



Public Health Care : India An Overview

**State Institute of Health & Family Welfare,
Jaipur**



Constitutional commitment:

Health: State subject

Central List

International Health, Port Health
Research

Technical & Scientific Education

State List

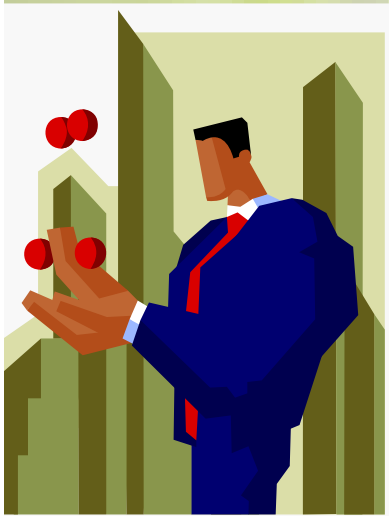
All other Health issues

Concurrent list

Epidemics



Milestones:



**Juggling
Priorities**

NRHM-2005
NHP-2002
NPP-2000

RCH-1996

UIP-1985
NHP-1983

Alma Ata-1978 (HFA)
Small pox eradicated-July 5, 1975

NFPP-1952
India Joins WHO-1948



HSDC-1946





- NO Health Policy for 36 years
- Committees and Commissions
- Single issue addressed by Committee
- Comprehension was missing
- Recommendations- reiterations of Bhore Committee.
- Individual “Health” Programs - situational exigency.
- Uni-purpose workers later baptized as Multi-purpose.
- Programs worked in complete isolation till 1980 (e.g. NTCP).
- Fragmented approach to Health



Still...62 yrs. of Health Services

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



Public Health

- Well developed administrative system
- Skills
- Reasonable Infrastructure
 - Poor health outcomes
- Design
- Misdirected efforts



Five year Plan	Period	Major areas addressed
I	1951-55	Infrastructure
II	1956-61	Industry
III	1961-66	Panchayat & Green Revolution
IV	1969-74	Expenditure , Agriculture
V	1974-79	Agriculture
VI	1980-85	Health , Technology
VII	1985-89	Poverty, Agriculture & Justice
VIII	1992-97	Pop., Agriculture , Poverty
IX	1997-02	Employment, Basic facilities
X	2002-07	HRD, Industry, Technology
XI	2007-12	Education, Health, Empowerment



Bhore Committee, 1946

PHCS : nodal points for Health care

Phased expansion

Prevention stressed

Population based



Health –State Subject ?

- Centralized planning
- Decentralized implementation
- Fiscal control of central Govt.
- Centre dictates States for Objectives & Priorities



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



Core Functions of Public Health

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



Health– A Dynamic Phenomenon

Health System ought to be, for-

- a. Rising costs,
- b. Changing political situations, and
- c. Social contexts (expectations of people from System)

