

**Comments on Report Submitted by the Government
of India on the *Article 12, Right to Enjoyment of
Physical and Mental Health*
To the
Committee of Economic, Social and Cultural Rights,
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Comments on Article 12, *Right to Enjoyment of Physical and Mental Health*

- 1. In the Government Report, 2006 to the Committee the Government accepted that to achieve the good health of the general population of the country it is important to increase the public health expenditure. One of the goals of the National Health Policy 2002 is to increase health sector expenditure to 6 per cent of GDP with 2 per cent of GDP being contributed as public health investment by the year 2010. But even in 2007 the public health expenditure is less than 1 per cent of GDP. The report also mentions that the different states in India are expected to increase budget for the health sector. But across the states the trend expenditure shows there has been no increase in the resources allocated for health. Instead there has been a decrease.**
- 2. The Government Report 2006 mentions that the private sector contribution in providing health services for the population group that can afford to pay for services should be enhanced. But in India, in the background of an unregulated growth of the private sector, differential pricing, irrational practices, the proportion of debt among the poor for availing medical care from the private sector is increasing. So far any attempts by the Government to engage the private sector in improving the public health services has led to privatization of the public facilities. This has adversely impacted the access to health services by the poor and the vulnerable groups in India.**
- 3. The Government Report 2006 mentions that there has been an improvement in the number and reach of the health delivery system in India. The table in page no. 127 of the report gives a false picture. The data from the Health Information India shows that though there is an actual increase in the number of the public health facilities, when the same data is disaggregated, wide variations of the availability of health services across the states and also regions, i.e., rural-urban are clearly visible. Again the trend in ratio between the population and available public health facilities shows that there has not been any increase. For example, the All India data shows that one government hospital serves 1, 56,088 (one fifty-six thousand). Similarly one bed serves 2336 (two thousand thirty six) population. The number of government allopath doctors serves 14,263 (Fourteen thousand two hundred sixty three) population. Source: Health Information India, 2005, <http://www.cbhidghs.nic.in/Introduction.asp>**
- 4. Under the section for *Programmes For Action for Various Diseases*, the Report mentions that the Central Government has been implementing National Health Programmes for Control, Eradication of various communicable diseases, non communicable diseases and mental health problems. But the communicable diseases like Malaria and TB continue to haunt substantial sections of population. According to the Economic Survey of 2004-05, in the year 2003 about 910 thousand people suffered from malaria and TB accounted for about 417 thousand deaths per year. Regarding the Malaria cases there has been gross underreporting in India given the fact that 75-80 per cent of outpatients seek care from the private sector which is not bound to any form of disease reporting. There are also major gaps in Malaria surveillance and official death reporting despite the fact that India has a national program on Malaria since 1952. (Review of Healthcare in India, www.cehat.org). Similarly, the current Tuberculosis Control Programme (RNTCP) remains inaccessible to a large section**

of the population requiring treatment. All the Disease control Programmes are vertical and there is a need to integrate these under one umbrella. This would not only improve the efficacy of these programmes but also optimal utilization of the resources. For example, in India, the funds available for the AIDS programme are huge as compared to other programmes as it receives large foreign funds.

5. The report submitted by the Government 2007 to the Committee, shows that at the All India level there has been a reduction in the prevalence of blindness but the data clearly indicates there are regional variations (State-wise and rural-urban) and other factors (literacy, occupation, gender) involved in affecting the prevalence of blindness among people. Comparison of the two surveys on blindness, i.e., 1986-89 and 2001-'03 shows that the North-eastern states in India, has had an increase in the prevalence of blindness. There is also rural urban variation in blindness. Apart from these gender, literacy, age and occupation has a strong relationship with the variation in the blindness prevalence. Source: Health Information of India, 2005 (<http://www.cbhidghs.nic.in/>)
6. The section of the report on *Medicine Production*, gives an incorrect picture. Over the past decade export of drugs has increased in India whereas the access to essential drugs has declined. The removal of the ceiling for essential drugs has led to steep rise in prices of these drugs.
7. The high level of mortality during the child birth indicates the inadequacy of facilities available for antenatal care and deliveries across the country. The National Family Health Survey, 2002 confirms that few women have access to adequate antenatal care in India. (<http://www.nfhsindia.org/>)
8. The section on Maternal and Child Health in the report mentions that the ICDS *kishori shakti yojana*, and other nutrition based programmes provide supplemental health and nutritional care to new born, lactating mothers and young girl children (pg 144). But access to the programme in terms of geography and social exclusion on the basis of tribe and caste has been a long standing issue for the implementation of ICDS. Under the National Prophylaxis Programme for prevention of blindness, all the children are expected to get a Vitamin A supplement starting at the ninth month of age and then six monthly till 3 yrs of age. Adolescent girl, children, women in the age-group 15-45 are expected to receive both Vitamin A and Iron and Folic Acid tablets. But the report of the Comptroller and Auditor General of India (CAG) in 2000 reveals that the Ministry of Health and Family Welfare was unable to provide any record of Vitamin A distribution. Infact no record of receipt or distribution of Vitamin A was found in any of the 72 projects tested in five states. In four states there was no supply of Vitamin A at all during 1992-'99. In 234 out of 283 project in eight states no beneficiary received Vitamin A. (<http://cag.nic.in/>)
9. India does not have a mental health policy till date. There is a huge gap between the available mental facilities against the number of persons requiring treatment. The infrastructure of existing mental health institutions is inadequate in terms of availability of drugs and other facilities. The treatment provided to the inmates violates the basic human rights, for example the inmates are chained to the beds, kept locked in rooms, administering ECT (Electro Convulsive Therapy) without anesthesia. Stigma and discrimination against the mentally ill is strong. There is a need to Mental Health Policy which will include both prevention and care.

- 10. The section on Medical Education and Research needs comment. There has been no review of the medical and nursing education in India. The Medical Council and the Nursing Council has been set up but their role in furthering medical education, regulation of the private sector, response on medical negligence and other related issues are poor. Medical education in India is highly subsidized through public finance. But there is a trend of migration of trained health professionals to developed countries is on the rise. Those who continue in India practice in the private sector which has impacted the availability of trained health professionals in the public health sector in India.**

Questions to be Addressed

IN THE BACKGROUND OF THE EXISTING INEQUITIES IN HEALTH AND HEALTHCARE IN INDIA, WE RECOMMEND THE COMMITTEE TO:

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1. Urge the State and exact its commitment to universalize access to healthcare by legislation and proper provisioning of services
2. Urge the State and exact its commitment to accept and support legislation to enact the right to healthcare as a fundamental right.
3. Urge the State, and exact its commitment, to take immediate steps to ensure that all people has equal access to and enjoyment of right to healthcare in accordance with the Convention, and that victims of denial of healthcare be provided economic and other assistance necessary to enable them to rebuild their lives and support their families and themselves.
4. Urge the State and exact its commitment to institute a mechanism to monitor the minimum clinical standards i.e., effectiveness of quality of services offered at both public and private facilities.
5. Urge the State and exact its commitment to standardize medical practice
6. Urge the State and exact its commitment to plan to address issues regarding equity of access and services to the poor and vulnerable
7. Urge the State and exact its commitment to increase public expenditure on health
8. Urge the State and exact its commitment to provide a safety net, fully sponsored by the government, for the poor and the vulnerable sections of the society.
9. Urge the State and exact its commitment to enforce relevant legislation and licensing Acts
10. Urge the State and exact its commitment to formulate a rational drug policy that ensures development and growth of a self-reliant industry for production of all essential drugs at affordable prices and good quality.
11. Urge the State and exact its commitment to devise a standard Pricing mechanism
12. Urge the State and exact its commitment to equip the primary health care institutions with trained village health workers, Sub-Centers, doctors, and community health functionaries
13. Urge the State and exact its commitment for a comprehensive need-based human resources plan to fulfill the shortage of skilled health professionals in the public health sector especially in the rural areas.



