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Evolution of the Healthcare Policy Framework in India

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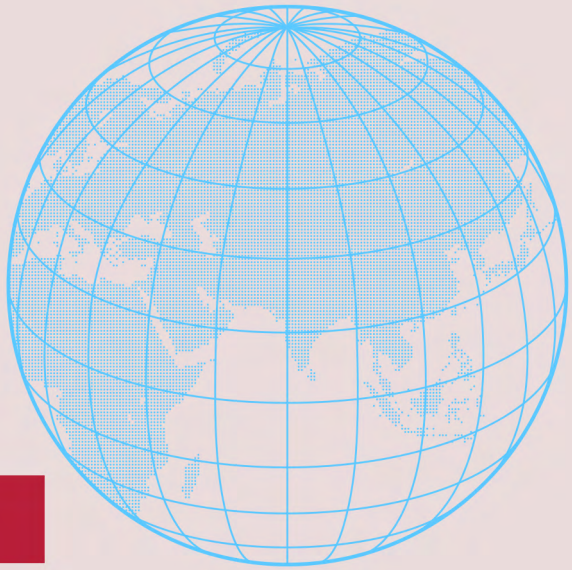

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Designed by Mukesh Rawat

Evolution of the Healthcare Policy Framework in India

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*He was with CSEP till 2023.

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Abbreviations

ABDM	Ayushman Bharat Digital Mission
ABHA	Ayushman Bharat Health Accounts
AIDS	Acquired Immune Deficiency Syndrome
AIIMS	All India Institute of Medical Sciences
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy
BCG	Bacillus Calmette-Guerin
BE	Budget Estimate
BPL	Below Poverty Line
CAG	Comptroller and Auditor General
CGHS	Central Government Health Scheme
CHC	Community Health Centre
CPHC	Comprehensive Primary Health Care
CPSU	Central Public Sector Undertaking
CRD	Chronic Respiratory Diseases
CSS	Centrally Sponsored Scheme
CVD	Cardiovascular Diseases
DCP	Disease Commodity Package
DH	District Hospital
DHSC	Department of Health and Social Care
ECRP	Emergency Covid Response Plan
EDL	Essential Drug List
EPI	Expanded Programme on Immunization
ESIS	Employee State Insurance Scheme
FC	Finance Commission
FYP	Five Year Plans
GBS	Gross Budgetary Support
GDP	Gross Domestic Product
GMCI	Government Medical College/Institution
GMSD	Government Medical Store Depot
GoI	Government of India
HCO	Health Care Organisations
HFR	Health Facility Registry
HIV	Human immunodeficiency viruses
HLEG	High-Level Expert Group
HPR	Health Professional Registry
HSS	Health System Strengthening
HWC	Health and Wellness Centre
IC	Insurance Company
ICMR	Indian Council of Medical Research
IMR	Infant Mortality Rate

IPHS	Indian Public Health Standards
ISA	Implementation Support Agencies
MMR	Maternal Mortality Rate
MMU	Mobile Medical Units
MNP	Minimum Needs Programme
MoHFW	Ministry of Health and Family Welfare
MSO	Management Services Organisation
NACP	National AIDS Control Programme
NCD	Non-Communicable Diseases
NCMH	National Commission on Macroeconomics and Health
NDC	National Development Council
NDCP	National Disease Control Programme
NDHB	National Digital Health Blueprint
NDHM	National Digital Health Mission
NFHS	National Family Health Survey
NHA	National Health Authority
NHM	National Health Mission
NHP	National Health Policy
NHS	National Health Service
NMHP	National Mental Health Programme
NMPU	National Programme Management Unit
NOHP	National Oral Health Programme
NOTTO	National Organ Tissue and Transplant Organisation
NPCBVI	National Programme for Control of Blindness & Visual Impairment
NPCDCS	National Programme for prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke
NPHCE	National Programme for Healthcare of the Elderly
NPPC	National Programme for Palliative Care
NPPCD	National Programme for the Prevention & Control of Deafness
NPPCF	National Programme for Prevention and Control of Fluorosis
NPPMBI	National Programme for Prevention & Management of Burn Injuries
NRHM	National Rural Health Mission
NSSO	National Sample Survey Office
NTCP	National Tobacco Control Programme
NUHM	National Urban Health Mission
OOPE	Out-of-Pocket Expenditure
OPD	Outpatient Department
PHC	Primary Healthcare Centres
PIP	Programme Implementation Plan
PM-ABHIM	Pradhan Mantri Ayushman Bharat Health Infrastructure Mission
PMASBY	Prime Minister Atmanirbhar Swasth Bharat Yojana
PMC	Primary Health Centre
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PMSSN	Pradhan Mantri Swasthya Suraksha Nidhi

