctors to do their work
One important question...

Why don’t the poor use public health facilities more?
Some facts about Public Health care in India
• Fact #1:
  – Most spending is private; the fraction on genuine public goods is tiny
• Fact #2:
  – The poor use private care as much as the rich
• Fact #3:
  – More public money on health goes to the rich than the poor (because hospital use is regressive)
A summary of why poor people may not be using the PHC system

• The doctors are low on competence
• They don’t show up for work
• When they do show up, they don’t work to the level of their knowledge
• And patients have to pay bribes anyway
Service delivery: 3-tier structure

- Tertiary Care
- Secondary Care
- Primary Care

Underutilized for Services
Supply Funding
3043  CHC  1: 100000 (Plains)
       1:80000 (Hilly/ Tribal)
23500  PHC   1:30000 (Plains)
       1:20000 (Hilly/Tribal)
137407  Sub- Centers  1:5000(Plains)
      1:3000 (Tribal/ Hilly)
640000  HWF-134000
      HWM-73000
1027 million People-2001  Villages-AWW/ SBA/ VHG/ ASHA
The Political Economy Context

- A democratic federal system which is subdivided into 28 States, 7 union territories and 593 districts.
- In most of the states three local levels of government (Panchayati-raj).
- Per capita income US $440.
- 435 million Indians are estimated to live on less than US $1 a day.
• 36% of the total number of the worlds’ poor are in India

• Tax based health finance system with health insurance

• 80% health care expenditure born by patients and their families as out-of-pocket payment (fee for service and drugs)

• Expenditure on health care is second major cause of indebtedness among rural poor
Characteristics of Indian Health System

- Complex mixed health system
  - Publicly financed government health system
  - Fee-levying private health sector
Different Phases of Indian Health System Development

- Pre-independence phase
- Development centred phase
- Comprehensive Primary Health Care phase
- Neoliberal economic and health sector reform phase
- Health systems phase
Main Systems of Medicine

- Western allopathic
- Ayurveda
- Unani
- Siddha
- Homeopathy
Government Health System

Three levels of responsibilities-

First-
- Health is primarily a state responsibility

Second-
- The central government is responsible for developing and monitoring national standards and regulations
- Sponsoring various schemes for implementation by state governments
- Providing health services in union territories

Third-
- both the centre and the states have a joint responsibility for programmes listed under the concurrent list.
Administrative Structure

1. Central Ministries of Health and Family Welfare –
   - Responsible for all health related programmes
   - Regulatory role for private sector
2. State Ministries of Health and Family Welfare
3. District Health Teams headed by Chief Medical and Health Officer
Service Delivery Structure

- Sub Health Centres-
  staffed by a trained female health worker and/or a male health worker for a population of 5000 in the plains and a population of 3000 in hilly and tribal areas.

- Primary Health Centres-
  staffed by a medical officer and other paramedical staff for a population of 30,000 in the plains and a population of 20,000 in hilly, tribal and backward areas. A PHC centre supervises six to eight sub centres.
Service Delivery Structure

- Community health centres- with 30-50 beds and basic specialities covering a population of 80,000 to 120,000. The CHC acts as a referral centre for four to six PHCs.
- District/General hospitals- at district level with multi speciality facilities (City dispensaries)
- Medical colleges, All India institute of Medical Sciences and quasi government institutes (NIHFW and SIHFWs)
Health Financing Mechanisms

- Revenue generation by tax
- Out of pocket payments or direct payments
- Private insurance
- Social insurance
- External Aid supported schemes
Spending on Health

- Annually over 150,000 crores or US$34 billion, which is 6% of GDP (Government spending on health is only 0.9% of GDP)
- Out of this only 15% is publicly financed 4% from social insurance, 1% by private insurance remaining 80% is out of pocket spending (85% of which goes in private sector)
- Only 15% of the population is in organised sector and has some sort of social security the rest is left to the mercy of the market
The Aspects of Neoliberal Economic Reforms Affecting Public Health

• Increasing unregulated privatisation of the health care sector with little accountability to patients
• Cutting down government Health care expenditure
• Systematic deregulation of drug prices resulting in skyrocketing prices of drugs and rising cost of health services
• Selective intervention approach instead comprehensive primary health care
• Measure diseases in terms of cost effectiveness
• Techno centric approach( emphasis on content instead processes)
Contradictions

• India has the largest numbers of medical colleges in the world
• It produces the largest numbers of doctors among developing countries
• It gets “medical Tourists” from developed countries
• This country is fourth largest producer of drugs by volume in the world
But... the current situation....

- Only 43.5% children are fully immunised.
- 79.1% of children from 6 months to 5 years of age are anaemic.
- 56.1% ever married women aged 15-49 are anemic.
- Infant Mortality Rate is 58/1000 live births for the country with a low of 12 for Kerala and a high of 79 for Madhya Pradesh.
- Maternal Mortality Rate is 301 for the country with a low of 110 for Kerala and a high of 517 for UP and Uttaranchal in the 2001-03 period.
- Two thirds of the population lack access to essential drugs.
- 80% health care expenditure born by patients and their families as out-of-pocket payment (fee for service and drugs)
- Health inequalities across states, between urban and rural areas, and across the economic and gender divides have become worse
- Health, far from being accepted as a basic right of the people, is now being shaped into a saleable commodity
Contd....

