“We don’t have a plan B because there is no planet B”

Project Report

Health Indicators from Sustainable Development Goals and their trends across India and its states

2017

Atal Bihari Vajpayee Institute of Good Governance and Policy Analysis
“We don’t have a plan B because there is no planet B”

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Executive Summary

Mr. Ban Ki Moon, Former Secretary General of the United Nations (UN) famously said, **“We don’t have a plan B because there is no Planet B”.** To make life sustainable on this planet, the time to do something is now; to make sure every citizen of each country enjoys a good quality and healthy life is the duty of its government.

SDGs, often known as “Transforming the world: 2030 agenda for sustainable development” are a set of 17 goals with 169 targets between them. This initiative was spearheaded by the United Nations (UN) via a deliberative process involving the 193 member states and the global civil society. Since India is a member state, it is imperative that we ensure sustainable development in our country.

India has made remarkable advancements over the past 5 years in improving the health and well-being of its people. Owing to such developments, we have been able to reduce the neonatal mortality rate (per 1000 live births) from 32.7 in 2010 to 27.7 in 2015 (WHO Statistics Summary), for instance. India is currently in a paradigm shifting stage of evolving from infectious diseases to chronic non-infectious diseases. Despite these significant advances, India still continues to face a heavy burden of both, communicable and non-communicable diseases.

The health sector in the country faces many issues, for example, roles played by public and private entities, monetary expenditure and resource allocation, management of health services, quality of services and the workforce. But that does not discount the amount of effort put in by public and private sector to attain the desired goals. India is constantly working to improve its health strategies in place, integration of technology in the sector, and improvement of the outcome of the various health programs.

Following is a quick snapshot of the advancements the country has made over the past few years. In the following report, we will only talk about the goals and targets concerning health and the health related indicators outlined in goals 3 and 6 of Sustainable Development Goals (SDGs) in India and its states, and the trends observed therein. It should also be borne in mind that since the SDGs are **“integrated and indivisible”**, other goals and targets which are confounding on health will also be looked at. Although the health status of India is improving altogether, we have a long way to go to achieve 100% affordability, availability, accessibility and equitability in our healthcare delivery system. Following that train of thought, let’s take a look at the health indicators and their trends over the past few years in India.
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1. Introduction

Our country is in a state of health sector reform, like many other countries across the globe. Reform, in plain terms, implies rectifying or correcting the fundamental issues in health sector. This report presents an overview of the trajectory covered by the country and its states, throughout this reform, in terms of health related targets and indicators laid out in SDGs. Health was chosen to be central for this study as there is global consensus amongst high-level policy makers that health is central to sustainable development.

The objectives of the study were: 1. To compare the states and UTs across the country in terms of the health indicators laid out in the SDGs, 2. to assess the pace of movement towards the laid out targets in the SDGs, and 3. To create a “ready reckoner” that could be used by academicians, program planners, policy makers and decision makers at various levels of the government, to appraise the progress and direct more attention and resources to the indicators lagging behind, thus ensuring sustainable development of the country and its citizens, in its entirety.

The methodology employed for the study was Meta analysis of secondary sources available, following which four major sources of data were identified, viz. NITI Ayog, Worldbank, National Family and Health Survey 3 and 4, and Indiastat. For case specific data, such as neglected tropical disease, tuberculosis and crime records, specific departments were written to for information and data, such as National Leprosy Eradication program (NLEP), Revised National TB Control Program (RNTCP) and National Crime Records Bureau (NCRB), respectively.

In the current times wherein Sustainable Development has become a catchphrase, various government and non-government organizations have embraced it as the new model. Owing to that, huge amount of literature has emerged around sustainable development. This compilation is an attempt to bring it all together and represent the data from various sources, in its current form to bring forth the qualitative and quantitative analysis of the indicators laid out in SDGs.
2. Demographic indicators

a. Decade Population growth from 2001-2011 (in %):

The population of India is approximately 18% of the entire world’s population. Above is a graphical presentation of the three most populous countries in the world. It is noteworthy that the decadal growth rate of China is less than that of the USA and nearly 1/3rd of India.