Centre for Enquiry into Health and Allied Themes

Appended-Report

Status of Health and Human Rights in India

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**Centre for Enquiry into Health and Allied Themes
April 2007**

About the Report

This is an important document that examines the implementation of the Article 12, *Right to Health*, of the ICESCR treaty which India has ratified on the 10th of July, 1979. The report reflects the status of health and human rights in India.

Background of the Report

The report is prepared by the Centre for Enquiry into Health and Allied Themes (CEHAT). CEHAT is a research centre of the Anushandhan Trust, Mumbai, India started in 1994. Its focus area is social and public health research and policy advocacy. This also includes work on strengthening education and training in public health in the country, linking up with social science institutions and university departments in order to promote and undertake health research and training, and demonstrating intervention models to strengthen public health systems. CEHAT has its headquarters in Mumbai.

CEHAT functions as an NGO but its research feeds into the progressive movements and influence policies. It has emerged as an important institution in the Indian health sector with significant work both at the macro and micro levels - household health expenditure and utilization studies, including specific studies on women's reproductive health, health services databases, critical reviews and study of the private health sector, health policy and planning, budget and financial analysis of the health and related sectors, provider and health facility surveys, quality of care studies of private and public providers and abortion services, community health training, advocacy on primary health care, quality, accreditation, regulation of the private health sector, budgetary allocations and health sector reforms and right to health care in India are some of the areas of work CEHAT has been and is involved in.

CEHAT's preoccupation with health rights has been since its beginning. CEHAT constantly strived to strengthen the health rights in India by providing inputs to various grassroots organizations through training and advocacy, have tirelessly promoted health rights among the deprived and the poor by training women health workers, by doing advocacy at local, state and national levels, by preparing research and strategy papers on the various issues related to health and human rights to increase awareness and inform and influence policy-making. Research on health and human rights involves analysis of data both at national and state-level and compilation of health-related information on health legislations to monitor health rights. Advocacy with the judiciary on the right to health includes filling public interest litigations on cases of denial of rights, organizing public hearings to encourage reporting of denial of healthcare through the Jana Swasthya Abhiyan (People's Health Movement, India Chapter).

The purpose of this report is to highlight pressing concerns with regard to systematic violations of Article 12 of this Convention with regard to the health rights in India through policies and programmes affecting access to health care among the population in India.

HEALTH AND HEALTHCARE IN INDIA

In the last decade, globalization and privatization¹ has had a perilous effect on the health systems of developing nations and has spawned-out perverse health impacts globally. Government decisions to introduce healthcare privatization have been and are being made in a number of developed and developing countries. These include service provision, user fees and also privatized insurance schemes. Governments all over the world have been deregulating and privatizing both the funding and the provisions of public services. In many countries, the public system is now a minority provider of services (Standing and Bloom,

¹ Privatisation of health poses a distinctive threat to the public service as the provisions are dictated by the requirements of profits.

2002). There are a number of different channels through which the process of globalisation is driving the privatisation of public services. The most prominent among them is the role played by the World Trade Organisation (WTO) and the liberalising drive of its agreement on trade in services.² The World Bank also has major impact on privatization of healthcare services through its projects, which often have greater privatization as a stated objective. There are influences of other institutions under globalisation. Structural adjustment programmes (SAPs) introduced under the IMF carried a large number of conditions. In some cases these conditions explicitly referred to the privatisation, or commercialisation of public services. Specific loans from the World Bank involved and were conditional upon, privatisation of the provision of the relevant services.³ Finally, the introduction of privatisation is ultimately a government decision, as a result of a mix of influences - national politics, international pressures, financial and economic crises or opportunities. Restructuring and privatisation of health services in ways which are now more familiar - decentralisation of authority, 'targeting' of services to the poor, introduction of user fees, introduction of private health insurance competing with public systems - but only for the money of the relatively rich and relatively healthy .

In India, in the late 1980s and nineties, the health sector experienced a major opening up. Since the beginning of the nineties major economic reforms had already started impacting the country both positively and negatively. The presence of international agencies in policymaking and programs was increasingly felt. Aided by western aid and agents, the health policies and programs started to be guided more by technological determinism rather than epidemiological priorities or geographical realities. These have seriously restricted the success of the health policies and affected the development of health services in India. The social sector expenditures experienced a steep fall in the late '90s. Within social expenditure, the decline was highest in the case of healthcare. Availability of resources in the health sector took a beating (Refer to Appendices, Table 2, *Trend of Social Sector Expenditure, Union Government*) .This trend was followed by a subsequent trend of substitution of the public resources by the private resources.

India's total health expenditure is 6 per cent of GDP of which less than 1 per cent is public expenditure leaving the rest as private expenditure. (Refer to Appendices, Figure 1, *Proportion of Health Expenditure in India*) This reduced the access of the poor to healthcare services. Cost of both outpatient and in-patient care increased sharply both in rural and urban areas in the nineties. The private outpatient cost increased by 142 per cent as against the 77 per cent in public sector in rural areas. In urban areas private outpatient cost increased by 150 per cent as compared to 124 per cent in the public sector. So the average cost of treatment rose by 436 per cent in the rural and 320 per cent in the urban areas. Medical expenditure emerged as one of the leading causes of indebtedness in India. The proportion of people not availing any medical attention due to high cost also increased between 1986-87 to 1995-96 from 10 to 21

² The WTO provides two kinds of threat to health services. The first is the potential threat of GATS, which could force more privatisation in future. The second is the effect of TRIPS in supporting pharmaceutical profits at the expense of health needs. The WTO agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) ensures that pharmaceutical companies are protected globally for a minimum of 20 years after they are patented. Because of the time it takes to get approval for use, this can mean that companies have only a decade of protected time to recoup the millions of dollars spent on research and development. Unfortunately it also means that over this decade the drugs are often too expensive for the world's poorest people. Some firms make some of these drugs without licensing agreements, and sell them to developing nations at knockdown prices. Pharmaceutical companies focus their investment in profitable drugs.

³ Additionally, there are various trade zones. The various regional trade zones of the world have rules which may already affect trade in services between countries in each zone. These rules may make privatisation easier or more likely in various ways, for example by giving rights to investors anywhere in the zone to enter a market elsewhere. They also include the rules of the regional trading zones, like NAFTA, or the EU, or Mercosur - these regions may already have in place trading rules and procurement rules that impact on privatisation of public services. And they include bilateral relations between countries, either through formal trade deals or through other international political relations. In certain cases the powerful state among the two can place conditions on other countries which concern privatisation or liberalisation of services.

per cent in urban areas and from 15 to 24 per cent in the rural areas respectively. (*National Sample Survey Organisation, <http://mospi.nic.in/websitensso.htm>*)

The process of shifting of balance of power from public to private was an easy transition facilitated by the global political economy. Globally, this period was marked by the diminishing role of the State in the social sector. The ratio of expenditure between public to private ratio subverted from 8: 2 in 1991 to 2: 6 in 2006. This impacted the utilization patterns of the public health services, especially due to reduced availability of non-salary inputs like medicines and other medical supplies, diagnostics, maintenance of facilities etc. The National Sample Survey Organisation in their 42nd and 52nd Round data clearly demonstrates the impact of globalization on health sector with reducing utilization of the public health services. Among the people who sought OPD services in 1995-96, more than 80 per cent did so in the private sector. The same trend was repeated even in the case of hospitalization. During the same period 55 per cent people in the rural areas and 57 percent in urban areas sought hospitalization in private sector. The introduction of User fees has also impacted the utilization of public health services. The National Family Health Survey also provides evidences of the consequences of globalization on health and health sector.

