

Evolution of the Healthcare Policy Framework in India

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India's healthcare policy framework has evolved from time to time to meet the emerging challenges of healthcare needs of its population—from eradicating communicable diseases until the early 1980s, to strengthening the primary healthcare system in the 1980s and the 1990s, to addressing the rural-urban divide in the 2000s, and to reducing catastrophic spending by the poor in the 2010s. Though healthcare has been a state subject, it is the Union Government that has spearheaded policy initiatives and provided a framework for providing healthcare services across the nation. The origin of India's healthcare policy framework can be traced to the pre-independence era when the "Health Survey and Development Committee," (Chairman: Sir Joseph Bhore) submitted its report in 1946. The Bhore Committee's report presented a bleak health landscape in terms of mortality rates, life expectancy, and healthcare infrastructure.

In the early years following independence, the focus of the authorities was on controlling and eradicating epidemics, with a substantial burden of communicable diseases such as malaria, tuberculosis, cholera, plague, leprosy, and smallpox. At the global level, the Declaration of Alma-Ata, co-sponsored by the World Health Organization (WHO), was signed in 1978, aimed at achieving "Health for All by 2000 AD" by focusing on the primary healthcare centre (PHC) model.

Following the success in reducing the burden of communicable diseases by the early 1980s, though they were not fully eliminated, the focus shifted to improving healthcare facilities in the country with the rollout of the first National Health Policy (NHP) in 1983. The key focus of the NHP-1983 was on integrating health services based on the PHC model, as articulated in the Alma-Ata Declaration. Despite some progress in establishing healthcare infrastructure, including primary healthcare centres, hospitals, and dispensaries, the overall healthcare infrastructure remained woefully inadequate, and concentrated in urban areas, exacerbating rural-urban disparities. In response, the National Health Policy (NHP) of 2002 was introduced, the main objective of which was to achieve an acceptable standard of good health of the general population of the country by increasing access to the health system through strengthening health infrastructure across the country and addressing the rural-urban divide in healthcare facilities. However, the provision of healthcare services in the country remained largely skewed in favour of urban areas.



Within three years after the launch of the NHP-2002, the National Rural Health Mission (NRHM) was rolled out in 2005 to improve healthcare accessibility, affordability, and quality in rural areas. Its key focus was on (i) the reduction in child and maternal mortality; and (ii) the provision of universal access to public health services. The NRHM articulated raising public health spending to 3 per cent of GDP (as against 2 per cent GDP articulated in the NHP-2002). NRHM (which later became National Health Mission with NRHM and National Urban Health Mission (NUHM) as its two sub-missions) helped in reversing the declining trend in health spending by state governments. Nevertheless, overall public health spending remained below 1 per cent of GDP.

Another notable initiative was the launch of Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) in August 2003 with the objective of creating advanced medical infrastructure. However, the creation of new medical infrastructure was marred by many implementation challenges, including time and cost overruns.

The healthcare scenario had changed in several ways after the NHP-2002. Therefore, a new NHP was framed in 2017 aimed at targeting a public health spending of 2.5 per cent of GDP, with the objective of allocating up to two-thirds or more of the budget to primary care, followed by secondary and tertiary care (GoI, 2017). The policy also brought the focus back to universal health coverage. This policy marked a major shift from the decentralised nature of healthcare governance in India, where states had significant responsibilities in managing health institutions, to the Central Government taking the lead.

Rashtriya Swasthya Bima Yojana (RSBY) was rolled out in 2008 aimed at addressing the issue of catastrophic health expenditure by providing insurance coverage to the poor. However, the scheme faced significant implementation challenges due to its complex design, lack of awareness among people, and the lack of flexibility to adapt to rising healthcare costs, hindering its effectiveness. To overcome the challenges faced in the case of RSBY and improve healthcare accessibility, the Pradhan Mantri Jan Arogya Yojana (PM-JAY) was introduced in 2018 as a part of the broader Ayushman Bharat initiative, offering comprehensive healthcare services to the poor to reduce their out-of-pocket expenditures. Though PM-JAY expanded healthcare access for millions of vulnerable families, it primarily focused on secondary and tertiary healthcare services, leaving out a significant portion of healthcare expenses, particularly those related to primary care.

Within three years after the launch of NHP-2017, the country faced the Covid-19 pandemic, exposing the deficiencies in its healthcare infrastructure. To address this, the immediate response was the introduction of the Emergency Covid Response Packages (ECRP) I and II, aimed at limiting the spread of Covid-19 infections and strengthening national and state health systems through capacity building, pandemic research, monitoring, and evaluation. In addition, to effectively manage any future pandemics and outbreaks, *Pradhan Mantri Ayushman Bharat Health Infrastructure Mission* (PM-ABHIM) was launched, which included the establishment of Health and Wellness Centres (HWCs) in rural and urban areas, improved diagnostic facilities, and increased critical care beds. India launched the largest vaccination drive in the world, administering more than 2.2 billion doses.

India's healthcare policy framework has consistently suffered from a lack of a clear roadmap as to how to achieve the laid-down objectives. India's healthcare history reveals three major concerns. First, health has all along been a low priority, with public health spending remaining largely unchanged over the last three decades. Despite policy after policy articulating to raise public health spending, it has remained at around 1 per cent of GDP, with out-of-pocket expenditure remaining one of the highest in the world (GoI, 2023). Inadequate health infrastructure, particularly in rural areas, and a massive shortage of health-related human resources suggest that we are far removed from the goal of universal health coverage. This has left most of the population dependent on the private sector, resulting in one of the highest rates of out-of-pocket expenditure and impoverishment, particularly for the disadvantaged. Second, India's healthcare system has largely focused on curative care at the relative neglect of preventive healthcare. Third, significant rural-urban disparities have persisted.

An enormous increase in public health spending in a time-bound manner is imperative, if we have to make a significant progress towards universal health coverage. The central as well as state governments need to commit that they will raise health spending by at least 0.2 percentage points of GDP each year until it reaches at least 3 per cent of GDP. To achieve this, public health expenditure will need to grow every year by 22-23 per cent (from the existing growth rate of 15 per cent) in the next 7-8 years, assuming nominal GDP growth of 11 per cent. At this rate, we can achieve the target of 3 per cent of GDP in next 7-8 years, which is the average public health spending to GDP ratio of low- and middle-income countries. After reaching this stage, the next target should be to steadily raise the public health spending to 5 per cent of GDP (Raj, 2023).

About the authors



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