Source: worldbank
b. Age-group profile:

Approximately 60% of India’s population is below 54 years of age indicating that majority of the population is in the labor force, thereby making the dependency ratio fall at 52.2.

Source: indexmundi
3. Economic Indicators

a. Gross national income per capita

Gross National Income has gradually improved over the past 16 years from $2240 to $6490.

Source: Worldbank
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b. **Total Telephone Subscribers (Wireless + Wireline)**

The telecom industry in particular has seen a dramatic increase in the number of subscribers during the last ten years, which in some way points to the increased market penetration of the telecom industry across the country.

Source: TRAI
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4. Sustainable Development Goals (SDG) specific Health Indicators

a. Neonatal Mortality Rate (Goal 3, Target 3.1, Impact Indicator): Number of newborns dying within the first 28 days of life per 1000 live births for a specified geographic region.

![Graph showing Neonatal Mortality Rate (NMR) in India]

Source: worldbank and NITI Ayog

While the numbers above do not show a remarkable change in the past few years, the NMR has decreased from 52 in 1990 to 28 in 2013, according to the State of newborn health in India, Journal of Perinatology. However, we still have a long way to go to achieve the target laid out in SDGs which is NMR at 12 by 2030.
Evidently from all the interventions aimed at reducing Infant Mortality Rate across the state, state of Madhya Pradesh has achieved about half the NMR within the span of three years (2011-2013) shown in the graph.

Source: NITI Ayog
b. **Infant Mortality Rate (IMR) (Goal 3, Target 3.2, and Impact Indicator):** IMR is defined as the number of deaths occurring under 1 year of age per 1000 live births (per year) for a specified geographic area.

![IMR for India](chart.png)

**IMR for India (Per 1,000 live births)**

Source: NITI Ayog and NFHS4

Infant Mortality Rate has seen a decline in the past 8 years which points to the impact of the various government interventions aimed at alleviating the numbers of infant mortality in the country.
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While almost all of the states are experiencing a declining trend, it is noteworthy that numbers for Chhattisgarh, Delhi, Jharkhand and Uttar Pradesh run an opposite trend.

Source: NITI Ayog and NFHS4
c. **Under-5 Mortality (Goal 3, Target 3.2, Impact Indicator):** Probability of dying between birth and exactly the age of 5 years for a child per 1000 live births (per year) for a specified geographic region.

Global target laid out in the SDGs for 2030 for the above indicator is at 25/1,000. While the numbers look impressive, we still have a long way ahead of us.
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States that have seen remarkable decline in U5MR are Assam, Bihar, Chhattisgarh, Jharkhand, Madhya Pradesh, Odisha and Rajasthan. Uttar Pradesh is hoping to gradually reach the targets.
d. **Maternal Mortality (Goal 3, Target 3.1, Impact Indicator):** The number of maternal deaths within 42 days of termination of pregnancy (puerperium) within a specified geographic region per 100,000 pregnancies.

![MMR in India (Per 1,00,000 pregnancies)](image)

**Source:** NITI Ayog

The NHM report 2017 reports the MMR at 230 for SRS 2011-13. The target laid out in the SDGs 3030 is at 70/100,000.
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Substantial change has been observed in the states viz. Assam, Chhattisgarh, Madhya Pradesh, Rajasthan and Uttar Pradesh. States approaching the laid out target are Andhra Pradesh and Tamil Nadu. And states which have achieved the target are Kerala and Maharashtra.

Source: NITI Ayog
e. **Adolescent Fertility Rate (Goal 3, Target 3.7, Impact Indicator):** Number of births per 1000 women aged 15 to 19 years of age.

![Adolescent Fertility Rate (15-19 years)](chart)

Source: Worldbank.org

NFHS 4 (2015-16) reports the % of population aged 15 – 19 years, who were already mothers or pregnant at the time of the survey was 7.9%, which is approximately half of what was reported in NFHS 3 (2005-06), i.e. 16%.
Higher age-specific fertility rates occur for a number of reasons which, more often than not, work synergistically and range from female illiteracy to lack of access to affordable family planning. All the states and union territories show furtherance in this area.
f. **Births attended by skilled health personnel (Goal 3, Target 3.1, Coverage Indicator):** According to the UN, the births attended by the skilled health personnel is the percentage of deliveries attended by the health personnel trained in providing life saving obstetric care, including giving the necessary supervision, care and advice to women during pregnancy, labor and post-partum period; conducting deliveries on their own and caring for newborns. It is noteworthy here that the traditional birth attendants, even if they have received a short training course, are not included in this category.