PMSSY	Pradhan Mantri Swasthya Suraksha Yojana
RE	Revenue Estimate
RKS	Rogi Kalyan Samitis
RMNCH+A/RCH	Reproductive-Maternal- Neonatal-Child and Adolescent Health
RSBY	Rashtriya Swasthya Bima Yojana
SC	Sub-Centre
SDGs	Sustainable Development Goals
SECC	Socio-Economic Caste Census
SHA	State Health Agencies
SHC	Sub Health Centre
SRS	Sample Registration System
STDs	Sexually Transmitted Diseases
TB	Tuberculosis
TFR	Total Fertility Rate
TPA	Third-party Administrator
UHC	Universal Health Coverage
UIP	Universal Immunization Programme
UK	United Kingdom
UT	Union Territory
VHSNC	Village Health Sanitation and Nutrition Committees
VPD	Vaccine Preventable Diseases
WHO	World Health Organization

Abstract

This paper traces the history of the evolution of India's healthcare policy framework, focusing on its major objectives, challenges faced, and outcomes emerged. Though the groundwork for the healthcare framework was laid down by the Bhore Committee's well-thought-out report in 1946, the country's attention was focused on controlling and eradicating several communicable diseases in the first three decades post-independence. It was only in 1983 that the country framed the first National Health Policy (NHP) with the goal of improving healthcare services. The NHP-1983 was replaced by NHP-2002, which, in turn, was replaced by NHP-2017. Several other policy initiatives were also concurrently undertaken, which, among others, included *Pradhan Mantri Swasthya Suraksha Yojana (PMSSY), National Rural Health Mission (NHRM) (which was subsumed under National Health Mission in 2015), Rashtriya Swasthya Bima Yojana (RSBY), Pradhan Mantri Jan Arogya Yojana (PM-JAY), and Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM).* The key themes prevalent across most of these policies and specific initiatives included: (i) increasing public health spending and reducing out-of-pocket or catastrophic health spending; (ii) addressing rural-urban inequalities in healthcare; (iii) developing primary healthcare; and (iv) achieving universal health coverage.

Undoubtedly, the country has made a good progress in healthcare facilities post-independence, with a significant improvement in various health indicators over the years, such as life expectancy at birth, child and maternal mortality rate, creating a large pool of medical and para-medical personnel, among others. However, despite these improvements, health has remained a low priority, with public health spending at about 1 per cent of GDP, much lower than many of its peers with similar tax-GDP ratios. Consequently, the out-of-pocket expenditures in India are among the highest in the world, pushing about 55 million people into poverty every year due to catastrophic health spending. The rural-urban divide in healthcare services remains wide, with the relative neglect of primary healthcare. The goal of universal health care has eluded so far, constrained primarily by inadequate public health spending. Research at a global level and experiences of many other countries suggest that achieving the goal of Universal Health Care (UHC) will require public health spending to rise to five per cent of GDP. Therefore, both the central and state governments need to commit to raising public health spending to five per cent of GDP in a time-bound manner.

Executive Summary

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 populationn 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).