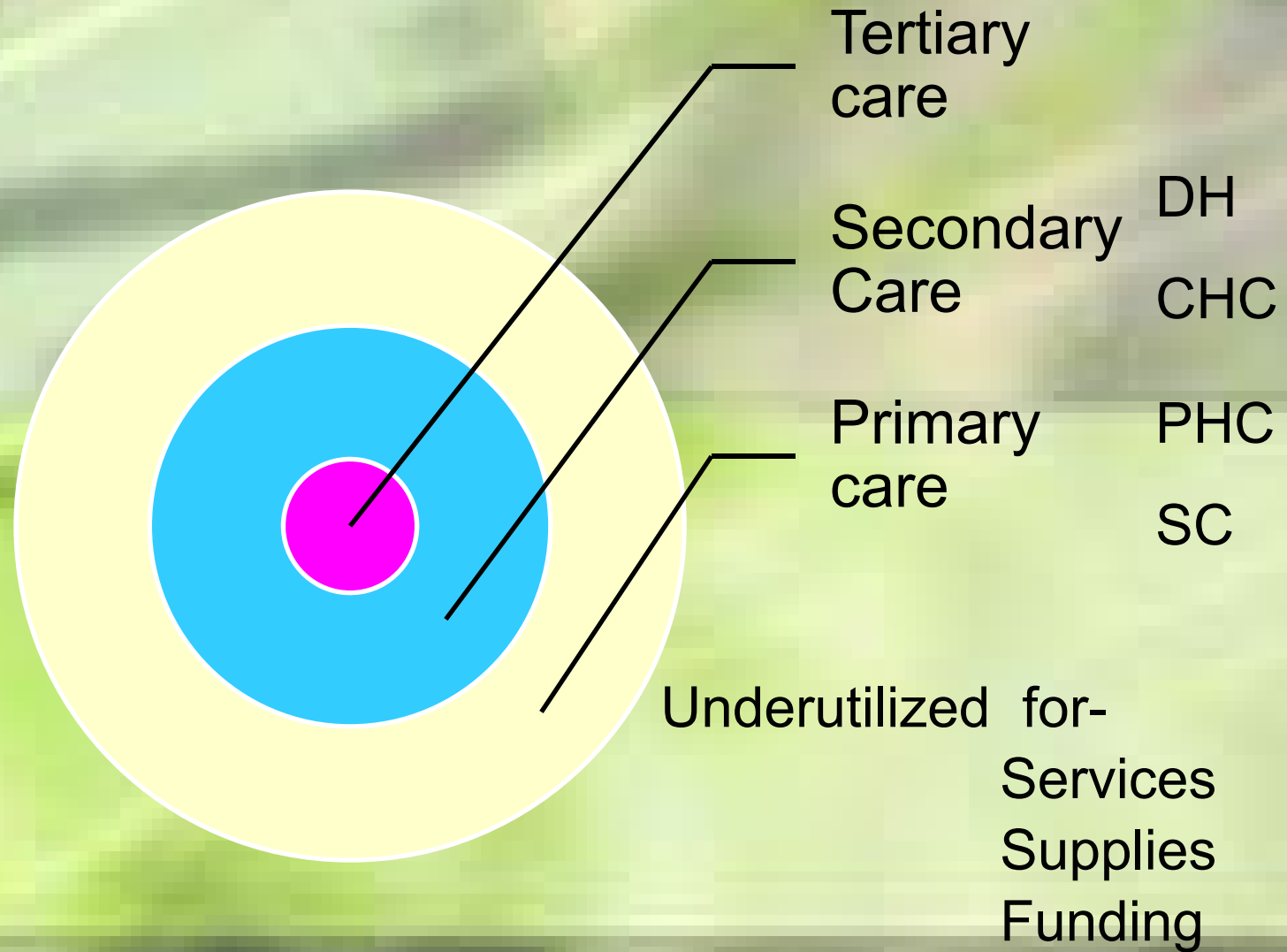


Public Health- Dilemma:

- Equity and Equality
- Quantity and Quality
- Public/Private/ Voluntary sector
- Education/ Persuasion/ Coercion
- Professional/ Para Prof/ Auxiliaries
- Privatization/ Disinvestment



Service delivery:3-tier Structure





Committees & Commissions

- **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 Man-Power



Limits to Modern Medicine

Spectacular Advances – Low Cost	Nutrition, Immunization, Antibiotics, Aseptic surgery, Maternal and child care, Healthy life styles
Grey Areas – High Cost	Degenerative diseases, Autoimmune diseases, Malignancies
Dark Areas	Idiopathic, Iatrogenic, Hospital Infections, Progressive, irreversible disorders



