

Understanding of the Thailand health system and its lessons for immediate health plans in India.

This note tries to compare how the Indian health sector is organized and financed in comparison to how Thailand has organized its health care services . Broadly this note compares how they differ or are similar in managing human resources, organizing service delivery or in financing of health care.

- a) Both Thailand and India have about 4.5 % of GDP as total health expenditure but whereas in Thailand it is 70% public in India it is 70% private and out of pocket. Worth noting there are many states in India where we too have 70% as public expenditure on health care.
- b) Thailand is very similar to our nation in the organization of health care services, and indeed they began by studying the Kerala example closely. In the UHC discussion the description of Thailand is presented in such a manner as to make it appear very different from ours- but in practice this is not so.
- c) One area of difference is that they have solved the problems of **human resources for health** while we still struggle with it. This they have done by the following three steps
 - i. a much greater emphasis on nursing and nurse to doctor ratio of 4 : 1
 - ii. A very high incentive for working in rural and remote areas almost 100 to 150% of what the urban counterpart would take home. We have introduced incentives but these are too little.
 - iii. A medical and nursing education that is exclusively in the Thai language, reducing the pressures to emigrate, and more important closing the cultural gap between provider and the community.
- d) **In the area of service delivery** it is again a district hospital that provides the entire range of services- and almost always in public ownership and a primary care unit- which is the sum of a PHC and its outreach workers. This is not unlike our system with the following three key differences:
 - i. A district in Thailand is more or less like a block in India with respect to population, but in terms of the district health system it is the same. At the lowest level- *the primary care unit* they have 3to 6 nurses and about 5 voluntary CHWs per 1000 population and the population covered is 2000 to 5000. There is rural hospital at the 30,000 unit- though in some places it can cover as much as 60,000 population (equivalent of our PHC) with 2 to 8 doctor and about 10 nurses. The Thai district hospital is at the 1 to 2 lakh population level, but equipped and staffed like our district hospitals, which cater to 10 to 40 lakhs population.
 - ii. the free services in India available in the public health system are largely focused on maternal health and

immunization and a few diseases – all of which taken together account for about 18% of all morbidity, and a much lesser part of mortality. However in Thailand the “free” services in the public hospital is much more comprehensive. Thus Thailand clocks about 350 OPD visits per 11.5 in patients per 100 population per year in the public sector, whereas we would be having about 50 OP visits and 2.5 IP per 100 population- the rest being in the private sector.

- iii. Primary care is population based and the primary care unit is responsible for comprehensive care delivery to every household , with the major part of OP care happening at that level, whereas in India, in practice primary care providers only treat those coming to them- and even then refer very many to higher centers. It is important to note that in Thailand in the primary care level, those registered with a PCU would get all drugs free for every chronic disease they have. Thus a diabetic would get free anti-diabetics on every day of the year- whereas in India one would get free drugs only for four days to one week at the time of the visit to the facility.

The difference between India and Thailand in the former having opted for selective primary health care approach and the latter for a comprehensive primary care approach is instructive. Both started out with a serious effort at adoption of the comprehensive approach after the Alma Ata declaration on very similar lines. But a) Thailand government spends 244 US\$ per capita per year on health and India spends 38 US\$ per capita. b) Thailand does not have the fragmentation between of responsibility and finances between center and states, the way India has it and c) Thailand (like Brazil) were firm in their rejection of World Bank tutelage, and the entire influence of external donors for selective care and pro-market reforms in health care, and undue and exclusive obsession with MDG goals- whereas in India, we adopted it more or less completely.

- d. **In terms of financing**-they share this feature that the main source of public expenditure is from general taxation., but differ in that public expenditure accounts for 70% of care. There is a trend to project Thailand as having a UHC approach to financing –and following a capitation fee approach- and many take this to mean a sort of insurance cover or market like mechanisms and incentives. This would not be true at all. In our view the financing of health care in Thailand is a much better organized form of public financing- of ensuring that resource allocation is responsive to needs. They achieve this through the following steps:
 - i. Most primary care units are public providers- over 90%. The government provides them a resource allocation based on their population. In return there is a clear list of tasks they have to do, and the PCU team is held responsible for the same. This list of tasks is also part of a specific plan- and

PCUs can make different plans within their resource allocation- with some additional allocation as required. The salaries of the PCU team are fixed and flow through the treasury route (or whatever is the equivalent.) It does not change with performance. The infrastructure is supposed to be part of it- but in practice local politicians manage extra funds for this head- much like it happens here.