1. Introduction

The healthcare policy framework in India has evolved in response to various challenges faced at different points in time. Health is a state subject, with major responsibilities for creating, maintaining, and managing health institutions resting with the States. The role of the Central Government in health was initially limited to family planning, health policy making, and research. This genesis can be traced back to 1914, when the colonial government announced through a resolution its intention to keep control of research under itself but to decentralise other branches of public health administration. This principle was incorporated in the Government of India Act, 1919. The position was clarified in the new Government of India Act, 1935, which maintained the *status quo* with respect to health subjects transferred to the provinces in 1919 and conferred on them a measure of autonomy not provided in the earlier Act (GoI, 1946). The control of medical education, public health, sanitation, and the collection of data was left in the hands of provincial governments (Carballido-Coria, 2022). The outcome was a healthcare system without a central authority and financial resources, and with a very limited outreach (Amrith, 2007). Though health is a state subject, it has been mainly the Centre that has driven policy initiatives and provided a framework for improving healthcare services in the country. The Central Government played an increasingly important role in healthcare financing as it has more resources at its command than the States. It is significant that economically weaker states depend more on transfers from the Centre than their own revenues for health spending (Raj *et al.,* 2024). However, it is also a fact that States have not paid adequate attention to health. As such, intervention by the Central Government through NHM has helped the States to pay greater attention to health by providing strategy, goals, finances, and healthcare infrastructure. In the absence of intervention by the Central Government, it perhaps would not have happened (Kapur *et al.,* 2024). Also, while States have the capacity to analyse the needs of the people, the fact is not much is happening on the ground. NHM helped ensure increased level of participation in healthcare by states (Kapur *et al.,* 2024).

The history of the healthcare policy framework can be traced back to pre-independent India when the first committee on health called the "Health Survey and Development Committee" (Chairman: Sir Joseph Bhore), was appointed in 1943. The committee's report was a detailed account of the then-prevailing health scenario in the country (GoI, 1946). The report painted a dismal picture of the health status in terms of mortality rate, life expectancy, and health infrastructure, and made wide-ranging recommendations to remedy the situation. Though the healthcare system in India post-independence has roots in the Bhore Committee's report, it is also a fact that many of its recommendations were either diluted or not implemented.

In the early years of independence, the entire focus of the health sector in India was on controlling and eradicating epidemics, with the country facing a high burden of a number of communicable diseases such as malaria, tuberculosis, cholera, plague, leprosy, and smallpox. Even amidst this, discussions also continued about the overall healthcare based on the Bhore Committee's report.

In the international sphere, the Declaration of Alma-Ata in 1978, co-sponsored by the World Health Organization (WHO), was the first international declaration emphasising the importance of primary health care (PHC) model for achieving "Health for All by 2000 AD" (WHO, 1978). India also ratified the Declaration.

The Alma-Ata Declaration was also endorsed in the first National Health Policy (NHP) 1983, which also marked the beginning of a systematic approach to health policymaking in India. Prior to that, health policy and planning in India were shaped by the Central Government through successive Five-Year Plans (FYP) and recommendations of various committees (Duggal, 2001). The frameworks within which States developed their health services infrastructure and facilities for medical education, research were provided by successive Five-Year Plans. Similar guidance was also underpinned by discussions and conclusions arrived at the Joint Conferences of the Central Councils of Health and Family Welfare and the National Development Council (NDC). For the FYPs, the health sector included schemes that had targets to be met. Each plan period introduced several schemes, and every subsequent plan added some new schemes and dropped a few (Duggal, 2001).

The thrust of the NHP-1983 was on integrated health services through the PHC model mentioned in the Alma-Ata Declaration. Though some progress was

made in developing health infrastructure in the country in the form of primary healthcare centres, hospitals, dispensaries, doctors, and nursing staff, the overall health infrastructure remained woefully inadequate. The goal of 'health for all by the year 2000' remained a dream as India could not marshal the resources and develop administrative capabilities to pursue such an ambitious goal (GoI, 2004). Even after 22 years when the goal was to be first achieved, we are nowhere close to achieving it any time in the foreseeable future.

As the focus of developing health infrastructure was in urban areas, disparities between rural and urban India also widened in the 19 years after NHP-1983 was framed. It was against this background that the NHP-2002 was rolled out. Its main objective was "to achieve an acceptable standard of good health amongst the general population of the country." Following this policy, the *Pradhan Mantri Swasthya Suraksha Yojana* (PMSSY) was launched in August 2003. Shortly thereafter, a major health initiative for rural masses, in the form of the National Rural Health Mission (NRHM), was announced by the Central Government in April 2005 in partnership with States to provide accessible, affordable, and quality healthcare to the rural population across the country, with a special focus on 18 states that had weak public health indicators and/or weak infrastructure. NRHM/NHP, 2002 helped reverse the declining trend in health spending by the state governments. Despite this, however, public health spending remained low, because of which out-of-pocket expenditure (OOPE) continued to be one of the highest in the world (GoI, 2021). Out-of-pocket expenditure is the direct payment made by individuals at the point of service where the full cost of the health service is not covered by any financial protection scheme (GoI, 2023). Increasing healthcare needs, combined with high OOPE, have been one of the leading causes of poverty in India. Not only it keeps people poor, but it also pushes nearly 55 million Indians back into poverty each year.[1] Health insurance was recognised as one of the ways to provide protection to poor households against the risk of health spending leading to poverty. Keeping that in mind, the Central Government announced a health insurance scheme called *Rashtriya Swasthya Bima Yojana* (RSBY) in 2008 to cover below-poverty-line (BPL) beneficiaries. However, the response to the scheme was not encouraging due to its complex design and lack of awareness.

