Healthcare in India

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Healthcare in India features a universal health care system run by the constituent states of India. The Constitution charges every state with "raising the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties". The National Health Policy was endorsed by the Parliament of India in 1983 and updated in 2002.

Parallel to the public health sector, and indeed more popular, is the private medical sector in India. Both urban and rural Indian households tend to use private medical sector more frequently than public sector.

Organization of the health system

The healthcare services in India extend 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. All the organizational levels necessary for an efficient Health for All Strategy are present.

1- 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 (ISMH), 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).

2- 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. But regardless of the job title, each programmer 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.

3- 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.

4- District level - In the recent past, states have reorganized their health services structures in order to bring all healthcare programmers in a district under unified control. The district level structure of health services is a middle level management organization 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 programmers in the district. They are responsible for implementing the programmers according to policies laid down and finalized at higher levels, i.e. State and Centre. These DMOs/CMOs are assisted by programmer 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 programmer officers vary from state to state.

5- Community level - For a successful primary healthcare programmer, 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 Centers (PHCs) or by creating a new centre wherever absolutely needed.

6- 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).

The 73rd and 74th constitutional amendments have given the powers to the local bodies in some states of India. In the process, different states have adopted different stakeholders for the benefit of health services, with the help of community participation, which gives stress on safe drinking water and sanitation at village level. The Panchayats are given the power to look after the welfare of the people

HEALTHCARE ISSUES

Malnutrition

42% of India's children below the age of three are malnourished, which is greater than the statistics of sub-Saharan African region of 28%. Although India's economy grew 50% from 2001–2006, its child-malnutrition rate only dropped 1%, lagging behind countries of similar growth rate. Malnutrition impedes the social and cognitive development of a child, reducing his educational attainment and income as an adult. These irreversible damages result in lower productivity.

High infant mortality rate

Approximately 1.72 million children die each year before turning one. The under-five mortality and infant mortality rates have been declining, from 202 and 190 deaths per thousand live births respectively in 1970 to 64 and 50 deaths per thousand live births in 2009. However, this rate of decline is slowing. Reduced funding for immunization leaves only 43.5% of the young fully immunized. A study conducted by the Future Health Systems Consortium in Murshidabad, West Bengal indicates that barriers to immunization coverage are adverse geographic location, absent or inadequately trained health workers and low perceived need for immunization. Infrastructure like hospitals, roads, water and sanitation are lacking in rural areas. Shortages of healthcare providers, poor intra-partum and newborn care, diarrheal diseases and acute respiratory infections also contribute to the high infant mortality rate.

Diseases

Diseases such as dengue fever, hepatitis, tuberculosis, malaria and pneumonia continue to plague India due to increased resistance to drugs. And in 2011, India developed a Totally drug-resistant form of tuberculosis. India is ranked 3rd among the countries with the most HIV-infected. Diarrheal diseases are the primary causes of early childhood mortality. These diseases can be attributed to poor sanitation and inadequate safe drinking water in India.

However in 2012 India was polio free for the first time in its history. This was achieved because of Pulse Polio Programme was started in 1995-96 by government of India.

Indians are also at particularly high risk for atherosclerosis and coronary artery disease. This may be attributed to a genetic predisposition to metabolic syndrome and changes in coronary artery vasodilation. NGOs such as the Indian Heart Foundation and the Medwin Foundation have been created to raise awareness about this public health issue.

Poor sanitation

As more than 122 million households have no toilets, and 33% lack access to latrines; over 50% of the population (638 million) defecates in the open. This is relatively higher than Bangladesh and Brazil (7%) and China (4%). Although 211 million people gained access to improved sanitation from 1990–2008, only 31% uses them. 11% of the Indian rural families dispose of stools safely whereas 80% of the population leave their stools in the open or throw them in the garbage. Open air defecation leads to the spread of diseases and malnutrition through parasitic and bacterial infections.