- ii. The district hospitals receive one flat amount plus they are reimbursed from the common state pool for the services they have provided. Insurance like mechanism without an insurance company. There are performance based incentives at this level, for doctors handling more cases and more complexity, but there are problems with this- and the jury is out on this. But anyway this is not the crux of it. District hospitals seeing referrals would provide free care- but those walking in may have to pay, especially if from outside the area. There can be private wards with co-payments in public hospitals and private practice for hospital doctors can be allowed- while preventing conflict of interest situations.
- iii. This reimbursement of care that is paid to hospitals is called insurance payments- but the difference is that most hospitals are public hospitals and almost everyone and every service is covered- making it in effect as sort of more flexible resource allocation.
- iv. Like us they have insurance scheme covering government servants- which is almost 4.5 times higher per capita spend than the general population and they have social security scheme like the ESI for covering organized workers which covers 15% of the population where the spend is the same as the general population.

In conclusion we can learn about incentives for working in rural areas, about moving from RCH care to comprehensive care and about more flexible financing and about larger budgets from them.

If government wants to learn from Thailand to make an immediate impact before 2014 it should make the following announcements

- a) Provision of year long free drugs and diagnostics to an expanded list of diseases, for the entire population delivered through PHCs and hospitals working as a continuum.
- b) Committing to supporting a much larger public health workforce with center taking a part of the load.
- c) much greater flexible and responsive district and primary care unit financing especially providing reimbursement for all care provided at DH and CHCs- and incentives over and above fixed salaries.
- d) increase of budgetary allocations to match the minimum proposed outlays of the 12th Five Year Plan.

We understand that there are many interpretations of Thailand- not the least because the Thais are so polite that they seldom disagree, and everyone hears what they want to hear. However our understanding is based on study of secondary material available, and discussion with leading public health professionals of Thailand and is consistent with the presentation made to the Hon Minister, which has been circulated to us for comments.

Yours Sincerely,

T. Sundararaman.

Annexure 1

HEALTH SYSTEM OF THAILAND

As a middle-income country, Thailand has come to be recognized as a success story in terms of its economic and social development. Thailand has strengthened its health system over the years with positive outcomes. In 2002 Thailand introduced universal healthcare for all Thai citizens. The 11th National Development Plan, 2012 – 2016 has proclaimed ‘quality’ and ‘universal security’ for all Thais as its main goal. In spite of considerable disparities across regions and social classes all health related Millennium Development Goals have been accomplished at the national level.

These successes notwithstanding, formidable challenges still confront Thailand on health front. The nature of development in Thailand has placed certain sections of the population at a considerably greater risk – for example large migrant and mobile population suffers from disproportionately higher burden of disease, public health hazards, exploitation and human trafficking. Even as public health challenges related to communicable diseases remain, non-communicable diseases and injuries have emerged as major public health hazards thus giving rise to a double burden of disease. HIV/AIDS, tuberculosis, malaria and emerging pathogens remain important and are compounded with emerging drug resistance particularly among mobile/border populations. Addressing these public health challenges would require multi-sectoral and multi-stakeholder collaboration taking into its fold the broader social determinants of health that underline the present health challenges (WHO, 2013e).

Thailand – Economic Profile

The complexion of Thai economy has metamorphosed from agriculture to services and manufacturing sectors over the past 50 years. From a share of 23% in the GDP in 1970, agriculture came down to 8.9% of GDP in 2009, while manufacturing increased from 21% to 39% of the GDP over the same period. Despite slumps in the economy associated with the economic crisis of 1996-97 and 2008-09, Thailand has achieved impressive economic growth rates over the past three decades. Industry, agriculture and tourism are the major sources of income for the country. With exports accounting for as much as 70% of the GDP, Thailand’s dependence on international trade has lent its economy particularly vulnerable to global financial and economic crisis (WHO, 2011e)

Thailand’s otherwise impressive economic growth has not succeeded in mitigating the enormous disparities between regions, between urban / rural localities. Time has failed to narrow down the gap between the rich and the poor, as per the ‘Thailand Human Development Report, 2009’. The wealth of the poorest quintile is about 3 to 4 times less than that of the richest quintile (WHO, 2011).