CREATION OF HEALTH MARKETS AND ITS IMPACT ON HEALTH OF THE POPULATION

Globalization and privatization of health services have opened the health sector to market players. Globalization has created health markets marked by imperfections. They enabled entities other than the state to provide services. Health markets are characterized by increased commercialization of health products, problem of market regulation, provider pluralism engendering access to reliable expertise, lack of reliable knowledge and limited regulation. In India, over the last two decades private sector has grown phenomenally. It has further led to health market failures comprising of the elements of public goods, positive externalities and information asymmetries. Unequal encounter between patient and provider creates imperfect market with severe quality problems and high cost of transaction.

Indian health system is marked by much inefficiency within the public healthcare system. The human resource management within the public health system is poor. There is lack of appropriate human resource development (HRD) policy to encourage the health workers to work in remote areas, poor work environment and dissatisfaction among the workforce and understaffing of remote and semi-remote facilities. The shortfall of doctors is evident from the fact that in India, one doctor serves 14263 populations.⁴ (Refer to Appendices, Table 3, *Manpower Shortage in Rural Areas*). There are significant variations by region, class, age, etc. As per the most recent available estimates, urban areas have only 3.49 allopathic hospitals, 3.48 dispensaries and 169 hospital beds and 4.63 dispensary beds per 100 thousand of (urban) population as on 1 January 2002 and these figures are far from adequate by any acceptable standard but seem to be much better than the corresponding figures for rural areas. For the rural areas the situation is much worse with 0.33 hospitals, 1.49 dispensaries, 3.1 Primary Health Centres (assuming that all Primary Health Centres are meant to serve the rural areas) and just 7.7 hospital beds and 2.11 dispensary beds per 100 thousand of (rural) population as on 1 January 2002. For the country as a whole, number of beds per 100 thousand of population, which had increased from 32 in 1951 to 83 in 1982, was only 93 in 1998, and subsequently, has declined to 89 as on 1 January 2002 as per Central Bureau of Health Intelligence (CBHI) data. Similarly the doctor: population ratio in the public health sector has increased. The number of doctors per 100 thousand of population has increased from 17 in 1951 to 47 in 1991, but stood at 52 in 1998, which according to latest CBHI (2002) figures has increased to 59.

In contrast the private health sector has expanded rapidly and increased its share in healthcare provision. However, while the public health services operate with a set of well-defined rules, the private health sector is completely unregulated – neither the state has attempted any serious governance of the private health sector nor have any of the professional bodies tried to have self-regulation. As a consequence

⁴ Health Information 2005, Government of India

there are plenty of unqualified and/or unlicensed practitioners as well as medical care institutions in the market, and malpractice and lack of ethics in practice is widespread (including amongst the qualified and licensed). All this is a major threat to patients, especially given the fact that more than 50% of hospitalizations and 80% of ambulatory care is provided by the private sector. The expansion of the private sector which remains virtually unregulated has reduced the role of public sector.

The spread and quality of preventive as well as curative healthcare system are far from adequate even six decades after independence and hence the morbidity and mortality rates are still at unacceptably high levels in the country. There is rise in Malaria and Tuberculosis. The malaria burden on certain vulnerable groups, for example among tribals, seasonal migrant workers, agriculture labourers and peasants directly engaged in agriculture work have increased considerable. There is a relationship between poverty and high incidences of malaria in India National Programme on Tuberculosis started in 1962 but it was later reintroduced as Revised National Tuberculosis Control Programme (RNTCP) in 1992-93 owing to certain weakness in the previous programme. The current programme has some component like Direct Observation of every dose popularly referred as DOTS has come under criticism as “the assumption that the drug administration must be directly observed by RNTCP staff, not only involves considerable expenses which includes high cost of the technology used, but it also requires enormous managerial and organizational efforts to ensure that the patients, who are scattered over large areas, receive treatment.”⁵ There area also other factors that is acting as a barrier to the DOTS Programme. The guidelines states that all individuals presenting to the clinics and diagnosed with TB need to be put on RNTCP regime and entered in the register for follow-up. But registration and coming to the DOTS centre every alternate day proved to a problem for daily wage earners, school going children and even those staying far away from the centre. Hence there has been an increase in the cases of non-registration of the number of people suffering from TB. There are other problems within the DOTS Programme that have excluded many patients from accessing treatment for the disease.⁶ Even common water-borne diseases like Gastroenteritis and Cholera are still contributing to the high levels of morbidity.

Another striking feature of marketization in the health sector is the rapid increase in the number and variety of sources of supply of drugs. Under the TRIPS regime, the cost of production of drugs would go up. The 1970 Patents Act encouraged Indian companies to develop new processes for patented drugs, also facilitated the development of good manufacturing facilities in India. Globally, the Multinational Companies have gained prominence through the patent regime and have collected huge profits through the patenting of top selling drugs. In the process the production of drugs became a separate activity less connected to the needs of the global population. On 23 March 2005, the Government of India got the Patents (Amendment) Bill passed in the Parliament to make it a law. The obligation under TRIPS is to provide product patent protection for inventions in pharmaceutical and agrochemical sectors. Indian companies that are now producing generic versions of drugs for which patent applications were submitted between the signing of the WTO agreement in 1995 and 1 January, 2005 are allowed to do so if they pay a “reasonable” royalty to the patent holder. But the Act has not clearly defined the term “reasonable royalty”. This ambiguity is bound to raise the prices of such drugs steeply. The most glaring failure of the new legislation relates to compulsory licensing. In a product patent regime, a proper compulsory licensing system is of fundamental importance to ensure competition and competitive prices. But the process in the Indian case has been made much more legalistic than what is required by the TRIPS Agreement. As a result it provides enough opportunities to the powerful patent holders to manipulate the process by litigation to prevent others from producing their patented products. In short, the new patent regime is likely to have made it quite difficult for the Indian Government to control monopolistic practices of the big pharmaceutical companies, which is likely to worsen the already very poor access by large sections of the masses to the essential drugs.

⁵ Banerji, D., (1993), **A social science approach to strengthening India’s National Tuberculosis Programme**, *India Journal of Tuberculosis*; 40:61-81

⁶ Singh V., et al. (2003), **TB Control in Delhi, India**, *Tropical Medicine and International Health*, Vol 7, No 8, August

The pharmaceutical industry in India is very large and is able to cater to not only almost the entire demand for drugs in the country but is also emerging as a major exporter at the global level. The role of public sector has reduced and has been replaced by the private sector considerably in the production of bulk or basic drugs. This is a dangerous development since in India there is a large proportion of unqualified segment of practitioners offering medical services largely in the rural areas. During the last two to three years prices of many essential drugs have doubled and this makes seeking of health care more expensive not only in the private health sector but also in the public health sector. The medical equipment industry in India is much smaller than the pharmaceutical industry and India still has to rely heavily on imports, especially of hi-tech equipment. Over the past decade export of drugs has increased in India. (Refer to Appendices, Figure 3, *Trend of Import Export of Drugs, Pharmaceuticals and Fine Chemicals, India*)

Irrational drug prescriptions have increased the burden of debt of poor on account of availing healthcare. At present in India, an estimated 60,000 to 80,000 brands of various drugs are available in the market of which majority of them are hazardous, irrational or useless. The growth of the pharmaceutical companies has coincided with the growth of the private sector, both with a profit motive. This gave impetus to the practice of irrational prescriptions. India produces 8 per cent of the drugs in the world and has been supplying drugs to a large number of countries in Asia, Africa and Latin America.