- poor are being excluded from health services
- Increased indebtedness among poor
  (Expenditure on health care is second major cause of Indebtedness among rural poor)
- Difference across the economic class spectrum and by gender in the untreated illness has significantly increased
- Cutbacks by poor on food and other consumptions resulting increased illnesses and increasing malnutrition
Health Inequities

- The infant mortality Rate in the poorest 20% of the population is 2.5 times higher than that in the richest 20% of the population.
- A child in the ‘Low standard of living’ economic group is almost four times more likely to die in childhood than a child in a better of high standard living group.
- A person from the poorest quintile of the population, despite more health problems, is six times less likely to access hospitalization than a person from richest quintile.
Health Inequities

• A girl is 1.5 times more likely to die before reaching her fifth birthday.
• The ratio of doctors to population in rural areas is almost six times lower than that for urban areas.
• Per person, government spending on public health is seven times lower in rural areas compared to government spending in urban areas.
Pop. Policy Draft 1976
Small pox free-July 5, 1975 & ICDS started
MTP Act(1969) in force-1972
MTP Act-1969
Dept. of Family welfare -1966

NSEP-1962
NMCP to NMEPP-1958
CHEB-1956
BCG Vaccination-1951
NMCP & NFPP-1951
India joins WHO- 1948
ICDS renamed Integrated Mother and Child Development (IMCD) -1995

CSSM-1992

National Blood safety program- 1989
National Aids Control Program -1987

UIP-1985

NLCP-NLEP, 1983

NHP-1983

Alma Ata-Declaration( 1977)-HFA-2000

NFWP-1977
NRHM-2005  
National Health Policy- 2002  
National Pop. Policy- 2000  
RCH-1997  
Family Planning Program made target free -1996  
Beijing conference-1995  
Legislation on Transplantation of human organs enacted 1995  
ICPD-1994
Public Health Care in India

• Well developed administrative system
• Skills
• Reasonable Infrastructure

Something is wrong

• Poor health outcomes
• Design
• Misdirected efforts

1999 Plague epidemic-loss of $ 1 billion (WHO)
“Ten Great Public Health Achievements of the 20th Century”

- Vaccination
- Motor-vehicle safety
- Safer workplaces
- Control of infectious diseases
- Decline in deaths from coronary heart disease and stroke
- Safer and healthier foods
- Healthier mothers and babies
- Family planning
- Fluoridation of drinking water
- Recognition of tobacco use as a health hazard

But we have known this for 64 years

“If it were possible to evaluate the loss, which this country annually suffers through the avoidable waste of valuable human material and the lowering of human efficiency through malnutrition and preventable morbidity, we feel that the results would be so startling that the whole country would be aroused and would not rest until a radical change has been brought about.”
After 64 years of Health Services:

- Crude Death Rate ↓
- Crude birth rate ↓
- Life expectancy ↑
- S.pox & G. worm eradicated
- Leprosy eliminated
- IMR ↓
- Infrastructure – expanded
Health care in India

- Entitlements by policy and not rights
- Focus on preventive and promotive care
- Grossly under-provided facilities
- Poor investments hitherto
- Declining public expenditures and new investments
- Structural Adjustment programming under World Bank dictate
Major Programs

• National AIDS Control Program
• National Cancer Control Program
• National Diarrheal Disease Control Program
• National Filaria Control Program*
• National Family Welfare Program
• National Iodine Deficiency Disorders Control Program
• National Leprosy Eradication Program
• National Malaria Eradication Program*
• National Program for Control of Blindness & Visual Impairment
• National Reproductive and Child Health Program
• National Program for surveillance Program for Communicable diseases
• National Tuberculosis Control Program (Revised)

(* Programs are merged into National Vector Borne Disease Control Program since 2003-04)
Epidemiological Profile
Diarrhea Cases

Source: CBHI, NHP–2010 and MOHFW

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<thead>
<tr>
<th>Year</th>
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SIHFW: an ISO 9001:2008 certified Institution
Diarrhea Deaths

Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Enteric Fever Cases
Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Measles Cases

Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Measles deaths

Source: CBHI, NHP–2010 and MOHFW
Polio

Cases

<table>
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<th>Year</th>
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SIHFW: an ISO 9001:2008 certified Institution
ARI Cases
Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
ARI Deaths

Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Neonatal tetanus Cases
Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Neonatal tetanus Deaths

Source: CBHI, NHP–2010 and MOHFW

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<tr>
<th>Year</th>
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<td>2007</td>
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<td>2010</td>
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Tetanus other than Neonatal cases

Source: CBHI, NHP-2010 and MOHFW
Tetanus other than Neonatal Deaths

Source: CBHI, NHP–2010 and MOHFW
Malaria Cases: India
Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Malaria Deaths: India
Source: CBHI, NHP-2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Dengue Cases: India

Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
Dengue Deaths: India

Source: CBHI, NHP–2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
TB Cases: India

Source: CBHI, NHP-2010 and MOHFW

SIHFW: an ISO 9001:2008 certified Institution
TB Deaths: India
Source: CBHI, NHP-2010 and MOHFW

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Chikungunya Cases : India
Source : NRHM India

SIHFW: an ISO 9001:2008 certified Institution

2001: 22113 cases
2006: 2461 cases
2007: 20000 cases
2008: 6271 cases
2009: 15000 cases
2010: 25000 cases
Kala Azar Cases : India

Source : NRHM India

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<th>Cases</th>
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SIHFW: an ISO 9001:2008 certified Institution
Kala Azar Deaths : India
Source: NRHM India

<table>
<thead>
<tr>
<th>Year</th>
<th>Deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
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<tr>
<td>2007</td>
<td>203</td>
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<tr>
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<td>2009</td>
<td>71</td>
</tr>
<tr>
<td>2010</td>
<td>65</td>
</tr>
</tbody>
</table>

SIHFW: an ISO 9001:2008 certified Institution
Viral Hepatitis Cases : India
Source: CBHI, NHP-2010

SIHFW: an ISO 9001:2008 certified Institution
Viral Hepatitis Deaths: India
Source: CBHI, NHP-2010

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Thank You

For more details log on to www.sihfwrajasthan.com or contact: Director – SIHFW on sihfwraj@yahoo.co.in

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