Thailand’s dramatic economic growth has produced new environmental challenges in this once agrarian society. The country now faces problems with air and water pollution, declining wildlife populations, deforestation, soil erosion, water scarcity, and hazardous waste (WHO, 2011).

Some of the selected economic indicators of Sri Lanka are (Index mundi, 2013f; *World Bank, 2013c):

- GDP (official exchange rate) – \$377 billion (2012 estimate)

- GDP – real growth rate - 5.6% (2012 estimate)
- GDP – per capita (PPP) - \$ 10,000 (2012 estimate)
- GDP – composition by sector – Agriculture (13%), Industry (43%), Services (44.1%)
- *Proportion of population living below \$1.25 a day – 0.4%

Socio-demographic Profile – Thailand

Demographic profile

Indicator	Year	Estimate	Source
Sex ratio (women / 100 men)	2011	104/100	UN statistics division*
Annual population growth rate (%)	2010-2015	.5	UN Population Division
% of population in urban areas	2011	34	UN Population Division
Annual rate of population change (%) – Urban / Rural	2010-2015	1.8/-0.2	UN Population Division
Crude birth rate (births per 1000 popl.)**	2012	12	World Bank
Crude death rate (deaths per 1000 popl.)**	2012	7	World Bank
Improved drinking water coverage (%) – Total/Urban/Rural	2008	98/99/98	UN statistics division*
Improved sanitation coverage (%) – Total/Urban/Rural	2008	96/95/96	UN statistics division*

Source: *United Nations Statistics Div. Available from: unstats.un.org/unsd/demographic/products/socindDec.../3c.xls on 10th of Feb 2013. **The crude birth and death rate data has been obtained from the World Bank data available from <http://data.worldbank.org/indicator/SP.DYN.CBRT.IN> and <http://data.worldbank.org/indicator/SP.DYN.CDRT.IN> respectively. The rest of data and source are as mentioned in - Country profile, Thailand, WHO. Available from 14th Feb 2013.

Literacy profile

Although Thailand has a very high literacy rate (almost 100%), there are still big differences in the proportions of higher-level education among people in provinces compared to Bangkok. Out of 134 universities and colleges, 65 are located in Bangkok, resulting in disparities of access to higher-level education (WHO, 2011).

Indicator	Year	Total	Men	Women	Girls share of enrollment
Adult (15+) literacy rate, by sex	2005	94	96	92	-
	2005	98	98	98	-
Youth (15-24) literacy rate, by sex	2009	-	90	89	48
	2004	-	68	77	51

Secondary net enrollment ratio, by sex	2009	-	53	40	56
Tertiary gross enrollment ratio, by sex					

Source: United Nations Statistics Division.

Employment profile

Indicator	Year	Total	Men	Women
Total labor force*	2011	39.77 million (2012 estimate)		
Employment by sectors (%)*	2010	Agriculture 40.7%, Industry 13.2%, Services 46.1%		
Adult unemployment (%)	2009**	-	1.2	1.1

Notes: *Source: Index mundi, 2013f. **United Nations Statistics Division, Available from unstats.un.org/unsd/demographic/products/socind/Dec.../5d.xls. on 12th Feb 2013.

Meta indicators

Indicator	Year	Value	Source
% Seats held by women in the national parliament	2011	13.3	Millennium Development Goals Indicators - UN.
Gender inequality index (GII)	2011	.382	UNDP International Human Development Indicators
Gender parity index in primary level enrolment (ratio of girls to boys)	2009	.98	Millennium Development Goals Indicators – UN
Global Hunger Index	2012	8.1	(IFPRI). Global Hunger Index 2012, 2012
Human Development Index (HDI)	2011	.682	UNDP International Human Development Indicators

Source: WHO Country Profile – Thailand, Available from: <http://apps.who.int/nutrition/landscape/report.aspx?iso=thaon> 12th Feb 2013.

Thailand healthcare services system and indicators

There are also inequities in access to quality health care in different parts of the country. Large gaps exist, for example, between Bangkok and the North-eastern Region in health resource distribution. The Bangkok area has significantly more beds and physicians per population than the North-eastern Region (Table 3). While private hospital beds account for about 25% of total beds, these mostly serve wealthy patients. Healthcare system in Thailand is characterized by unequal access to medical care by different social groups due to the rise in imported sophisticated technologies that increase the cost of medical services.