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

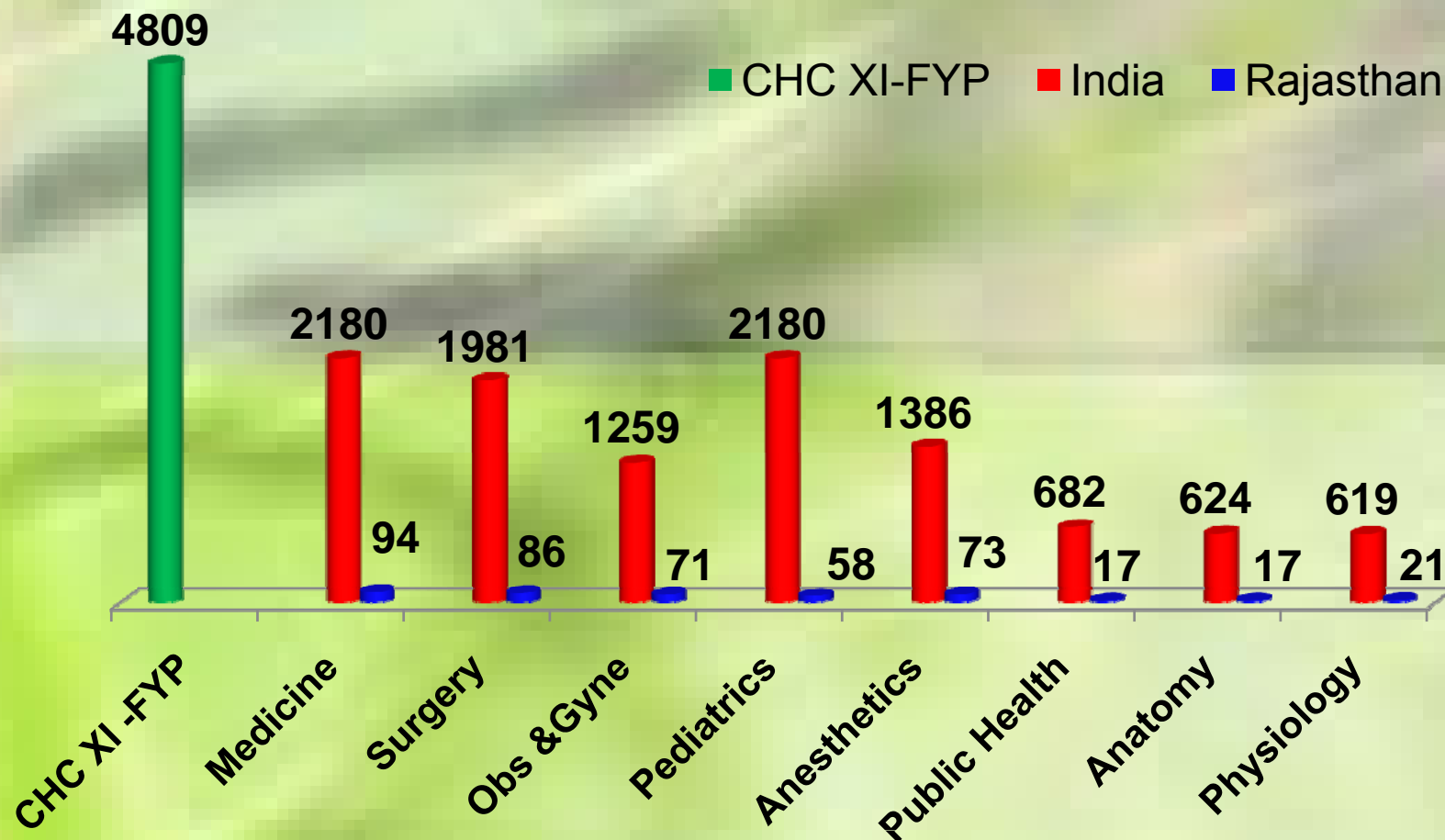


Challenges

- Manpower- Number & Norms
- Rural / Urban differential
- Geographical divide across States
- S-E groups –accessibility/ reach
- Gaps between Policy & Action
- Health sector expenditure
- Newer Infections



CHC- XI FYP vs. PG seats



Source: RHS 2011 MCI, 2012 (www.mciindia.org)

Rural : Urban Differentials

Sector	Pop. BPL (%) (NHP 10) ref. period '04-'05	IMR/ Per 1000 Live Births (SRS 2011)	<5Mortality Per 1000 (NFHS III)	Weight For Age-% of Children Under 3 years (<2SD)
India	27.5	47	74.3	44.9
Rural	28.2	51	82	45.6
Urban	25.7	31	51.7	32.7