In October 2010, the then Planning Commission of India established the High-Level Expert Group (HLEG) on Universal Health Coverage (UHC) (Chairman: Prof. K. Srinath Reddy). The report of the HLEG on UHC, submitted in October 2010, made key recommendations in six areas crucial for the achievement of UHC: (i) health financing and financial protection; (ii) health service norms; (iii) human resources for health; (iv) community participation and citizen engagement; (v) access to medicines, vaccines, and technology; and (vi) management and institutional norms. The HLEG recommended that public expenditure on health be increased to 2.5 per cent of the GDP by 2017 and to 3 per cent by 2022. It also recommended improving primary healthcare by ensuring that it accounts for 70 per cent of health expenditures. The HLEG proposed the development of a National Health Package offering essential health services to citizens and advised that each citizen be issued a National Health Entitlement Card to provide cashless transactions, allow for mobility, and contain personal health information.

In 2015, the National Health Mission, a centrally sponsored scheme (CSS), and a flagship programme of the Centre was launched, with NRHM and National Urban Health Mission (NUHM) as its two constituents. Since then, it has become a major instrument of the Central Government to intervene in healthcare. Many initiatives were taken under the programme, mainly aimed at addressing concerns related to maternal and child health.

In 2017, a new National Health Policy was announced, replacing NHP-2002. Since NHP-2017 was announced just two years after NHM, many of the targets set under NHM were also targets under NHP-2017, though the latter had a much broader canvas. The key objective of NHP-2017 was to inform, clarify, strengthen, and prioritise the role of the government in shaping health systems in all its dimensions. Under these two health initiatives, further progress was made in demographic trends such as the reduction in child and maternal mortality, but epidemiological effects in terms of control of communicable diseases lagged behind the targets. A major disappointment with NHP-2017, and even earlier policies/programmes, has been their failure to step up public health spending, which in turn impacted healthcare infrastructure and human resources engaged in healthcare.

[1] https://www.cabdirect.org/globalhealth/abstract/20103159699.

India's healthcare system came under siege during the unprecedented Covid-19 pandemic, which began in March 2020. It seriously exposed India's poor healthcare infrastructure, especially in terms of hospital beds, beds with oxygen support, and critical medicines, especially after the second wave in April/May 2021. It was a wake-up call to strengthen India's health infrastructure. Consequently, the India Covid-19 Emergency Response and Health Systems Preparedness Package (ECRP) I and II were launched to build resilient health systems that could address not just the Covid-19 pandemic but also future outbreaks in the country.

Overall, the Central Government has played a key role in shaping health policies/programmes in India. With the launch of NHM, the Centre has expanded its footprint in healthcare, a subject that is in the domain of the States. However, on a positive side, NHM has helped reverse the declining trend of health spending by States.

Three key points emerge from the evolution of health history in India. One, health has all along been a low priority in India, which is reflected in low spending on health, despite policy after policy articulating to raise it. Second, the primary healthcare infrastructure continues to be grossly deficient. Consequently, universal health coverage, which, in some form, was first articulated by the Bhore Committee even before Independence and its reiteration in many subsequent committees/national health policies 1983 and 2017, has remained elusive. Third, large imbalances continue to exist in healthcare infrastructure in rural and urban India.

In the above backdrop, this paper traces the history of the evolution of the healthcare policy framework in India. Though the paper goes back to history even before independence, its focus is on NHP-1983 and onwards. Some state governments have also been taking some health initiatives. However, the paper focuses only on initiatives at the Central Government level, which has been the main driving force of the health policy framework in India. It explores the development of policies, expansion of healthcare facilities/infrastructure, investments in the health sector, and the outcomes in terms of demographic and epidemiological targets set. It is important to note, however, that this study does not focus on medical education, healthcare workforce, pharmaceutical policies, and the political economy of healthcare.