Against the backdrop of a poor public health system and the fierce unregulated growth of the private sector medical tourism is being promoted in India. Medical tourism refers to phenomena where patients go to a different country for either urgent or elective medical procedures. Medical tourism is fast becoming a worldwide, multibillion-dollar industry. India's National Health Policy declares that treatment of foreign patients is legally an "export" and deemed "eligible for all fiscal incentives extended to export earnings." Government and private sector studies in India estimate that medical tourism could bring between \$1 billion and \$2 billion US into the country by 2012. The reports estimate that medical tourism to India is growing by 30 per cent a year. More than 1, 50,000 medical tourists came to India in 2003.⁷ Medical tourism at present is dealing with large specialist hospitals run by corporate entities. The wide differences in comparative health costing and long waiting for inpatient and outpatient care across the globe opened an opportunity for India with better technical know how and low cost of healthcare services as compared to developed countries. Some private hospitals in India are registered as Trust (not-for-profit) hospitals which have not honored the conditionalities for receiving government subsidies in turn of providing treatment of a certain proportion of patient free of cost. If anything, increased demand on private hospitals due to medical tourism may result in their expansion. Medical tourism is likely to further devalue and divert personnel from the public sector rather than strengthen them.

POOR HEALTH AMONG VULNERABLE GROUPS ESPECIALLY CHILDREN AND WOMEN

There exist wide inter-state differences in health outcomes and resource allocations to health sector. Even within states, there exist wide disparities in health outcomes along class, gender and social factors. The Ministry of Health and Family Welfare in its National Health Policy, 2002 admits that the: '*national averages of health indices hide wide disparities in public health facilities and health standards in different parts of the country*'. Disparities among the various groups are evident from their low health status and reduced access to health services. The macro data⁸ clearly points out that groups like scheduled castes and scheduled tribes and those from lower economic groups have poor health and nutritional status. This explicates the presence of inequity in the health system. The NSSO data on utilization of public and private healthcare facilities across classes and social groups also highlight the adversities in access to healthcare among vulnerable groups.⁹ (National Sample Survey Organisation, http://mospi.nic.in/nssso_test1.htm)

⁷ Express Healthcare Management, 1-15 March, 2005

⁸ National Family Health Survey- 2

⁹ NSSO (1998): Report No 441 on Morbidity and Treatment of Ailments

There are differences in health outcomes among vulnerable groups, women, children, elderly, migrants, disabled, Scheduled Castes and Scheduled Tribes. Infant and child mortality rates are high. In the 0-4 age group the average burden of disease is almost four times than that in China and 16 times than that in developed economies. Within India the differentials in child mortality is visible across region, gender, class and social groups. Children from Scheduled Tribes (26 per cent) are lowest in terms of immunization for vaccine preventable diseases as compared to Scheduled Castes (40), Other Backward Classes (43 per cent) and Others¹⁰ (47 per cent). Only 30 per cent of children from households with low standards of living are fully vaccinated compared with 65 per cent of children from households with a high standard of living. Children from the scheduled castes (83.0), scheduled tribes (84.2) and other backward classes (76.0) have higher rates of infant mortality rates than children from the other population (61.8). Similarly child mortality rates are higher among the SC (39.5), ST (46.3) and OBC (29.3) than among Others (22.2). The infant and mortality rates shows quite a variance among those from medium (70.3; 26.1) and low standard (88.8; 45.2) of living index as against those from the higher (42.7; 9.1) SDL. Rural mortality rates among children are considerably higher than urban mortality rates. Child mortality is almost twice as high in rural areas (32.8) as in urban areas (16.9), neonatal mortality is 47 per cent higher in rural areas, post-neonatal mortality is 73 per cent higher in rural areas, and infant mortality is 56 per cent higher in rural areas. Under-five mortality is 64 per cent higher in rural areas than in urban areas.

	Scheduled Castes	Scheduled Tribes	Other Backward Castes	Others	All
Infant Mortality	83	84.2	76	61.8	67.6
Neonatal Mortality	53.2	53.3	50.8	40.7	43.4
Child Mortality	39.5	46.3	29.3	22.2	29.3
Under Five Mortality	119.5	126.6	103.1	82.6	94.9

Source: National Family Health Survey (NFHS) 1998-'99 (<http://www.nfhsindia.org/>)

There are glaring shortcomings in the case of women's healthcare like poor coverage and quality of antenatal care, unsafe deliveries, lack of emergency obstetric care and poor referral services also contribute to high rates of maternal deaths. The NFHS-2 estimates the maternal mortality ratio in the country to be 540 per 1, 00,000 live births for the two year period before the survey. The ratio is more severe for rural India, being 619, in comparison to urban India which records 267 during the same period.¹¹ Maternal mortality ratio in the country has been 'steadily falling' during the past decades. Indirect estimates of maternal mortality in rural India discovered the ratio to be higher for certain social groups. State level estimates of maternal mortality ratio shows that variation exists.¹² A large proportion of women are reported to have received no antenatal care.¹³ In India, institutional delivery is lowest among women from the lower economic class as against those from the higher class¹⁴.

¹⁰ Others refer to the General Population

¹¹ IIPS and ORC Macro, 2000

¹² Assam has the highest maternal mortality ratio in the country, followed by Uttar Pradesh and Madhya Pradesh. Maternal mortality in Punjab and Kerala is understood to be very low owing to which estimating it from sex differentials in adult mortality of a sample population is difficult. Among the states for which estimates could be arrived at, Tamil Nadu has the lowest maternal mortality ratio.

¹³ Only 16 per cent of the women in India received all the antenatal care i.e., at least 3 antenatal check-ups, and at least one tetanus toxoid injection and supplementary iron in the form of iron folic acid tablets/syrups daily for 100 days as recommended by the RCH Programme. (RCH-DLHS-3,2002-04)

¹⁴ In India, the percentage of home delivery is highest (59 per cent), whereas institutional delivery (public and private health institutes) accounts for only 40.5 per cent. Home delivery assisted by skilled birth attendants accounts for 7.1 per

A characteristic feature of access to healthcare in the Indian context is the unevenness in the physical and functional provisioning of facilities across the country. India is classified in the *Class B* category of nations in the world where between 11 to 50 per cent of the districts are at 'high risk' of neonatal and maternal tetanus.¹⁵ In no state is there universal coverage of such a service. Other indicators of antenatal care services are as discouraging. Only 43.8% of the births in the preceding three years of the survey had received three or more antenatal checkups and there exists large interstate variations.¹⁶ Records show that women from low socio-economic levels with less education are less likely to receive antenatal care during their pregnancy.¹⁷ Like antenatal care, delivery and post natal checkups are limited and skewed across social groups in the country. A major public health problem plaguing the country like maternal mortality can be tackled by the provisioning of emergency obstetric care.¹⁸

cent. Institutional delivery by background characteristics shows that only 22 per cent childbirths of Scheduled Tribes women takes place in institutions as compared to 33 per cent births to Scheduled Caste women. (RCH-DLHS-3,2002-2004, pg 98)

¹⁵ Neonatal and maternal tetanus can be prevented by universal coverage of antenatal services and safe delivery practices. The tetanus toxoid injections which form part of routine antenatal care in the country would help in countering the problem to a large extent. However, given the poor coverage in antenatal care services in the country, the elimination of neonatal and maternal tetanus remains an unrealized goal. NFHS-2 indicates that nationally only two-thirds (66.8%) of the births in the three years preceding the survey had received two or more tetanus toxoid injections during the pregnancies (IIPS and ORC Macro, 2000).

¹⁶ States like Kerala (98.3%) and Goa (95.7%) have recorded higher proportion of women with three or more antenatal check-ups while Uttar Pradesh (14.9%) and Bihar (17.8%) are far behind the goal of universal coverage of maternal health services. Similarly, in less than half (47.5%) of the births had there been the supply of iron or folic acid tablets or syrup for three months and more.