Differentials in Health Status Among States



Better States	Pop. BPL (%) (NHP 2010) @	IMR (SRS 2011)	<5Mortality (NFHS III)	Weight For Age-% of Children Under 5 years (<2SD) (NFHS III)	MMR (SRS Spl. Bulletin, Apr. '09)\$	Leprosy – prevalence rate/100 00 population (NHP 2010)	Malaria +ve Cases (NHP 2010)
Kerala	15.0	13	16.3	22.9	95	0.23	2162
Bihar	41.4	48	84.8	55.9	312	1.08	1149
Raj.	22.1	55	85.4	39.9	388	0.19	47054
UP	32.8	61	96.4	42.4	440	0.81	59114

@ref. period '04-'05

\$ ref. period 2004-06

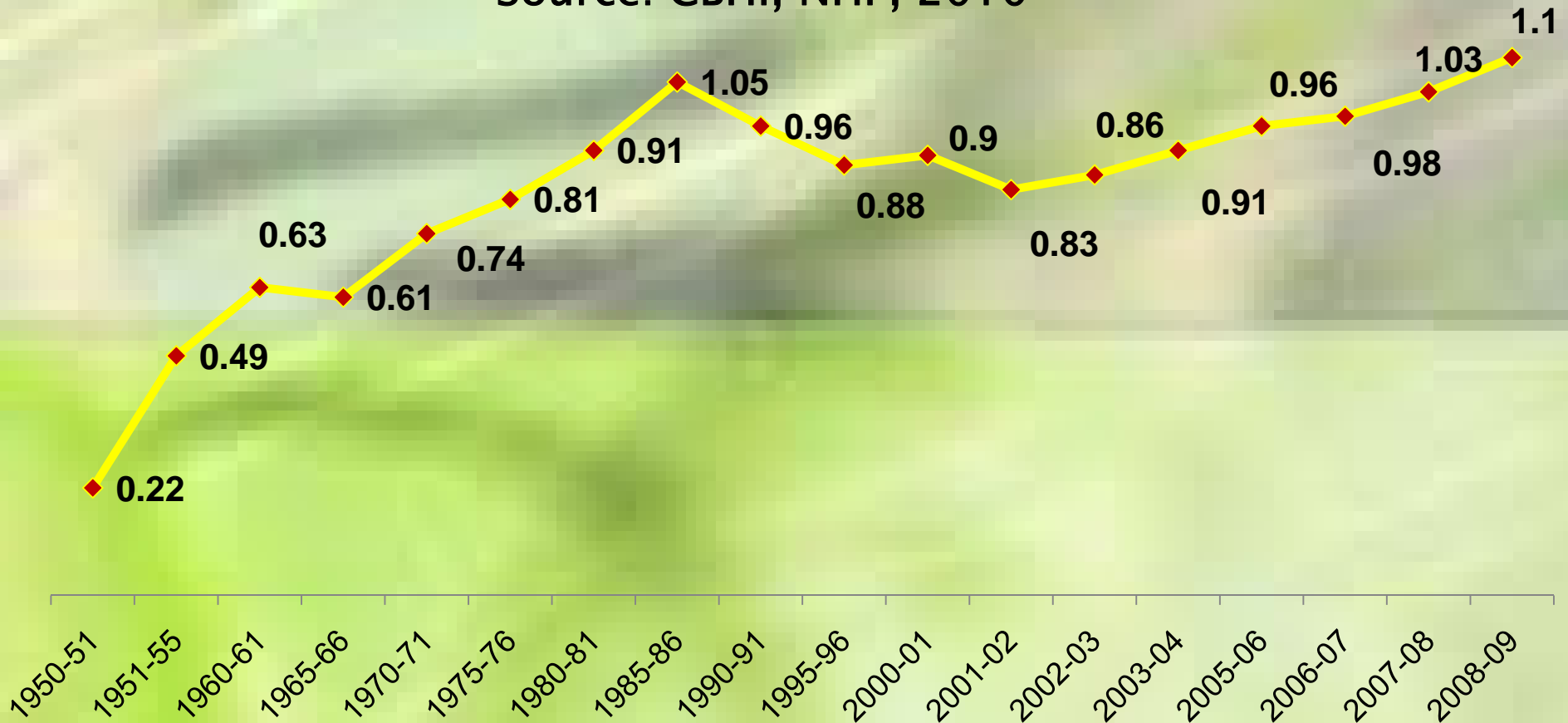
Health status Differentials among Socio-Economic Groups (NFHS III)

