



## **India - Researched and compiled by the Refugee Documentation Centre of Ireland on 16 October 2012**

### **Information on the Indian health care system**

A Country Health System Profile by the World Health Organizations states under the heading 'Organization of the health system':

"The healthcare services' organization in the country extends from the national level to village level. From the total organization structure, we can slice the structure of healthcare system at national, state, district, community, PHC and sub-centre levels.

National level – The organization at the national level consists of the Union Ministry of Health and Family Welfare. The Ministry has three departments, viz. – Health, Family Welfare, and Indian System of Medicine and Homeopathy, headed by two Secretaries, one for Health and Family Welfare and the other for ISM and H. The department of Health is supported by a technical wing, the Directorate General of Health Services, headed by Director General of Health Services (DGHS).

State level - The organization at State level is under the State Department of Health and Family Welfare in each State headed by Minister and with a Secretariat under the charge of Secretary/Commissioner (Health and Family Welfare) belonging to the cadre of Indian Administrative Service (IAS). By and large, the organizational Structure adopted by the State is in conformity with the pattern of the Central Government. The State Directorate of Health Services, as the technical wing, is an attached office of the State Department of Health and Family Welfare and is headed by a Director of Health Services. However, the organizational structure of the State Directorate of Health Services is not uniform throughout the country. For example, in some states, the Programme Officers below the rank of Director of Health Services are called Additional Director of Health Services, while in other states they are called Joint/Deputy Director, Health Services. But regardless of the job title, each programme officer below the Director of Health Services deals with one or more subject(s). Every State Directorate has supportive categories comprising of both technical and administrative staff.

The area of medical education which was integrated with the Directorate of Health Services at the State, has once again shown a tendency of maintaining a separate identity as Directorate of Medical Education and Research. This Directorate is under the charge of Director of Medical Education, who is answerable directly to the Health Secretary/Commissioner of the State. Some states have created the posts of Director (Ayurveda) and Director (Homeopathy). These officers enjoy a larger autonomy in day-to-day work, although sometimes they still fall under the Directorate of Health Services of the State.

Regional level – In the state of Bihar, Madhya Pradesh, Uttar Pradesh, Andhra Pradesh, Karnataka and others, zonal or regional or divisional set-ups have been created between the State Directorate of Health Services and District Health Administration. Each

regional/zonal set-up covers three to five districts and acts under authority delegated by the State Directorate of Health Services. The status of officers/in-charge of such regional/zonal organizations differs, but they are known as Additional/Joint/Deputy Directors of Health Services in different States.

District level - In the recent past, states have reorganized their health services structures in order to bring all healthcare programmes in a district under unified control. The district level structure of health services is a middle level management organisation and it is a link between the State as well as regional structure on one side and the peripheral level structures such as PHC as well as sub-centre on the other side. It receives information from the State level and transmits the same to the periphery by suitable modifications to meet the local needs. In doing so, it adopts the functions of a manager and brings out various issues of general, organizational and administrative types in relation to the management of health services. The district officer with the overall control is designated as the Chief Medical and Health Officer (CM & HO) or as the District Medical and Health Officer (DM & HO). These officers are popularly known as DMOs or CMOs, and are overall in-charge of the health and family welfare programmes in the district. They are responsible for implementing the programmes according to policies laid down and finalized at higher levels, i.e. State and Centre. These DMOs/CMOs are assisted by Dy. CMOs and programme officers. The number of such officers, their specialization, and status in the cadre of State Civil Medical Services differ from the State to State. Due to this, the span of control and hierarchy of reporting of these programme officers vary from state to state.

Sub-divisional/Taluka level – At the Taluka level, healthcare services are rendered through the office of Assistant District Health and Family Welfare Officer (ADHO). Some specialties are made available at the taluka hospital. The ADHO is assisted by Medical Officers of Health, Lady Medical Officers and Medical Officers of general hospital. These hospitals are being gradually converted into Community Health Centres (CHCs).