¹⁷ Almost half of the births among illiterate women (48.4%) and poor women (45.1%) are not preceded by *any* antenatal checkups .

¹⁸ The Facility Survey conducted under the aegis of the Reproductive and Child Health project indicate adequacies of public healthcare facilities in categories of staff, laboratories, operation theatres, drugs, equipments, training of staff for various services, etc. According to the survey, *no hospital* is fully equipped to discharge the services, though the District Hospitals (DH) in the country are found to be better placed in critical inputs¹⁸ than the First Referral Units (FRUs) who, in turn, are better situated than the Community Health Centres (CHCs) (IIPS,2001b). As is characteristic of facilities and services in the country, there are considerable interstate differences with the indices being *usually* (though neither always nor exclusively) poorer for the BIMARU states. Among district hospitals, 80% or more of the facilities have adequately equipped laboratory, generator, separate operation theatre for gynaecology and OPD facilities for gynaecology/obstetrics, but only 66% of the facilities have linkages with a blood bank. The proportion of the FRUs having such facilities falls with about 70% having adequately equipped laboratory, generator and separate operation theatre for gynaecology. OPD services for gynaecology/obstetrics are available in 63% of the FRUs. At least 60% of the CHCs have adequately equipped laboratories and 57% have separate operation theatre for gynaecology. OPD facilities for gynaecology/obstetrics are available in only 43% of the CHCs. In the area of staff, district hospitals are most likely to have the medical and paramedical staff required for reproductive and child health services. In the FRUs and the CHCs, excepting certain categories of paramedical staff (e.g. laboratory technician, staff nurse and pharmacist), the others (including specialist doctors) are more likely to be absent. Training of the staff in the fields of sterilization, IUD insertion, emergency contraception, RTI/STI, new born care and emergency obstetric care was inadequate across the various types of facilities. Emergency obstetric care kits are available in about 30% of the district hospitals and FRUs and 15% of the CHCs. Normal delivery kits are available in about half or more of such facilities. About a third of the district hospitals and the FRUs and a quarter of the CHCs had attended to referred cases of delivery during the three months prior to the survey. Among the PHCs surveyed, 88% had a male medical officer and 20% had a female medical officer. Normal delivery kit was available in 46% of the PHCs, labour room table/equipment in 53% and MTP suction aspirator present in only 16% of the facilities. Barring contraceptive services, provision of reproductive services is very limited in the PHCs. Only 34% of the PHCs carry out deliveries and a meagre 3% conduct MTPs. RTI/STI services are provided in 16% of the PHCs. Indeed, a telling comment on the primary healthcare system in the country, built on an edifice of community location and a referral chain.

MENTAL HEALTH

There are only 42 mental hospitals in the country with bed availability of 20,893 in the government sector and another 5096 in the private sector hospital settings to take care of an estimated 1,02,70,165 people with severe mental illness and 5,12,51,625 people with common mental disorders. Psychiatric medicines are supplied only in a few primary health centers, community centers and district hospitals. Services like child guidance and rehabilitative services are also available only in mental hospitals and in big cities. Several states do not have mental hospitals.

AVAILABLE PROVISION OF CARE FOR MENATALLY ILL PERSONS

Total psychiatric beds per 10,000 population	0.25
Psychiatric beds in mental hospitals per 10,000 population	0.2
Psychiatric beds in general hospitals per 10,000 population	0.05
Psychiatric beds in other settings per 10,000 population	0.01
Number of psychiatrist per 100, 000 population	0.2
Number of psychiatric nurses per 100,000 population	0.05
Number of psychologist per 100,000 population	0.03

Mental Health in India-An Overview, 2006

Appendices

TABLE 1

COMMITTEES ON HEALTH IN INDIA SINCE INDEPENDENCE

Committees	Year	Salient Recommendations
Bhore Committee	1946	<ul style="list-style-type: none"> No individual should lack access to medical care because of inability to pay for it Special emphasis should be placed on preventive methods, and on communicable diseases Health services should be as “close to the people as possible in order to ensure the maximum benefit to the community to be served” All facilities for diagnosis and treatment should be available in the health services when it is fully developed One primary health unit per 10-20,000 population with 75 beds and 6 doctors and 6 public health nurses One bed per 175 population. One doctor per 1,600 and one nurse per 600 population One 650 bed hospital at taluka (3 lakh population) level and one district hospital of 2,500 beds No patents in pharmaceutical products 15% of government expenditure on health care
Chopra Committee	1948	Suggested synthesis of Indigenous and modern medicine through integration in education and multi-disciplinary research.
Homoeopathic Enquiry Committee	1949	Suggested establishment of Central Council of Homoeopathic Medicine and standardisation of homoeopathic education and equipment
Dasgupta Committee	1949	Looked into housing, water supply, general sanitation, conservancy and drainage systems, waste disposal, vector control etc..
Pandit Committee	1951	This was to follow up on the Chopra Committee and it advised against integration of modern and indigenous medicine for teaching or otherwise and it was instrumental in setting up the Jamnagar based Central Research Institute in Indigenous Systems of Medicine.
The Pharmaceutical Enquiry	1954	This looked into business practices of the

Committee		pharmaceutical industry and recommended that drug production must be done from basic chemical stage so that foreign dependence is reduced and suggested the need for an essential drug list.
Model Public Health Act Committee	1955	Bringing together all health legislation and rationalising them
Committee to study the formulation of uniform standards in respect of education and regulation of practice of vaidyas, hakims and homoeopaths,	1956	Standardised degree courses at 5 ½ years, including internship and compilation of pharmacopaeia and dictionary
Dave Committee	1956	Committee to study and report on standards for education and regulation of practice of indigenous systems of medicine, defined admission criteria and registration of practitioners both institutionally qualified and traditional.
Udupa Committee	1960	Committee to assess and evaluate present status of Ayurvedic medicine, emphasised on shudh ayurveda, need for standardization of pharmaceutical products, and suggested investigation into secret remedies and to make ayurveda system open and modern.
Manickavale Committee	1960	Committee to study and report on pattern of statistical units for Health Departments, setting up of reporting and registration agencies for vital and health statistics at all levels
Renuka Roy Committee	1960	School Health Committee, promotion of preventive care through schools, provision for school meals, health education as part of school curricular, and integration of school health through the primary health care network.
Mudaliar Committee	1961	<ul style="list-style-type: none"> ~ Strengthen Primary Health Centers (PHCs) ~ One PHC per 40,000 population without hospital services ~ One bed per 1,000 population and one doctor per 3000 population ~ One 50 bedded basic specialty hospital for each taluka and one district hospital of 500 beds ~ Explicit Central Government to control communicable diseases ~ One medical college per 5 million population ~ Only process patent for 5-10 years for drugs ~ No integration of systems of medicine
Ayyar Committee	1964	Hospital Equipment Standardisation Committee, Worked out standards for hospital furniture,