Indicator	Infant Mortality	<5 Mortality	% Children Underweight Under 3 years (<2SD)
<u>India</u>	57	74.3	44.9
Social Inequity			
S/C	50.7	65.4	47.9
S/T	43.8	53.8	54.5
OBC	42.2	54.5	43.2
Others	36.1	42.1	33.7

Total Govt. Expenditure on Health as % of GDP



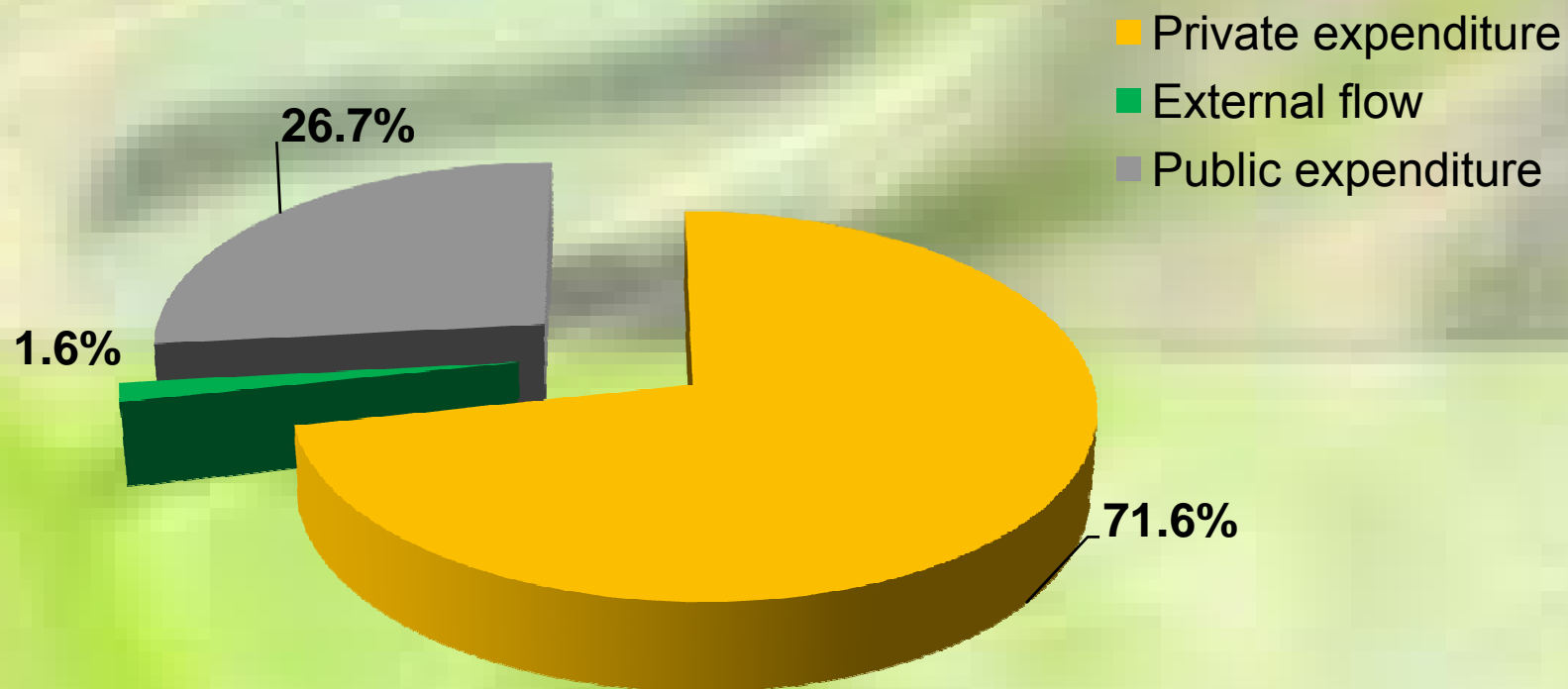
Source: CBHI, NHP, 2010



Planning Commission has decided to increase its spending on health to 2.5% of the GDP in the 12th Five Year Plan.