Selected health service indicators of Thailand:

Indicators	Value (Year)
Births attended by skilled health personnel (%)*	99.4 (2009)
Dentistry personnel density (per 10,000 population)	0.65 (2004)
Nursing and midwifery personnel density (per 10,000 population)	15 (2004)
Density of environment and public health workers (per 10,000 population)	0.4 (2000)
Density of pharmaceutical personnel (per 10,000 population)	1.17 (2004)
Physicians density (per 10,000 population)	3.0 (2004)

Hospital beds (per 10,000 population)*	22 (2008)
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Source: *WHO Country Profile – Thailand, Available from: <http://apps.who.int/nutrition/landscape/report.aspx?iso=tha> on 12th Feb 2013 and World Health Statistics, 2012. Other data is obtained from ‘Global Health Observatory Data’ of WHO.

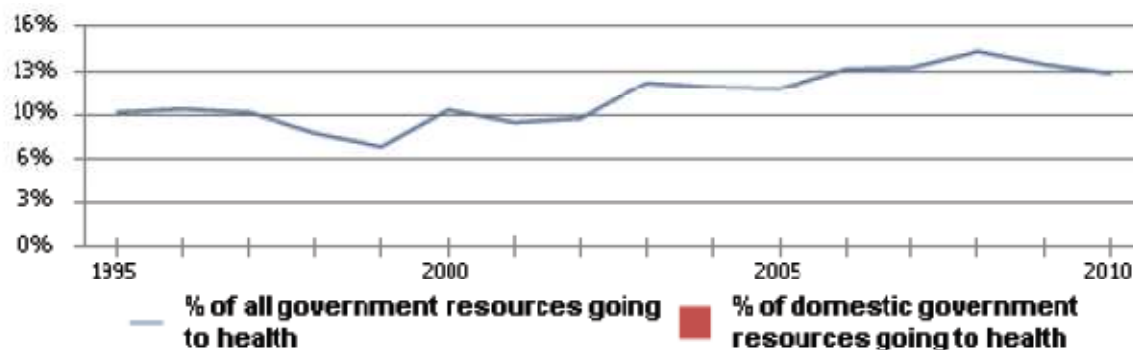
Health financing in Thailand

The following indicators for health financing are reflective of the political commitment of the state towards healthcare of the people.

Indicator	Year		
	2008	2009	2010
Total expenditure on health (TEH) as % of GDP	4	4.2	3.9
External resources on health as % of TEH	.3	.3	.3
General government expenditure on health (GGHE) as % of TEH.	76.2	74.6	75.0
Private expenditure on health (PvHE) as % of TEH	23.8	25.4	25
GGHE as % of general government expenditure	14.3	13.3	12.7
Private insurance as % of PvHE	26.7	28.5	31.4
Out of pocket expenditure as % of PvHE	60.9	59.6	55.8
Total expenditure on health / capita at purchasing power parity (NCU per US \$)	318	327	330
General government expenditure on health / capita at purchasing power parity (NCU per US \$)	242	244	247

Source: WHO, Thailand – Thailand- National Expenditure on Health (Thailand Bhat), Available from: Global Health Expenditure Database, WHO on 13th Feb 2013.

Government resources allocated to health



Source: WHO Global Health Expenditure Atlas, 2012, p 103.

Thailand – health outcome indicators

Indicator	Sex	Thailand	Regional average	Global average
Life expectancy at birth (yrs) (Data refers to yr 2010)	Male	66	64	66
	Female	74	67	71
	Both sexes	70	65	68
Infant mortality rate	Both	15.9		37 (2011)

(probability of dying between birth and age 1 per 1000 live births)	sexes	(2012 est.)*		
Under five mortality rate / 1000 live births (yr 2010)	Both sexes	13	57	57
Adult mortality rate (probability of dying between 50 and 60 years per 1000 population) (yr 2010)	Both sexes	205	209	176
Maternal mortality ratio (per 100 000 live births) (yr 2010)	-	48	200	210
Prevalence of HIV (per 1000 adults aged 15 to 49) (yr 2010)	-	13	3	8
Prevalence of tuberculosis per 100,000 population (yr 2010)	-	182	278	178

Source: WHO, Thailand Health Profile. Available from: <http://www.who.int/gho/countries/tha.pdf> on 13th Feb 2013.* Available from CIA World fact book at <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2091rank.html> on 9th April 2013.