![Institutional Births in India (In %)](image)

Source: NFHS 3, 4

Institutional births have a direct bearing on Infant and Maternal Mortality Rates, which, as shown by the graph here, has remarkable improved which is also reflected in the graphs showing lowering of the Infant and Maternal Mortality Rates.
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Low performing states include Arunachal Pradesh, Meghalaya, and Nagaland. The remaining states and union territories have shown remarkable furtherance for this particular goal.

Source: NFHS3, 4
g. **Family planning Coverage (Goal 3, Target 3.7, Coverage Indicator):** For this indicator, we will look at the Unmet need for family planning, as it refers to the fertile women in the reproductive age group (15-49 years) who wish to postpone the next birth or stop childbearing altogether.

![Total Unmet Need for Family Planning](chart.png)

**Source:** NFHS3, 4

India has a long history of promoting family planning since 1935 when the National Planning Committee was set up by the Indian National Congress. However, we haven’t been able to achieve as much improvement as is acceptable for the growing social economy, family happiness and national planning.
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Total Unmet need for family planning

Source: NFHS3, 4
h. **Mortality due to Unsafe Water, Air pollution, Sanitation and Hygiene (WASH) (Goal 3, target 3.9, Impact Indicator and Goal 6, Target 6.1, 6.2, 11.6, Determinant Indicator).**

No state or UT reports mortality due to unsafe water directly. However, data for improved water sources, sanitation and clean household energy is available via NFHS.

- Water quality monitoring and Surveillance program runs as a component under the National Rural Drinking Water Program (NRDWP), under which funds are allocated to all the states and Union Territories. According to the latest data available for the year 2015, largest amount was allocated to Assam, Uttar Pradesh and Maharashtra.

- In lieu of directly correlated data of mortality due to unsafe water, mortality due to the most common waterborne disease in India, i.e. Cholera, has been graphically presented below.

![Cholera Deaths](source: Indiastat)
Rural Sanitation Coverage in India (In %)

Source: Ministry of Drinking Water and Sanitation

Rural Sanitation Coverage broadly includes liquid and solid waste disposal, domestic and environmental hygiene as well. The increase in the rural areas has been gradual as shown in the graph above.
Individual Household Lavatory Status of States and UTs

Source: Ministry of Drinking Water and Sanitation

A component of the sanitation coverage initiative, individual household lavatory status seems promising.
i. **Treatment of substance abuse disorders (Goal 3, Target 3.5, Coverage Indicator):** Following graph shows the coverage of the general population under the **scheme of Assistance for prevention of alcoholism and substance abuse in India and across the states.** The scheme was introduced in 1985-86 with further revisions in the years 94, 99 and 2008. The objective of the scheme is to:

a. Create awareness and educate people about the ill effects of alcohol and substance abuse.

b. To provide for the whole range of community based services for the identification, motivation, counseling, de-addiction, after care and rehabilitation for Whole Person Recovery (WPR) of addicts to make a person drug free, crime free and gainfully employed.

c. To alleviate the consequences of drug and alcohol dependence amongst the individual, the family and society at large;

d. To facilitate research, training, documentation and collection of relevant information to strengthen the above mentioned objectives; and

e. To support other activities which are in consonance with the mandate of the Ministry of Social Justice & Empowerment in this field.
For all the states and union territories, number of beneficiaries shows a decreasing trend except Gujarat and Maharashtra.
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Funds sanctioned and utilized under the scheme remain the same for the shown year.

Source: Indiastat.com
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j. **Communicable Diseases (Goal 3, Target 3.3, Impact Indicator):**
   a. **HIV/AIDS: Adult HIV prevalence (%) over the years:** Prevalence is the proportion of population in the given geographic region affected by the medical condition, in this case, HIV/AIDS.