Inadequate safe drinking water

Access to protected sources of drinking water has improved from 68% of the population in 1990 to 88% in 2008. However, only 26% of the slum population has access to safe drinking water, and 25% of the total population has drinking water on their premises. This problem is exacerbated by falling levels of groundwater caused mainly by increasing extraction for irrigation. Insufficient maintenance of the environment around water sources, groundwater pollution, excessive arsenic and fluoride in drinking water pose a major threat to India's health.

Rural health

Rural India contains over 68% of India's total population with half of it living below poverty line, struggling for better and easy access to health care and services. Health issues confronted by rural people are diverse and many – from severe malaria to uncontrolled diabetes, from a badly infected wound to cancer. Postpartum maternal morbidity is a serious problem in resource-poor settings and contributes to maternal mortality, particularly in rural India.

A study conducted in 2009, found that 43.9% of mothers reported to have experienced postpartum morbidities six weeks after delivery. Rural medical practitioners are highly sought after by people living in rural India as they more financially affordable and geographically accessible than practitioners working in the formal public health care sector.

Female Health Issues

- Malnutrition : According to tradition in India, women requires to eat last, even during pregnancy and lactating period, which is the main cause of female malnutrition.
- Breast Cancer : One of the most growing problems among women causing an increased number of mortality rates in India.
- Stroke
- Polycystic ovarian disease (PCOD): PCOD is another issue causing increase in infertility rate in females. It is a condition in which there are many small cysts in the ovaries, which can affect a woman's ability to conceive.
- Maternal Mortality: Indian maternal mortality rates in rural areas are highest amongst the world.

National Rural Health Mission

The National Rural Health Mission (NRHM) was launched in April 2005 by the Government of India. The goal of the NRHM was to provide effective healthcare to rural people with a focus on 18 states which have poor public health indicators and/or weak infrastructure.

Public and private sector

According to National Family Health Survey-3, the private medical sector remains the primary source of health care for the majority of households in both urban areas (70 percent) and rural areas (63 percent) of India. Reliance on public and private health care sector varies significantly between states. Several reasons are cited for relying on private rather than public sector; the topmost reason at national level is poor quality of care in public sector, with more than 57% households pointing to this as the reason for the preference of private health care. Other major reasons are distance of the public sector facility, long waiting time, and inconvenient hours of operation.

HEALTHCARE INFRASTRUCTURE

The Indian healthcare industry is growing at a rapid pace and is expected to become a US$280 billion industry by 2020. Rising income levels and a growing elderly population are all factors that are driving this growth. In addition, changing demographics, disease profiles and the shift from chronic to lifestyle diseases in the country has led to increased spending on healthcare delivery. In order to meet manpower shortages and reach world standards India would require investments of up to $20 billion over the next 5 years.

India's public health delivery infrastructure is characterized by an overly bureaucratic legal and regulatory framework that fails to protect the interests of vulnerable groups or generate the trust of providers or the public; this failure could be addressed by India's Ministries of Health through active inclusion of a range of stakeholders to monitor and advise on the use of public and private health care providers.

Country reported Data for Basic Health Indicators including health related MDG Indicators

Indicator	Latest available data	Year	Source	Remarks
POPULATION AND VITAL STATISTICS				
Total population (in thousands)	1,097 million	2005	31	
Population density (persons per sq km)	334	2005	31	
Sex ratio (females per 1000 males)	933	2001	31	Computed value
Population under 15 years (%)	35	2001	31	0-14 years
Population 60 years and above (%)	7.8	2001	1	
Crude birth rate (per 1000 population)	23.8	2005	4	
Crude death rate (per 1000 population)	7.6	2005	4	
Natural (population) growth rate (%)	1.95	2001	31	Computed value Average annual Exponential Growth Rate
Total fertility rate (per woman)	2.7	2005-06	31	
Urban population (%)	27.78	2001	1	

Can we achieve the same Organizational Structure in Lebanon?
When would it be completed? All what we need is the political will.