Community level – For a successful primary healthcare programme, effective referral support is to be provided. For this purpose one Community Health Centre (CHC) has been established for every 80,000 to 1, 20,000 population, and this centre provides the basic specialty services in general medicine, pediatrics, surgery, obstetrics and gynecology. The CHCs are established by upgrading the sub-district/taluka hospitals or some of the block level Primary Health Centres (PHCs) or by creating a new centre wherever absolutely needed.

PHC level – At present there is one Primary Health Centre covering about 30,000 (20,000 in hilly, desert and difficult terrains) or more population. Many rural dispensaries have been upgraded to create these PHCs. Each PHC has one medical officer, two health assistants – one male and one female, and the health workers and supporting staff. For strengthening preventive and promotive aspects of healthcare, a post of Community Health Officer (CHO) was proposed to be provided at each new PHC, but most states did not take it up.

Sub-centre level – The most peripheral health institutional facility is the sub-centre manned by one male and one female multi-purpose health worker. At present, in most places there is one sub-centre for about 5,000 populations (3,000 in hilly and desert areas and in difficult terrain).” (World Health Organization (undated) *Country Health System Profile - India*)

A report by the UN Human Rights Council states under the heading 'Right to Health':

"UNICEF reported on the eight states with the highest under-five mortality rate and that two-thirds of maternal deaths occurred in Bihar, Jharkhand, Orissa, Madhya Pradesh, Chhattisgarh, Rajasthan, Uttar Pradesh, Uttaranchal and Assam. The best performing state was Kerala. In 2010, the Special Rapporteur on the right to health stated that India had a legally binding international human rights obligation to devote its maximum available resources to the health of its population. Public spending on health that continued to bracket India with "the lowest in the world" was in breach of this international legal obligation. In many districts, life-saving care was unavailable to women giving birth. Recourse to the private sector impoverished many women and their families. The Special Rapporteur concluded that in India, monitoring, accountability and redress in relation to the public and private health sectors were egregiously underdeveloped. CESCR urged India to take all necessary measures to ensure universal access to affordable primary health care; and to take effective measures to fully implement the National Rural Health Mission (2005-2012).

In 2010, the Special Rapporteur on the right to health stated that the rate of maternal deaths in India was shocking. Taking into account resource availability, the Special Rapporteur considered that India was in breach of its right to health obligations because it fell far short of having a sufficient number of skilled birth attendants. There was a gulf between India's commendable maternal mortality policies and their urgent, focused, sustained, systematic and effective implementation. The Special Rapporteur strongly recommended that the Government urgently establish an independent body to accelerate progress by galvanizing action and ensuring that those in authority properly discharge their responsibilities to reduce maternal mortality. CESCR recommended that India expand availability of and accessibility to reproductive and sexual health information and services. " (UN Human Rights Council (11 April 2012) *Compilation : [Universal Periodic Review] : India / prepared by the Office of the High Commissioner for Human Rights in accordance with paragraph 5 of the annex to Human Rights Council resolution 16/21, A/HRC/WG.6/13/IND/2, p. 12*)

A report by Inter Press Service states:

"The latest review of the National Rural Health Mission (NRHM), released last week, speaks of continuing difficulties in providing free drugs to patients and "the imperative of prescribing medicines from outside," when the government is committed to raising public spending on health from 0.9 percent of gross domestic product to two to three percent of GDP.

Many public hospitals, says NRHM – which has the stated goal of improving the availability of and access to quality healthcare for people, especially those residing in rural areas, the poor, women and children – now run commercial pharmacy shops within their premises.

What that means is that patients who do not have the cash to buy medicines with may have to do without them. The same goes for the hospital canteens from where patients are expected to buy food for themselves and their attendants.

In sharp contrast to the services at the RMS centre are the swish hospitals dotting the capital that cater to the health needs of the well-to-do and to a burgeoning medical tourism industry that attracts 450,000 foreign patients each year.

Hospitals such as the 'Indraprastha Apollo,' which ranks among the world's biggest private health facilities, do not allow attendants and provide patients with meals prepared under the careful supervision of dieticians.