		medical equipment and staff pattern for different levels of hospitals.
Jain Committee	1966	<ul style="list-style-type: none"> ~ One bed per 1,000 population ~ One 50 bed hospital at taluka level ~ Enhancing maternity facilities at each level ~ Health insurance for a larger population coverage ~ Charging health access to augment resources
Shah Committee	1966	Committee to study the legalisation of abortion, Estimated abortions @ 13 per 1000 population, found the provision under IPC very restrictive and recommended liberalization of abortion
Jungalwalla Committee	1967	Committee on Integration of Health Services, Integration of all different programs of the Health department and consolidation of a single cadre of doctors
Medical Education Committee	1969	Standardization of medical admissions criteria, discontinuation of licentiate course, continuation of reservations, and making PSM an integral part of medical education.
Kartar Singh Committee	1974	<ul style="list-style-type: none"> Integration of all health programs and health workers: retrain health workers as multi-purpose workers ~ A team of one male and one female worker at subcentre level (3,000 population) ~ One PHC per 50,000 population ~ One health supervisor for every 4 health workers
Srivastava Committee	1975	<ul style="list-style-type: none"> One male and one female health worker per 5,000 population ~ One health assistant per 2 health workers ~ One additional doctor and nurse at PHC for MCH services ~ Increase PHC drug budgets ~ Compulsory national service of 2 years at PHC by every doctor between 5th and 15th year of career ~ Establish medical and health education commission ~ Integration of various health systems
Small Family Norm Committee	1978	This committee made recommendations to restrict benefits if a couple had more than three children, like maternity benefits, bonus to women employees, compensation for IUD and sterilization to continue, special health and welfare benefits for those accepting sterilization, liberalization of abortion,

		income tax benefits for those with small families, etc.
Icmr-Icssr Joint Panel	1980	<p>Village health unit at 1,000 population level with one male and one female health worker</p> <ul style="list-style-type: none"> ~ Subcentre for 5,000 population with one male and one female health worker ~ One 30 bedded Community health centre per 100,000 population with 6 general doctors and 3 specialists ~ District health centre for 1 million population and specialist centre at 5 million population ~ No further expansion of medical education and drug production but only their rationalization and reorientation ~ 6% of GNP must be ultimately spent on health care services
National Health Policy	1983	<p>Provision of universal, comprehensive primary health care services</p> <ul style="list-style-type: none"> ~ Involvement of private practitioners and NGOs to expand coverage of services so that access improves ~ Transfer of knowledge of simple skill to village based workers ~ Evolving a decentralized system of health care and establishment of a referral systems ~ Establish nationwide chain of epidemiological stations ~ Encourage private investment in health sector to reduce government burden ~ Specification of health and demographic outcome targets to be achieved by year 2000
National Population Policy	2000	<p>Articulates a mix of socio-demographic and health goals for 2010 with the primary aim of bringing the TFR to replacement level.</p> <ul style="list-style-type: none"> ~ Increased outreach and coverage of comprehensive package of reproductive and child health services by government in partnership with NGOs and the private sector. ~ A one-stop, integrated service delivery to be provided at the village level ~ Expand public health infrastructure by increasing numbers of Sub-centers, Primary Health Centres and Community Health Centres ~ Decentralized of planning and program implementation with high involvement of the Panchayati Raj Institutions (PRIs) and community groups. ~ Promote inter-sectoral approach between a number

		<ul style="list-style-type: none"> ~ of key government departments ~ Establish a national commission on population with equivalent structures at the state level ~ Set up a National Technical Committee with medical experts and government representatives. ~ Proposes doubling the annual budget of the Family Welfare Department. ~ Recommends a set of promotional measures and incentives to promote the adoption of the small family norm.
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TABLE 2

TREND OF SOCIAL SECTOR EXPENDITURE, UNION GOVERNMENT

Year	Total expenditure (in Rs. crore)	Total social sector (in Rs. crore)	Share of social sector as % of total budget expenditure	Share of Health as a percentage of total budget expenditure	Health as a percentage of GDP	Share of education as % of total budget expenditure	Education as percentage of GDP	Trends in expenditure of the union government on health & family welfare (in Rs. crore)
1996-97	201007	13659	6.80	0.55	0.998	1.51	0.24	2751
1997 -98	232053	15894	6.85	0.59	1.044	1.76	0.29	3174
1998-99	279340	19750	7.07	0.63	1.134	2.00	0.35	3993
1999 - 2000	298053	23406	7.85	0.72	1.208	1.98	0.33	5012
2000 -01	325592	25222	7.75	0.76	1.207	1.91	0.32	5291
2001 -02	362310	28462	7.86	0.78	1.253	1.81	0.32	5977
2002 -03	413248	29349	7.10	0.73	1.191	2.11	0.39	6521
2003 -04	471368	35224	7.47	0.80	1.276	2.08	0.39	6856
2006 -07 (BE)	563991	50015	8.87	1.44	1.265	4.28	0.55	12546

Note: The above table is the figure of Current Values. If we deflate the actual figures we can arrive at the real value. It is evident that even though in the table the actual value shows an increase in expenditures, in reality it may just be stagnant or declining.