The remainder of the paper is divided into seven sections. Section 2 briefly traces the healthcare policy that existed on the eve of independence. Section 3 outlines the evolution of history from the early years of independence until the early 1980s. Section 4 details the key elements of various national health policies beginning from the first NHP in 1983 and other major policy initiatives in the health sector, including the management of the Covid-19 pandemic. Section 5 delineates the major features of health insurance policies. Section 6 presents the evolution of health spending after 2005-06. Section 7 reflects on the major issues facing the country in the healthcare sector. Section 8 sums up the main points emerging from the paper.

2. Healthcare Policy–On the Eve of Independence

The healthcare system that existed in India before independence was designed by the British rulers and was primarily intended to serve army personnel and colonial administrators. The healthcare system was broadly urban-based, elite-centric, and curative-oriented, and neglected the healthcare needs of the masses (Sapru, 2021).

The genesis of the present healthcare system in India can largely be traced to the recommendations of the Health Survey and Development Committee (Chairman: Sir Joseph Bhore), appointed in 1943, which submitted its report in 1946 (GoI, 1946). Interestingly, the committee, comprising 24 members, was primarily made up of health experts, and, a year after its constitution, was also assisted by international advisers. A three-volume in-depth report examined almost all important aspects relating to health and identified the challenges the country's then health system faced. The committee presented a poor state of public health in India in terms of high mortality and morbidity, low life expectancy, inadequate health infrastructure, shortage of health personnel, and a lack of coordination.

The committee was ahead of its time in emphasising the positive impact of good health on economic growth, when it observed:

"*Apart from the intrinsic importance of maintaining individual and community health at its highest level, we strongly hold the view that the carrying out of the*

health measures we propose is one of the most effective ways of ensuring the economic prosperity of the country and of materially raising the level of the national income. It is obviously impossible to assess accurately, in terms of money the effects of ill-health on the community" (Vol. II, pp 35).

In addition to recommending certain principles for the future development of the healthcare sector, it underlined the integration of curative and preventive medicine at all levels and made several recommendations for remodelling health services in India. The underlying approach of the committee was based on some form of universal health coverage, as evidenced when, after studying the then cross-country experiences, it observed:

"*…the modern trend is towards provision by the state of as complete health service as possible and the inclusion, within its scope, of the largest possible proportion of the community. The need for assuring the distribution of medical benefits to all, irrespective of their ability to pay, has also received recognition.*" (1946, Vol. II, pp 12).

Taking a holistic view of the healthcare system in the country, the committee made wide-ranging recommendations relating to areas such as setting up primary and secondary healthcare infrastructure, health services for school children, occupational health, services for all kinds of diseases, health education, environmental health, malnutrition, unsanitary conditions, professional education, and medical research. The committee also provided a special focus on the provision of safe drinking water, sanitation, and housing.

The committee recommended a programme to be developed in 10 years, as well as over a longer period (over 40 years). It recommended the development of PHCs in two stages. In the near term, with a development timeline of 10 years, it was recommended to establish one PHC for every 40,000 individuals. Each PHC would be equipped with a team comprising 2 doctors, one nurse, four public health nurses, four midwives, four trained *dais* (traditional birth attendants), two sanitary inspectors, two health assistants, one pharmacist, and fifteen other class IV employees. Secondary health centres were designed to offer support to the PHCs, coordinating and overseeing their operations. In the long run (to be put in place over a period of 40 years), primary health units with 75-bedded hospitals for every 10,000 to 20,000 population and secondary units with 650-bedded hospitals were recommended. The report faced criticism for not planning for the immediate present. However, this was a conscious decision of the committee, as observed in the following statement:

"In outlining this programme, we have tried to bear in mind the necessity for tempering enthusiasm with a sense of reality. In the earlier years the lack of sufficient trained staff and of adequate financial resources will inevitably limit the scope of practical achievement. With the initial impediments overcome or reduced, however, the pace of advance should be materially quickened…." (GoI, 1946, Vol. II)