Take home points

Positives

- Though not on a very high growth trajectory, Thailand has used its economic growth to address the developmental needs of its population and has successfully met all the Millennium Development Goals.
- Government bears nearly 3/4th of the total expenditure on health with private expenditure accounting for only 1/4th of the total health expenditure.
- Government's commitment to social security for all citizens along with very low levels of unemployment help in creating a situation where the subaltern sections of the society can seek services without compromising their dignity.

Negatives

- Despite its achievements in social sector, Thailand remains a highly unequal society.
- Dichotomy between the rich and the poor and between different regions of the country has resulted in differential access of the people to health services.
- The private sector comprising nearly 1/4th of the bed strength primarily caters to the rich while the poor access the public sector health facilities.

- High dependence of the Thai economy on export led economic growth renders its vulnerable to international economic shocks and therefore raise questions over the continuing viability of its social sector policies.

HEALTH SYSTEM OF INDIA

Economic Profile of India

Though India's Constitution enshrines her as a – 'sovereign, socialist, secular, democratic republic', it has fast emerged as an open market economy since the adoption of the '*new economic policies*' of '*globalization*', '*liberalization*' and '*privatization*' since the beginning of 1990s. In fact since late 1990s until 2010-11 India's economy grew at a unprecedented rate of 7 to 9 %, thus making it the second fastest growing economy after China. However, nearly two third of this growth has come from the growth of the services sector of the economy which accounts for barely one third of the labor force (Index mundi, 2013g). Even manufacturing sector has varied between stagnation or a very modest growth. Agricultural sector, though accounting for less than 20 percent of India's GDP, is still major source of employment for more than 50 percent of the workforce. Most importantly, India's economic growth has largely bypassed the agricultural sector of the economy with stagnation becoming the defining feature of Indian agriculture (World Bank, 2011). This period of 'neo-liberal' economic reforms has also been characterized by huge number of suicides by peasantry due to economic distress.

There are important consequences to India's growth story by passing the agricultural sector. Nearly 70 percent of the country's population still lives in rural areas where agriculture constitutes the bed rock of rural economy. Its stagnation leads to difficulties in tackling the problem of 'enormous poverty' and raising the living standards of the majority of its population. Even though about 30 percent of the population is below the measly official poverty line, the proportion below the international poverty line of \$ 1.25 a day is 33 percent.

This economic picture also explains very well the fact that while on one hand there is a section of the population that is becoming a victim of lifestyle / non-communicable diseases; on the other hand a very large section of the population continues to be the repository of infectious diseases (Quigley, 2006).

Some selected economic indicators of India are (Index mundi, 2013f):

- GDP (official exchange rate) - \$1.947 trillion (2012 est.)
- GDP - real growth rate - 5.4% (2012 est.)
- GDP - per capita (PPP) - \$3,900 (2012 est.)
- GDP - composition by sector- Agriculture (17%), Industry (18%), Services (65%) (2011 est.)
- Poverty head count ratios - 33 percent below \$ 1.25 expenditure a day; 30 percent below national poverty line (World Bank, 2013e).

Socio-Demographic Profile

Demographic profile

Indicator	Year	Estimate	Source
Sex ratio (women / 100 men)	2011	94	UN statistics division*
Annual population growth rate	2010-2015	1.3	UN statistics division

(%)	2011	30.3	UN statistics division
% of population in urban areas	2010-2015	2.4 / .8	UN Population Division
Annual rate of population change (%) – Urban / Rural	2010	22	
Crude birth rate (births per 1000 popl.)	2009	8	WHO country profile: India*
Crude death rate (births per 1000 popl.)	2008	88/96/84	WHO country profile: India*
Improved drinking water coverage (%) – Total/Urban/Rural	2008	31/54/21	UN statistics division
Improved sanitation coverage (%) – Total/Urban/Rural			UN statistics division

Source: * Country profile, India, WHO. Available from: <http://apps.who.int/gho/data/view.country.10400> on 11th April 2013. Rest of the data is from UN Statics Division.