FIGURE 1
PROPORTION OF HEALTH EXPENDITURE IN INDIA

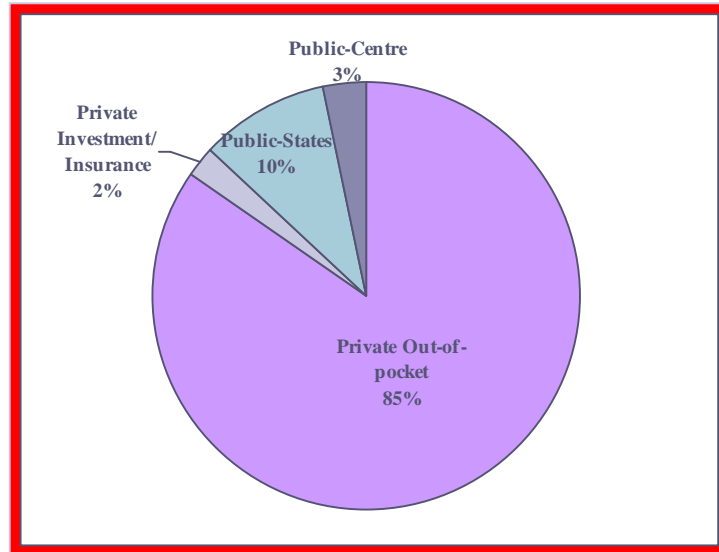


FIGURE 2

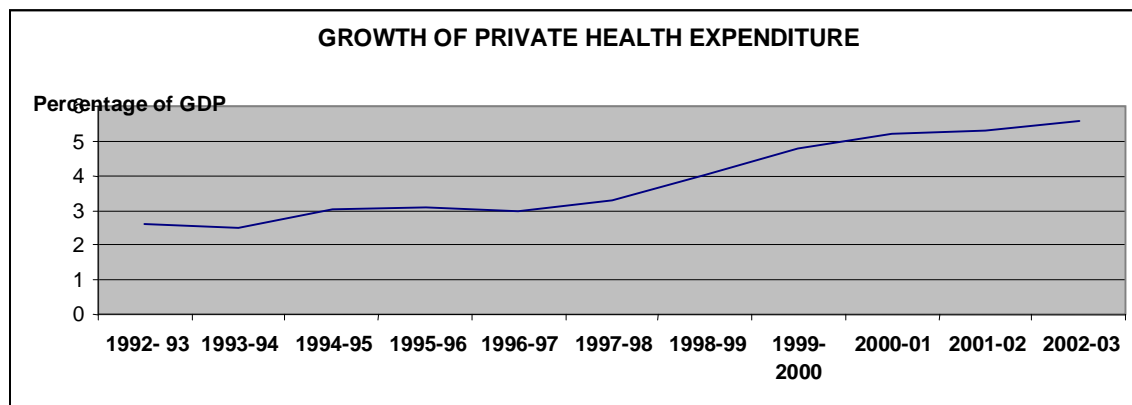


TABLE 3

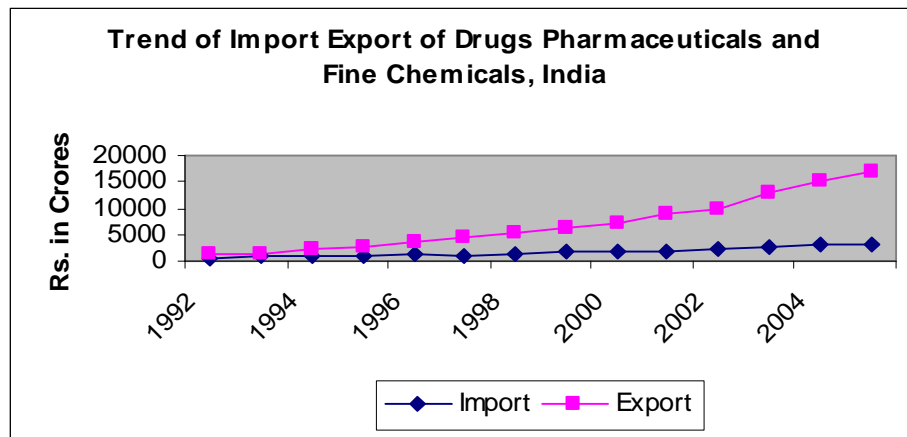
MANPOWER SHORTAGE IN RURAL AREAS

MANPOWER	REQUIRED	IN-POSITION	SHORTAGE
Dr. At PHC	23109	21974	880

Physicians	3222	895	1457
Obstetricians & Gynaecologists	3222	1189	1074
Surgeons	3222	1154	1121
Health Workers	165764	138906	11191

Health Information India, 2005

FIGURE 3



Centre For Monitoring Indian Economy, Mumbai

TABLE 4

TOTAL PUBLIC HEALTH EXPENDITURE (REVENUE + CAPITAL) TRENDS 1975-2003

AND SELECTED RATIOS

Year	Total Public Health Expenditure (Rs. billions)	Percent of GDP	Percent of Total govt. Expenditure	per capita (Rupees)	capital as ratio to revenue expend
1975-76	6.78	0.90	3.13	11.16	0.11
1980-81	12.86	0.99	2.96	18.94	0.08
1985-86	29.66	1.19	3.29	39.28	0.09
1991-92	56.40	0.96	2.96	65.89	0.08
1992-93	64.64	0.74	2.71	74.13	0.04
1993-94	76.81	0.98	2.89	86.21	0.04
1994-95	85.65	0.93	2.33	94.33	0.05
1995-96	96.01	0.89	2.47	103.57	0.04
1996-97	109.35	0.88	2.43	115.96	0.04
1997-98	127.21	0.92	2.50	132.65	0.05
1998-99	151.13	0.94	2.66	155.01	0.04

1999-00	172.16	0.96	2.61	173.72	0.05
2000-01	186.13	0.98	2.69	182.66	0.04
2001-02RE	211.06	1.02	2.72	203.53	0.05
2002-03BE	219.59	1.00	2.60	208.54	0.05

Source: 1. upto 1986 – Combined Finance and Revenue Accounts, respective years, GOI, New Delhi; 2. 1987 –2003 Finance Accounts of States and Union Government, respective years; and RBI – Finances of the State Governments, respective years, RBI, Mumbai; 3. GDP and Population data - National Accounts Statistics, CSO, 2003

TABLE 5

TRENDS IN HEALTH EXPENDITURE IN INDIA 1961 - 2003

		1961	1971	1981	1986	1991	1995	1998	2001	2003*
Health Expenditure In Rs. Billion	Public	1.08	3.35	12.86	27.15	50.78	82.17	126.27	178.54	209.41
	Private	2.05	6.18	29.70	90.54	146.98	279.00	459.00	981.68	1200.00
Health Expenditure as percent of Gross Domestic Product	Public	0.71	0.84	1.05	1.32	0.92	0.95	0.81	0.87	0.91
	Private	1.34	1.56	2.43	3.63	2.88	3.04	3.30	5.12	5.22
Health Expenditure as percent to Govt. Total Expenditure	Public	5.13	3.84	3.29	3.40	2.88	2.13	2.7	2.9	3.0

Source : Public= Finance Accounts, GOI and respective state govts.; Private = estimate from private consumption expenditures (from 1986 new series) National Accounts, EPW Foundation 2002, Mumbai; * private sector estimated by author

FIGURE 4

CHILD MORTALITY AMONG SOCIAL GROUPS

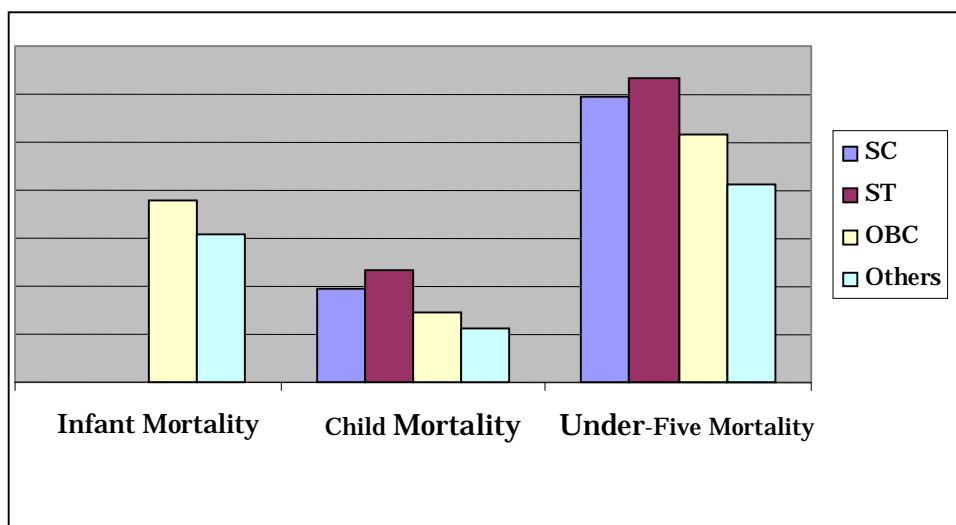


TABLE 6

Infant mortality rate by sex and residence, India 2002 (for bigger states, smaller states and union territories)

Bigger states

	Total			Rural			Urban		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
India	63	62	65	69	67	72	40	40	39
Andhra Pradesh	62	64	60	71	69	72	35	47	23
Assam	70	70	71	73	72	73	38	34	43
Bihar	61	56	66	62	57	67	50	47	53
Gujarat	60	55	66	68	60	76	37	39	34
Haryana	62	54	73	64	56	75	51	43	61
Karnataka	55	56	53	65	67	62	25	23	27
Kerala	10	9	12	11	8	14	8	11	4
Madhya Pradesh	85	81	88	89	85	94	56	60	51
Maharashtra	45	48	42	52	54	49	34	38	29
Orissa	87	95	79	90	101	80	56	45	69
Punjab	51	38	66	55	41	73	35	28	43
Rajasthan	78	75	80	81	79	83	55	49	62
Tamil Nadu	44	46	43	50	51	49	32	35	28
Uttar Pradesh	80	76	84	83	78	90	58	66	47
West Bengal	49	53	45	52	55	49	36	45	25

Smaller states

	Total		
	Total	Male	Female
Arunachal Pradesh	37	38	36
Chhatisgarh	73	76	70
Goa	17	18	16
Jharkhand	51	47	56
Himachal Pradesh	52	57	45
Jammu & Kashmir	45	49	41
Manipur	14	14	14
Meghalaya	61	60	62
Mizoram	14	16	11
Nagaland	N.A.	N.A.	N.A.
Sikkim	34	34	33
Tripura	34	35	34
Uttaranchal	41	38	46

Union territories

	Total		
	Total	Male	Female
Andaman & Nicobar islands	15	14	16
Chandigarh	21	22	21
Dadar & Nagar Haveli	56	61	51
Daman & Diu	42	55	27
Delhi	30	29	32
Lakshadweep	25	20	29
Pondicherry	22	22	23

Source: SRS Bulletin, 2004.