Reflecting the paradox, Britain's Oxford University commented in a study released in March last year that "quality healthcare remains inaccessible throughout the country [India] despite the presence of a highly skilled and qualified medical workforce."

According to the study one million Indians die every year as a result of inadequate healthcare and that 700 million of India's 1.1 billion people have no access to specialist care simply because 80 percent of specialists live in urban areas.

The NRHM, which runs from 2005 to 2012, was set up after the government recognised that curative services favour the rich and that for every dollar spent on the poorest 20 percent of the population, three dollars are spent on the richest quintile.

Only 10 percent of Indians have some form of health insurance, mostly inadequate, and hospitalised Indians spend, on average, 58 percent of their total annual expenditure on medical care.

The NRHM also acknowledges that over 40 percent of hospitalised Indians borrow heavily or sell assets to cover medical expenses and that over 25 percent of hospitalised Indians fall below the poverty line because of hospital expenses." (Inter Press Service (2 January 2010) *Health-India: Hunger Haunts Hospitals*)

The US Travel.State.Gov states under the heading 'Medical Facilities and Health Information':

"The quality of medical care in India varies considerably. Medical care in the major population centers approaches and occasionally meets Western standards, but adequate medical care is usually very limited or unavailable in rural areas." (United States Travel.State.Gov (3 April 2012) *India - Country Specific Information*)

The UK Foreign and Commonwealth Office states:

"Local medical facilities are not comparable to those in the UK, especially in more remote areas. In major cities private medical care is available, but expensive. A list of the most commonly used can be found on the British High Commission website. For psychiatric illness, specialised treatment may not be available outside major cities." (UK Foreign & Commonwealth Office (1 October 2012) *Travel Advice – India*)

Amnesty International's annual report states:

"According to official estimates, India's poor accounted for between 30 and 50 per cent of the country's population. At least 15 per cent of the population were leading a precarious existence in urban slums without proper access to health care, water, food

and education.” (Amnesty International (24 May 2012) *Amnesty International Annual Report 2012 - India*)

The US Department of State report under the heading ‘Reproductive Rights’: “

“The laws provide reservations for government jobs and subsidies to those who have no more than two children and reduced subsidies and access to health care for those who have more than two... According to the 2011 UN Population Fund State of World Population Report, the maternal mortality ratio was 230 deaths per 100,000 live births in 2008. The major factors influencing the high maternal mortality rate were lack of adequate nutrition, medical care, and sanitary facilities. The World Bank estimated that 75 percent of women received some prenatal care during the year, and the World Health Organization (WHO) estimated 47 percent of births were attended by skilled help, 75 percent of women made at least one prenatal visit, and 50 percent made at least four prenatal visits.” (United States Department of State (24 May 2012) *2011 Country Reports on Human Rights Practices - India*)

This report also states under the same heading:

“The government and NGOs started numerous initiatives to improve women and children's health, including providing financial incentives for women willing to give birth in a hospital, improving midwife training, and increasing prenatal care via text messages, which provide information on vaccinations, exercise, diet, medication, and how to deal with emergencies that arrive during pregnancy.

The National AIDS Control Organization (NACO), which formulates and implements programs for the prevention and control of HIV and AIDS, reported that women accounted for about one million of the estimated 2.5 million citizens with HIV/AIDS. Infection rates for women were highest in urban communities, and care was least available in rural areas. Traditional gender norms, such as early marriage, limited access to information and education, and poor access to health services continued to leave women especially vulnerable to infection. NACO actively worked with NGOs to train women's HIV/AIDS self-help groups.” (Ibid)

This report states under the heading ‘People with Disabilities’:

“The MHFW [Ministry of Health & Family Welfare] estimated that 6 to 7 percent of the population suffered from a mental or psychosocial disability and that 25 percent of the mentally ill were homeless. Disabled rights activists estimated that the country had 40 to 90 million persons with disabilities.