Literacy profile

Indicator	Year	Total (%)	Men	Women	Girls share of enrollment
Adult (15+) literacy rate, by sex	2006	63	75	51	-
Youth (15-24) literacy rate, by sex	2006	81	88	74	-
Primary net enrollment ratio, by sex	2007	-	89	92	47
Secondary net enrollment ratio, by sex	2010	-	-	-	45
Tertiary gross enrollment ratio, by sex	2009	-	13	19	39

Source: United Nations Statistics Division.

It is noteworthy here that the proportion of women in education at all levels is less than 50 percent, while that for other countries women have a higher proportion, especially in higher education.

Employment profile

Indicator	Year	Total	Men	Women
Total labor force	2012 (est.)	498.4 million	-	-
Employment by sectors (%)	2011 (est.)	Agriculture (53%), Industry (19%), Services (28%)		
Adult unemployment (%)	2012 (est.)	9.9%	-	-

Source: Index mundi, 2013g.

Meta indicators

Indicator	Year	Value	Source
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% Seats held by women in the national parliament	2011	10.8	Millennium Development Goals Indicators - UN.
Gender inequality index (GII)	2012	0.61	UNDP International Human Development Indicators
Gender parity index in primary level enrolment (ratio of girls to boys)	2007	0.97	Millennium Development Goals Indicators – UN
Global Hunger Index	2012	22.9	(IFPRI). Global Hunger Index 2012, 2012
Human Development Index (HDI)	2012	0.554	UNDP International Human Development Indicators

India healthcare services system and indicators

The foundation of India's public health system was laid on the basis of the recommendations made by the 'Health Survey and Development Committee', popularly known as the 'Bhore Committee', in its report submitted in 1946. The Committee specified three levels of care – Primary (to be delivered by 'Primary Health Centre' and its associated Sub-Centers), Secondary level (to be delivered by a sub-district hospital at the level of a development block) and the Tertiary level (to be delivered through a tertiary care referral hospital at the district level).

Even though subsequent health planners retained the basic scheme of public health structure as proposed by Bhore Committee, the targets set by the Committee in terms of population norms, physical infrastructure and health manpower etc. could not be achieved till date. The development of health services in India has suffered from the colonial dichotomy of curative versus preventive and urban versus rural (Banerji, 1990; Duggal, 2003). Hence large hospitals to provide curative care came up in the bigger cities vis-à-vis preventive services for rural areas that were provided through a series of vertical disease control programs. Gradually, this led to the evolution of city based costly curative care for the rich, while public sector health care became synonymous with poor service for poor people. The economic liberalization pursued since 1990 has given further fillip to expansion of privately managed healthcare in India. The private sector accounts for more than 80 percent of healthcare in the country (PricewaterCoopers, 2007; CII & KPMG, undated).

It is in this context that the Government of India launched a series of social sector programs beginning 2005. The 'National Rural Health Mission' (NRHM) was launched with a view to reinvigorating the rural healthcare set up in the country. A series of measures were initiated under NRHM to reach out the healthcare services to the most marginalized of the sections of the population in the remotest areas of the country. This has resulted in some laudable achievements in public health in the country even though much still remains to be achieved in terms of improving country's health indicators.

Selected health service indicators of India:

Indicators	Value (Year)
Births attended by skilled health personnel (%)	52.7 (2008)
Dentistry personnel density (per 10,000 population)	0.8 (2008)
Nursing and midwifery personnel density (per 10,000 population)	10 (2008)

Density of environment and public health workers (per 10,000 population)	Not available
Density of pharmaceutical personnel (per 10,000 population)	5.2 (2006)
Physicians density (per 10,000 population)	6.5 (2009)
Hospital beds (per 10,000 population)*	9 (2005-11)

Source: WHO 'Global Health Observatory Data'. *Available from <http://www.globalhealthfacts.org/data/topic/map.aspx?ind=78> on 11th April 2013.