While majority of the states and union territories show a declining trend, states and union territories showing unfavorable trend are Arunachal Pradesh, Assam, Delhi, Gujarat, Jharkhand, Punjab, Sikkim, Tripura, Chandigarh, Dadra and Nagar Haveli and Daman and Diu.
b. **Tuberculosis:** Incidence is defined as the number of new cases of a medical condition diagnosed within a geographic region in a year.

![TB Mortality (Per 1,00,000) in India over the years](chart)

Source: Indiastat

Caused by Mycobacterium Tuberculosis, most often affects the lungs and is curable and preventable. Vouching for the powerful initiatives of the country, the mortality has almost halved in the past 8 years.
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Evident from the graph the above, significant inter-state variations are reported, highest numbers in Uttar Pradesh, Maharashtra and Madhya Pradesh with Chhattisgarh and Rajasthan not far behind. Extremely well performing states and union territories include Daman and Diu, Goa, Haryana, Himachal Pradesh, Kerala, Manipur, Meghalaya, Mizoram, Nagaland and Tripura.

Source: Indiastat
c. Hepatitis B:

Mortality due to Hepatitis B in 2002

Source: Indiastat

Reporting for deaths due to Hepatitis B has not been up to par based on the data from Indiastat.
k. Non-Communicable Diseases (Goal 3, Target 3.4, Impact Indicator):

a. Breast Cancer

![Mortality due to Breast Cancer per 100,000 women diagnosed](image)

Source: Indiastat

Although there has been an increase in the awareness of breast cancer and benefits of early screening, most of the states and union territories show an increasing trend.
b. Cervical Cancer

Screening and early detection of cervical cancer will lessen the burden on the healthcare economy of the country to a large extent as it’s one of the leading cancers for women. However, the number of deaths due to cervical cancer does not seem to have changed much over the past couple of years.
c. Diabetes Mellitus

Diabetes is fast gaining the status of a national epidemic in India, as recorded in various research literatures on the morbidity. However, when we look at the record from the past two years, a mixed picture emerges with some states reporting high number of newly diagnosed cases, viz. Andhra Pradesh, Chandigarh, Madhya Pradesh, Odisha and Uttar Pradesh.
I. Interventions against and Mortality due to Neglected Tropical Diseases (NTDs) (Goal 3, Target 3.3, Impact Indicator)

**Leprosy**

The year 2008-09 started with 0.87 lakh cases on hand as on April 1st 2008, with prevalence rate (PR) of 0.74/10,000. The following graph plots the Annual Case Detection Rate and the Prevalence Rate for the country from 2004 through 2016.

![Leprosy in India Graph](image)

**Source:** National Leprosy Eradication Program
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While majority of the states are approaching the goal of eradicating leprosy, Odisha is lagging far behind.
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m. Suicide Mortality Rate (Goal 3, Target 3.4, Impact Indicator)

The World Health Organization (WHO) estimates that nearly 900 000 people worldwide die from suicide every year, including about 200 000 in China, about 170 000 in India, and 140 000 in high-income countries. The suicide mortality rate in India also hasn’t changed much owing to the rapid growth of population.

Source: Indiastat
The states with the highest number of suicides are Karnataka, Kerala, Madhya Pradesh, Maharashtra, Tamil Nadu, Telangana and West Bengal.
According to the report of the Ministry of Road Transport and Highways, Government of India, although the number of road accidents has dropped 4.1% during 2016, with the year seeing 4,80,652 road accidents as against 5,01,423 in the year 2015, deaths have risen 3.2% during the same time period.
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No. of people injured by road accidents in 2015

Source: Indiastat
During 2016, 13 States accounted for 86 per cent of the total road accidents in the country. These are Tamil Nadu, MP, Karnataka, Maharashtra, and Kerala, UP, AP, Rajasthan, Telangana, Gujarat, Chhattisgarh, West Bengal and Haryana. Similarly, 13 States accounted for 84 per cent of the total persons killed in road accidents during 2016. These are UP, Tamil Nadu, Maharashtra, Karnataka, Rajasthan, MP, AP, Gujarat, Telangana, West Bengal, Punjab, Haryana and Bihar.
o. **Mortality due to unintentional poisoning (Goal 3, Target 3.9, and Impact Indicator):** WHO defines poison as “any substance that can cause serious organ damage and/or death if ingested, inhaled or absorbed through skin”, therefore, mortality due to accidental ingestion of pesticides is represented below.