Most of those with mental disabilities were dependent on public health-care facilities and fewer than half of those who required treatment or community support services received such assistance. There was a severe shortage of trained staff; a WHO report released in September 2010 estimated that the country had less than one psychiatrist for every 300,000 persons, and most psychiatrists worked in urban areas. In rural areas the ratio shrank to less than one psychiatrist per one million persons. Continued lack of awareness about mental disability led many patients, particularly in rural areas, to seek assistance from traditional healers before seeking regular medical treatment.” (Ibid)

Human Right Watch's World Report states:

"Despite repeated claims of progress by the government, there was no significant improvement in access to health care and education." (Human Rights Watch (22 January 2012) *World Report 2012 - India*)

This report also states:

"Despite considerable progress on maternal health, vast disparities remain and a spate of maternal deaths continues to be reported from Madhya Pradesh and Rajasthan states." (Ibid)

An article by the Times of India states:

"India has, in effect, one of the most privatized healthcare systems in the world. World Bank data for 2010, the latest available, shows that public expenditure on health in India was just 29.2% of total health spending, against the global average of 62.8%.

The only countries for which data was available with a lower proportion of public spending to total spending on health were Guinea Bissau, Guinea, Sierra Leone, Afghanistan, Myanmar, Azerbaijan, Haiti, Ivory Coast, Uganda, Georgia, Yemen, Chad and Tajikistan. Not only was India's proportion of public expenditure to total spending on health considerably lower than the global average, it did not even come close to matching the average for "low income" countries, which was 38.8%. Even sub-Saharan Africa, with 45.3%, was doing significantly better.

Taken along with the data on how much of the GDP total health expenditure accounts for, India's figures make for even more dismal reading, with the global average being 10.4% of GDP.

The figure for OECD, a club of the world's most economically developed countries, was 12.9%. Middle-income countries, a group that includes India, averaged 5.7% and even low-income ones registered 5.3%. Against this, India spent a measly 4.1% from all sources of health.

Put the two sets of numbers together and what it tells us is that India's public expenditure on health was equivalent to a mere 1.2%. That's against a global average of 6.5%, an OECD average of 8.4%, a middle-income countries level of 3.0% and 2.1% for low-income countries as a whole. Once again, sub-Saharan Africa with public health expenditure equivalent to 2.9% of GDP does considerably better than India.

In short, not only does India spend less on healthcare than most of the world, including countries which are significantly worse off economically, even what little is spent comes largely from private sources." (Times of India (8 August 2012) *India's healthcare: It's a privatized system anyway*)

A report in the Sunday Telegraph of Australia states:

"India is moving ahead with ambitious plans to spend nearly \$5 billion to supply free drugs to patients, bringing the country closer to universal health care.

The 'game-changing' scheme, in the words of one top Indian health ministry official, is part of the government's latest five-year spending program and is expected to start in October. The Congress government will pay 200 billion rupees or \$3.52 billion while India's 29 states will be asked to kick in 66 billion rupees (\$1.17bn) over the next five years, a statement said.

This initiative 'would be a giant step in vastly expanding the access to medicines' in the country of 1.2 billion people, Ministry of Health joint secretary Arun Panda said.

The plan is set for formal approval next month but the drug scheme has already received its first chunk of 10 billion rupees from India's Planning Commission for 2012-13. Prime Minister Manmohan Singh, a champion of the so-called 'free-medicines-for-all' scheme, has also asked the health ministry to set up a central drugs procurement agency.

'This starts us on the road to universal health care,' K. Srinath Reddy, head of the Public Health Foundation of India, said.

'It won't happen overnight. It may be 10 or 15 years but we're on our way,' said Reddy, who chaired a high-level government panel that laid out a roadmap for universal coverage." (Sunday Telegraph (Australia) (8 July 2012) *\$5bn boost for India's health care system*)

Please also see Health Action International (December 2011) *Report on availability, prices and affordability of medicines in the private and public sector.*

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This response was prepared after researching publicly accessible information currently available to the Refugee Documentation Centre within time constraints. This response is not and does not purport to be conclusive as to the merit of any particular claim to refugee status or asylum. Please read in full all documents referred to.

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