Share in health care spending



Source: NHP 2011

Goals : 2000–2015

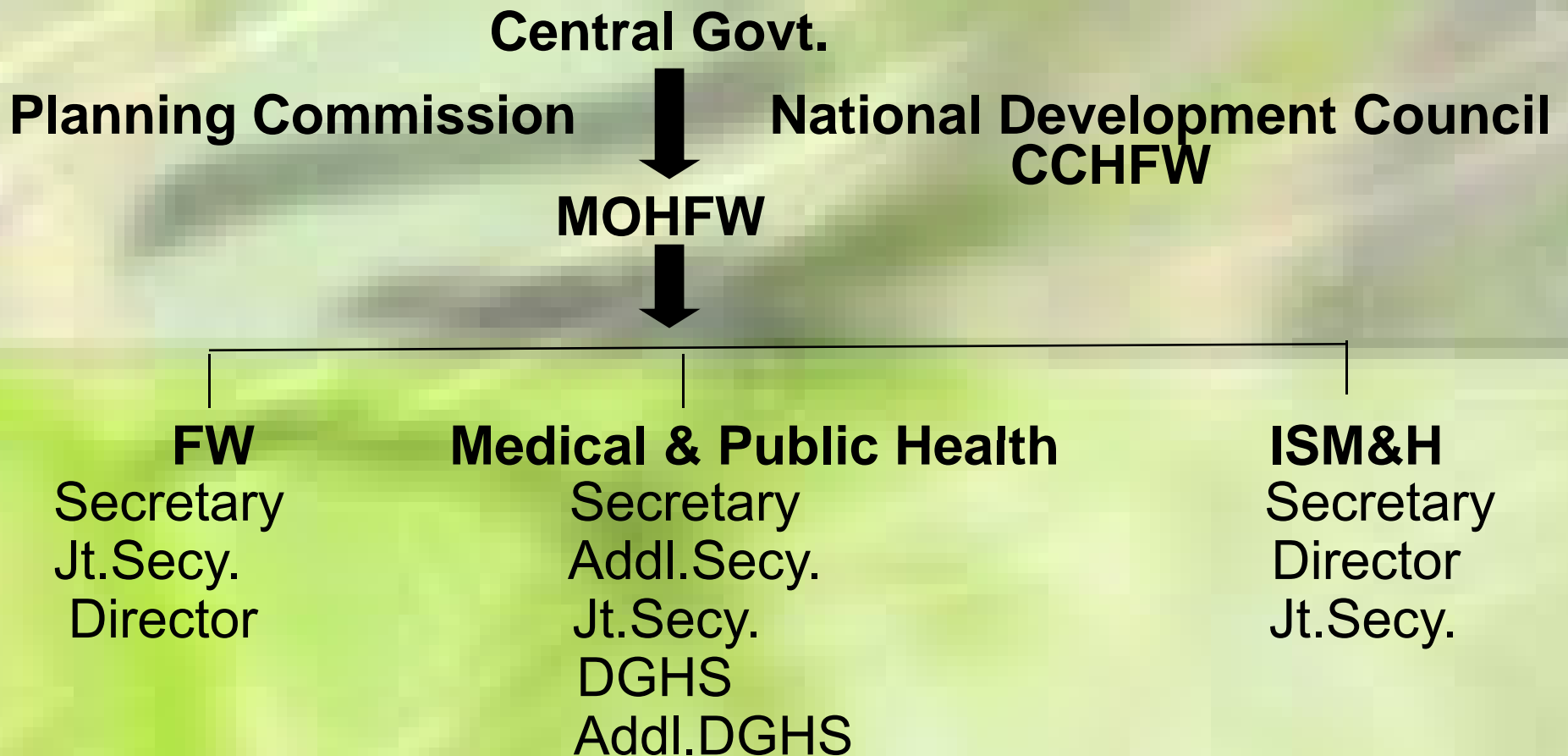


Eradicate Polio and Yaws	2005
Eliminate Leprosy	2005
Eliminate Kalazar	2010
Eliminate Lymphatic Filariasis	2015
Achieve Zero level growth of HIV/AIDS	2007
Reduce Mortality by 50% on account of TB, Malaria and Other Vector and Water Borne diseases	2010
Reduce Prevalence of Blindness to 0.5%	2010
Reduce IMR to 30/1000 And MMR to 100/Lakh	2010
Increase utilization of public health facilities from current Level of <20 to >75%	2010
Establish an integrated system of surveillance, National Health	2005



Health care Governance in India

Health System's Organization-India





Role of Central Govt. in Health Care

- Policy formulation