![Deaths in 2015 due to accidental ingestion of insecticide/pesticides](chart.png)

**Source: Indiastat**

It is interesting to note here that Madhya Pradesh is leading as a state where accidental ingestion of pesticide/insecticide has proved fatal.
p. Mortality due to Natural Disasters (Goal 3, 11 and 13, Target 11.5, 13.1, Impact Indicator)

The trend across all the states and union territories is ideal, i.e. declining.
q. **Homicides (Goal 16, target 16.1, Impact Indicator)**

Data reports significant variations amongst states and union territories. For instance, in states such as Arunachal Pradesh and Mizoram, number of victims of murder is very low when compared against states such as Bihar and Uttar Pradesh.
r. **Immunization Coverage (Goal 3, Target 3.8, and Coverage Indicator):** Children aged 12-23 months fully immunized (BCG, Measles, and three doses each of Polio and DPT in %).

![Immunization coverage graph](image)

Source: NFHS3, 4

Immunization coverage varies remarkably interstate. From the above graph, high performing states and union territories include Goa, Kerala, Lakshadweep, Puducherry, Sikkim, and West Bengal. States/Union Territories which need to further their efforts in this area include Arunachal Pradesh, Assam, Dadra and Nagar Haveli, Gujarat, Madhya Pradesh, Mizoram, Nagaland, Tripura, Uttar Pradesh and Uttarakhand.
s. Health Systems and HR Capacity (Goal 3, Target 3.8, Coverage Indicator):
   a. Physician density per 1000 of population hasn’t changed remarkably in the last decade, which points towards the severe gap in human resources and the healthcare delivery system in the country.

   ![Physician Density in India](chart.png)

   Source: worldbank

As the current discourse on Universal Healthcare debates the means of providing universal health coverage, one factor all stakeholders agree upon is the scarcity of doctors in the workforce. Evidently from the above graph, the parameter hasn’t changed, which poses a significant challenge to the country.
Evidenced by various researches and “on-ground” reality, there exists a severe nursing personnel gap in the current healthcare system in the country. The reasons are manifold ranging from international migration of nurses from India to more nurses preferring to work in urban areas.
c. Hospital beds per 1,000 population:

Number of beds available per 1,000 population has not seen much change over the past two decades. One major contributing factor is the population growth in the country.
d. Health expenditure per capita:

Health expenditure per capita by the government, in the form of activities performed by health institutions or healthcare personnel (medical, paramedical and nursing) and healthcare technology for the purpose of promoting, maintaining or restoring health of the population, has increased almost 4 times in the last decade.

Source: worldbank
t. **Emergency Preparedness:** Mainly looked after by the National Disaster Management Authority (NDMA), National Policy on Disaster Management and various institutions for capacity development for disaster management.

National Institute of Disaster Management is one of the premier institutions and it conducts various types of training programs, including, face-to-face training, web-based training, satellite based training, self-study courses, and capacity building programs for engineers and architects in earthquake risk management. NDMA conducts various mock exercises, table-top exercises, and panchayati raj institutions trainings. Tabulated below are the various mock exercises conducted by NDMA in the year 2009-10:

<table>
<thead>
<tr>
<th>S. No.</th>
<th>Disaster</th>
<th>State/s</th>
<th>No. of states where mock exercise conducted</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Earthquake</td>
<td>Uttarakhand, Arunachal Pradesh, Delhi, Meghalaya, Mizoram, HP, J&amp;K, Nagaland, A&amp;N Islands</td>
<td>9</td>
</tr>
<tr>
<td>2</td>
<td>Cyclone</td>
<td>Gujarat</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Floods</td>
<td>TN, Bihar, Chhattisgarh, Maharashtra</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Urban Fires</td>
<td>Haryana, Karnataka, J&amp;K, Sikkim</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>Chemical (Industrial)</td>
<td>Karnataka, Goa, TN, Punjab, MP, Maharashtra, Gujarat</td>
<td>7</td>
</tr>
<tr>
<td>6</td>
<td>Terrorist Related</td>
<td>Delhi</td>
<td>1</td>
</tr>
</tbody>
</table>