Note: • Due to part receipt of returns, data for Nagaland not given. Consequently the IMR estimates for India do not include figures for rural Nagaland.

•The IMR for smaller states and union territories are based on figures for three years. Due to wide annual fluctuations, the sex disaggregated IMR is not given for smaller states and union territories.

Body Mass Index (BMI) and anaemia among women of select groups

TABLE 6

Background characteristic	Mean BMI	Weight for height % with BMI			% of women with any anaemia	% of women with		
		< 18.5 kg/m ²	≥ 25.0 kg/m ²	≥ 30.0 kg/m ²		Mild anaemia	Moderate anaemia	Severe anaemia
Residence								
Urban	22.1	22.6	23.5	5.8	45.7	32.0	12.2	1.5
Rural	19.6	40.6	5.9	0.9	53.9	36.1	15.8	2.0
Education								
Illiterate	19.5	42.6	5.1	0.9	55.8	36.7	16.8	2.3
Literate- less than middle school	20.6	32.6	12.9	2.7	50.1	34.4	13.8	1.9
Literate- middle school complete	21.1	28.0	15.7	3.2	48.0	34.0	12.6	1.3
Literate-high school complete and above	22.5	17.8	26.0	6.4	40.3	29.7	9.7	0.9
Caste/tribe								
Scheduled caste	19.5	42.1	5.8	0.9	56.0	37.2	16.5	2.3
Scheduled tribe	19.1	46.3	3.3	0.5	64.9	41.2	21.4	2.3
Other backward class	20.2	35.8	9.4	1.7	50.7	34.3	14.5	2.0
others	21.0	30.5	15.4	3.7	47.6	33.3	12.9	1.5
Standard of living index								

Low	18.9	48.1	2.6	0.3	60.2	38.9	18.6	2.7
Medium	20.1	35.6	8.6	1.5	50.3	34.5	14.1	1.7
High	22.7	17.3	27.2	6.8	41.9	30.1	10.7	1.1

Source: NFHS-2.

Morbidity levels according to different NFHS rounds

Morbidity*	Urban		Rural		Total	
	Male	Female	Male	Female	Male	Female
(NFHS-2)						
Asthma	1,955	1,978	2,784	2,508	2,561	2,369
Tuberculosis#	446	330	690	507	624	460
Jaundice during the past 12 months	1,354	1,085	1,675	1,134	1,589	1,121
Malaria during the past 3 months	2,133	2,180	4,320	4,184	3,734	3,658
(NFHS-1)						
Blindness (partial)	1,972	2,666	2,482	2,900	2,346	2,839
Blindness (complete)	366	386	411	450	399	433
Tuberculosis	397	286	625	393	564	365
Leprosy	104	79	162	95	147	91
Physical impairment of limbs	671	439	814	513	776	494
Malaria during the past 3 months	1655	1810	3984	3804	3363	3283

Source: NFHS-1 and NFHS-2.

Note: *number of persons per 1,00,000 suffering from the stated ailments.

includes medically treated tuberculosis.

TABLE 7

Antenatal care received by select social groups in the country

Background characteristic	ANC only at home from health worker	ANC outside home* from			no ANC	% recd two or more TT injections	% given iron and folic acid tablets or syrup for 3+ months
		Doctor	Other health professional	TBA, Other			
Residence							
Urban	2.0	74.8	8.8	0.2	13.6	81.9	87.5
Rural	6.6	41.2	11.5	0.3	39.8	62.5	80.5
Education							
Illiterate	7.3	32.1	11.2	0.3	48.4	54.7	77.4
Literate- less than middle school	4.8	62.1	12.9	0.3	19.3	78.4	83.0
Literate- middle school complete	3.0	71.8	11.2	0.1	13.5	84.2	86.4
Literate-high school complete and above	1.2	85.4	7.2	0.1	5.8	91.2	90.4
Religion							
Hindu	6.2	47.2	11.2	0.2	34.5	66.5	82.5
Muslim	3.3	50.7	8.5	0.4	36.4	65.6	80.8
Christian	3.0	73.4	7.5	0.2	15.4	74.0	87.9
Sikh	1.3	44.7	29.0	0.0	24.9	87.5	80.7

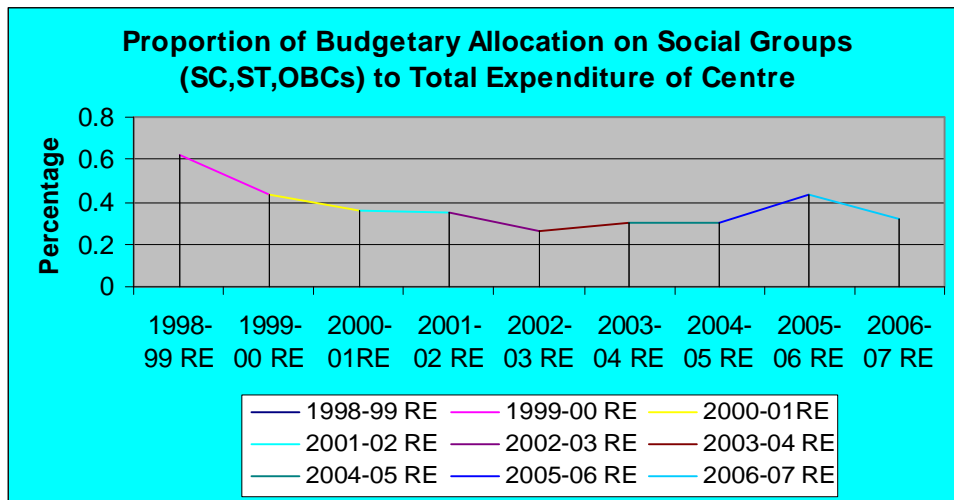
Jain	3.1	84.7	6.5	0.0	5.7	87.9	85.5
Buddhist/Neo-Buddhist	1.4	74.9	9.2	0.0	14.5	65.3	90.8
Other	0.3	59.9	15.7	0.1	19.7	52.0	89.0
No Religion	10.0	53.7	0.7	0.0	35.6	43.5	86.6
Caste/Tribe							
Scheduled caste	5.9	41.7	13.3	0.2	38.2	64.8	80.7
Scheduled tribe	10.0	34.7	11.5	0.3	43.1	46.4	81.6
Other backward class	5.9	48.9	9.6	0.2	34.8	68.4	84.9
others	4.0	56.5	10.6	0.2	27.9	72.2	82.0
Standard of Living Index							
Low	7.3	35.8	11.0	0.2	45.1	55.4	79.1
Medium	5.1	50.1	11.1	0.3	32.8	68.7	81.8
High	2.8	73.7	10.5	0.2	12.4	87.5	88.4
India Total	5.6	48.6	10.9	0.2	34.0	66.8	82.5

Source: NFHS-2

Note: Information based on two recent births in the three years preceding the survey.

• refers to births in which the women received ANC outside home, even if they might have received ANC at home. Though the woman might have received ANC from different types of providers, provider with the highest qualification shown.

Figure 5



Source: Response to the Union Budget 2006-07, CBGA (<http://www.cbgaindia.org/>)

Acknowledgements:

The report has been prepared by extensive reference from the book, *Review of Healthcare in India, A Country Health Report*, 2005 published by CEHAT and relevant documents from the Janaswasthya Abhiyan (People's Health Campaign, <http://phm-india.org/>) besides the available macro data on health and health status in India. The *Review of Healthcare in India* is an edited book published by CEHAT carrying chapters by experts on different issues related to health and healthcare in India health. It is available free of cost from CEHAT, Vakola Office, Mumbai. It can also be downloaded from the internet free of cost (<http://www.cehat.org/flib.html>).

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Centre for Enquiry into Health and Allied Themes