- Maintaining International health relations
- Administration of central health institutions
- Regulating Medical education through statutory bodies-MCI/DCI/Councils
- Medical & Public health research-funding
- Standards- laying & maintenance(Drugs/Education)
- Coordination-Other ministries/States/Statutory bodies
- Central Health Acts
- Negotiation with International agencies



Functions of Dept of Family Welfare

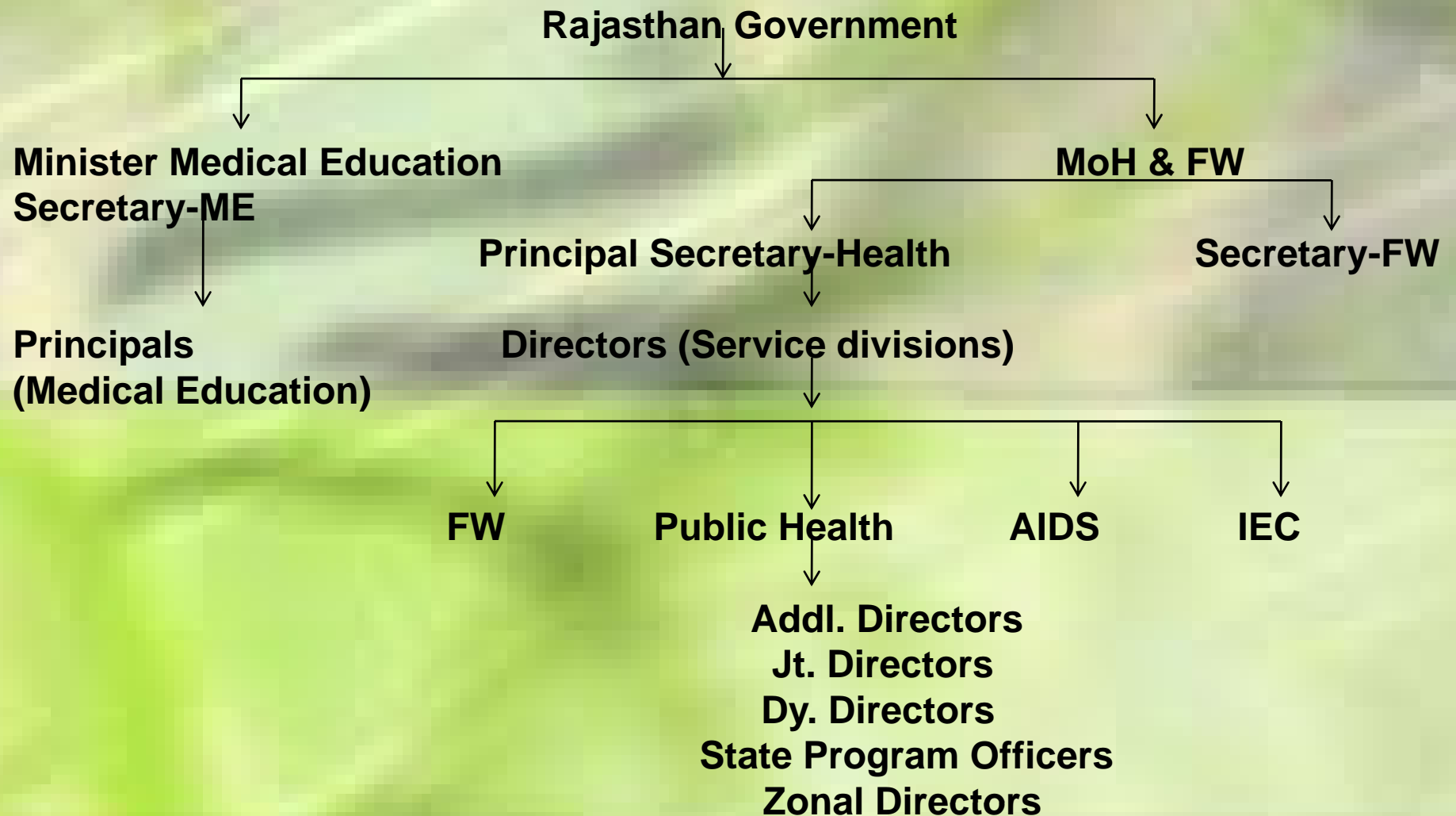
- Policy preparation & Planning
- Information collection & Evaluation
- Contraceptive-Research /Supply
- Seeking International support
- EPI/UIP/CSSM/RCH/ARI/ORT-Trainings & area development
- IEC
- Rural Health
- Paraprofessional training
- NGO support
- Development of Sub-center