NDMA conducts various awareness campaigns through electronic and print media. Government of India has also set up Disaster Management Centers in each State and UT, listed below.
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<table>
<thead>
<tr>
<th>S. No.</th>
<th>State/UT</th>
<th>Location</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>Hyderabad</td>
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<td>2</td>
<td>Arunachal Pradesh</td>
<td>Itanagar</td>
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<td>3</td>
<td>Assam</td>
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<td>Bihar</td>
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<td>Chhattisgarh</td>
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<td>New Delhi</td>
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Sustainable development is a global goal and is supported by countries around the world. The developments in India pertaining to the laid out goals and targets is underpinned by a strong body of evidence, based on which this document has been prepared. The crucial question, which still remains is “Has the battle been won?”

While this document directs us to a promising development and much desired reform in the health domain of our country, many challenges still remain which need to be timely and adequately addressed. Nationally, there are a few areas of concern which evidently require immediate attention, viz. physician density per unit of population, nursing personnel density per unit of population and beds per unit of population.

To ensure delivery of quality health services to the masses, it requires, among other things that the health personnel supply is met with the demand of the population and its needs. High physician density is associated with lower incidence rate of many communicable and non-communicable diseases, which significantly lowers the economic burden of health on the state and the nation. According to the WHO, 45% of the WHO member states report less than 1 physician per 1,000 population. That being said, USA, country with one-fourth of the Indian population has a physician density of 2.5/1,000. China, with more population than us, reports physician density at 1.8/1,000 population. The situation needs immediate remedial measure, for instance, encouraging a higher number of youth cohorts to take up medicine/nursing/paramedical courses as a career and pursue admission into medical/nursing colleges, which in turn, will require increasing the pay of the healthcare personnel, from the lowermost rung to the highest one in the ladder (from duty medical officer to the super specialist in the district hospital) and better working conditions. State may also consider increasing the intake of students into the medical schools, or at least discuss raising it. To tackle the inequalities in geographic distribution of physicians, the state government also has

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educational and regulatory policies that may need a revisit. Against the rising trend of medical students running towards super specialties, enhanced and amplified awareness and attractiveness can be built in the careers of primary care setups. May be the government takes a page from the corporate sector and devises a payment system for physicians which reward the quality of care directly, wherever that is feasible.

At Madhya Pradesh state level, when infant mortality and maternal mortality are addressed at war-footing, which is reflected in the lowered IMR and MMR rates and higher percentage of institutional deliveries in the past decade, mortality due to non-communicable diseases is observed to be following an increasing trend. More in-depth research is required to study the usage of non-communicable disease set up in the state and to study the “perceived susceptibility, “perceived severity” and “cues to action” of the state-wide population.

Another area of concern is the increase in the number of deaths due to accidental ingestion of insecticides and pesticides. A remedial measure to counter this conundrum and reducing mortality and infirmity can be better medical management of these cases and restrictions on the most toxic products along with better farmer education and awareness building.

Aforementioned recommendations are intended to bring health related governance to center stage within the state. Also, it is of crucial importance to realize that inter-sectoral coherence and coordination of effort is absolutely mandatory to reach a state of acceptable health of the state population. It is well known that during the setting up meeting of the targets for sustainable development of health, it was vividly argued that the targets present an “unattainable utopia” for which the aid assistance from the OECD countries needs to be increased.

It is sincerely hoped that the report is used by policy makers, academicians, decision makers and program planners at various levels of the government to appraise the progress, monitor and evaluate the performance, and thereby put forth the country on the path of sustainable development in health of its citizens. It is to be borne in mind that a great deal in terms of health has been achieved; however, if we do not maintain our commitment to sustainable development in health, the progress can be easily reversed.
“We don’t have a plan B because there is no planet B”