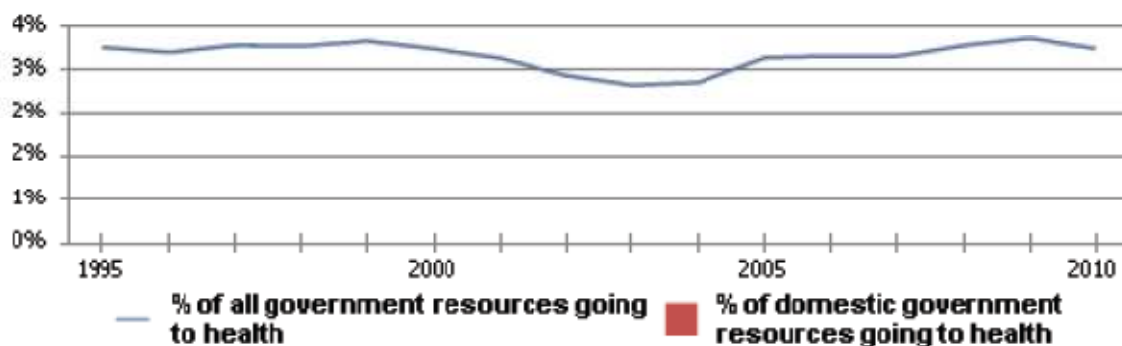
Health financing in India

The following indicators for health financing are reflective of the political commitment of the state towards healthcare of the people.

Indicator	Value (Year)		
	2008	2009	2010
Total expenditure on health (TEH) as % of GDP	4.0	4.2	4.1
External resources on health as % of TEH	1.7	1.1	1.2
General government expenditure on health (GGHE) as % of TEH.	27.6	30.3	29.2
Private expenditure on health (PvHE) as % of TEH	72.4	69.7	70.8
GGHE as % of general government expenditure	3.6	3.7	3.6
Private insurance as % of PvHE	4.1	4.6	4.6
Out of pocket expenditure as % of PvHE	87	86.4	86.4
Total expenditure on health / capita at purchasing power parity (NCU per US \$)	116	124	132
General government expenditure on health / capita at purchasing power parity (NCU per US \$)	32	38	39

Source: WHO, Cuba – National Expenditure on Health (Indian rupees), Available from: on 10th Apr 2013.

Government resources allocated to health



Source: WHO Global Health Expenditure Atlas, 2012, p 98.

India – health outcome indicators (2010)

Indicator	Sex	India	Regional average	Global average
Life expectancy at birth (yrs)	Male	63	64	66
	Female	66	67	71
	Both	65	65	68

	sexes			
Infant mortality rate (probability of dying between birth and age 1 per 1000 live births)	Both sexes	46.07*	51.64**	
Under five mortality rate / 1000 live births	Both sexes	63	57	57
Adult mortality rate (probability of dying between 50 and 60 years per 1000 population)	Both sexes	212	209	176
Maternal mortality ratio (per 100 000 live births)	-	200	200	210
Prevalence of HIV (per 1000 adults aged 15 to 49)	-	3	3	8
Prevalence of tuberculosis per 100 000 population	-	256	278	178

Source: WHO, India Health Profile, year 2010. Available from: <http://www.who.int/gho/countries/ind.pdf> on 10th Apr 2013. *Figure for IMR is obtained from Country profile India, Available at http://www.indexmundi.com/india/infant_mortality_rate.html on 11th April 2013. Regional IMR figure for South Asia is World Bank data from a report published in 2012. It is available from <http://www.tradingeconomics.com/south-asia/mortality-rate-infant-per-1-000-live-births-wb-data.html> on 11th April 2013.

Take home points

Positives

- Over the years India has developed an extensive network of health facilities to reach out to the remotest corners of the country.
- Launching of programs like NRHM shows government's commitment towards providing affordable and accessible healthcare to the people of the country, especially the marginalized sections.
- Despite huge variation in terrain, culture, ethnicity, infrastructure and economic development across different regions of the country, India has successfully implemented nationwide health programs which have resulted in consistent improvement in the health indicators of the country.

Negatives

- Despite robust economic growth in the last decade or so large sections of the Indian population have been left outside the ambit of social and economic progress. The official poverty line of the country continues to be defined very stingily thus preventing many people to avail of the facilities / concessions reserved for poor.
- Unlike in the case of other developing countries, women in India continue to lag behind in social and economic development which limits the scope of securing health of the families, especially the children.

- The fact that for profit sector is the dominant player in healthcare service provisioning makes it difficult to ensure the access of the poor to an affordable curative care. This is also a big limitation in leveraging public health goals of the government.
- Government expenditure on health continues to be a small percent of the total expenditure on health. Much of this expenditure is confined to provide preventive services to the people.