Functions of Medical & Public Health

- Health Policy preparation
- National Health Programs conduction
- Drug Control
- PFA enforcement
- Diseases control-
Communicable/Non-communicable
- Supplies & Disposal Maintenance
- CME & Trainings
- Medical Education & Research
- Vital statistics & Health intelligence
- International support

Organization at State level





District Health Care Administration



District

An Administrative unit

Defined Geographical boundary and Population

- Peripheral most Planning unit
- A self contained segment of National Health System

District Health Organization



CMHO
(Rural), Preventive

PMO
(Urban), Curative

Dy. CMHO ↓ Program Officers
(registered society-DHS)

Block CM&HO
C H C

Pop.-80000-120000

Beds(30)

Specialists(7-IPHS)

Referral

P H C

Pop.20-30000

Primary health

Medical Officer(2-IPHS)

SC (3-5000) HW-M/F
SBA/AWW/VHG/ ASHA



Functions of District Health System

- Liaison between Field units & Headquarter
 - Field reports
 - Inspections
 - Meetings
- Implementation of Policy & Programs
- District level planning & Action Plans
- Rationale use of Finance & Resources
- Communication Management
 - Plans/Schedules/Progress/Problems
- Control & Monitoring



Problem Areas at District

- Quantity v/s Quality
- Cluttered Policy guidelines
- Decentralization on papers
- Roles/Responsibilities poorly defined
- Program integration ?
- HMIS-generation & use ?
- Managerial skills
- Donor initiative – “Societies”
- Resource restriction



Rural Health services

- Institution–
 - Primary Health Centers(20-30000)
- Functions-
 - Medical Care
 - RCH services
 - Immunization
 - Child Health
 - Obstetric services
 - MTP
 - NHP
 - School Health
 - Environment
 - Health/ Nutrition education
 - Management



Manpower at PHC

	Existing	Recommended (IPHS)
Medical Officer	1	2(one AYUSH or LMO)
Pharmacist	1	1
Nurse-midwife (Staff (Nurse)	1	3 (for 24-hour PHCs) (2 may be contractual)
Health workers (F)	1	1
Health Educator	1	1
Health Asstt. (M&F)	2	2
Clerks	2	2
Laboratory Technician	1	1
Driver	1	Optional/vehicles out-sourced.
Class IV	4	4
Total	15	17/18



- Sub-Centre (3-5000)
- Manpower- Male & Female Health Worker, Additional ANM under IPHS/ NRHM
- Support manpower-
 - VHG
 - SBA
 - AWW
 - ASHA
 - Jan Mangal Couples



Thank You

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