The present healthcare system in India has its roots in the report of the Bhore Committee, with many of the committee's recommendations becoming the foundation stone for the healthcare system in the first few years of India's independent life (Carballido-Coria, 2022). However, it is also significant that many of committee's recommendations were diluted (Duggal, 2001). The recommendations of the committee were partially implemented for only a certain category of government employees as a test case. The costs and administrative work for implementing the committee's recommendations proved too much for the British and the rulers of independent India (Murthy, *et al.,* 2013). In this context, it is important to understand the thought process of colonial rulers, which was clear from what the then Viceroy, when confronted with a National Health Service (NHS) in 1944, wrote, as quoted in Murthy *et al.,* (2013):

"[P]*roductive items such as electrification, industrial development, irrigation projects and agricultural improvement should come before unproductive items such as health and education*."

The Bhore Committee was perhaps also not oblivious to such a mindset, when it observed:

"…to shut our eyes to the consequences which a halting, ineffective and timid health policy imposes on the country can only result in perpetuating a tragedy which is as poignant on the national as on the individual side" (Vol. II, pp 35).

Even as many of its recommendations were never implemented, the Bhore Committee's Report remains the most enduring in developing the health services in India (Bajpai and Saraya, 2011).

3. Early years of Independence–Managing Epidemics and Ensuring Immunisation

In the early years of independence, the country faced a widespread burden of communicable diseases and an acutely deficient healthcare infrastructure and medical personnel, some aspects of which were covered in the Bhore Committee's report. However, in the First Five Year Plan it was recognised that the resources for implementing the Bhore Committee's recommendation relating to setting up of primary and secondary healthcare during the following five years were not likely to be available (GoI, 1974). The entire focus of the health sector in India was on controlling/eradicating epidemics, with the control of malaria standing very high in the order of priorities. The burden of tuberculosis (TB) disease was also alarming, causing 0.5 million deaths every year, with 2.5 million suffering from TB and another 2.5 million suffering from active TB disease (GoI, 1951). Leprosy was another disease that assumed serious proportions, affecting more than 1.5 million people. India reported the largest number of smallpox cases in the world. The country also faced cholera and plague epidemics. Various mass programmes were launched to control or eradicate these diseases. A programme for TB control, based, among others, on BCG vaccination, was launched in the 1st FYP. National Leprosy Control Programme was launched in 1954-55.

Even as the country was engaged in the control or eradication of many communicable diseases, discussions about the overall healthcare based on the Bhore Committee Report continued. The Mudaliar Committee was constituted in 1959 to review the developments that had taken place after the release of the Bhore Committee's report, with a view to formulating further health programmes for the country. The Mudaliar Committee, which submitted its report in October 1961, lamented that the increase in the number of hospitals, dispensaries, and hospital beds were outpaced by the growth in population. Therefore, by 1960, the actual progress in terms of hospital beds, doctors, and nurses was below the target set by the Bhore Committee (Table 1). The committee also found many organisational defects such as overcrowding of hospitals, inadequate staff, and non-availability of essential medicines and drugs. These defects, the committee recommended, should be remedied without any delay. The Mudaliar Committee admitted that the overall picture of health did not enable them to take an overly optimistic view of the then state of healthcare in the country and of future health protection of the citizens.

One of the key recommendations of the Bhore committee was to set up PHCs based on population norms. As this recommendation could not be implemented due to a lack of finance and a shortage of medical and paramedical personnel, the Mudaliar Committee felt that establishing PHCs without adequate facilities, resources, and personnel would not serve any useful purpose. Therefore, the committee recommended discontinuing the PHC programme until it could be implemented on the scale recommended by the Bhore Committee, even though it accepted that the idea of a PHC was an excellent one. It also argued that, in course of time, when facilities regarding personnel, finance, and other requirements were sufficiently enlarged, the Bhore Committee formula of PHCs could be adopted.

Table 1: Health Infrastructure Position – 1960 *versus* 1946

Indicator	1946		Bhore Committee Targets	1960	
	No.	Ratio	Ratio	No.	Ratio
Hospitals and Dispensaries	7,400	1:40,000***	-	12,000	1:35,800
Beds	1,13,000	0.24 per 1,000	2 per 1,000*	1,85,000	0.40 per 1,000
Doctors	47,524	1:6,300	1:2000**	88,000	1:4850
Nurses	7,000	1:43,000	1:500**	30,000	1:14300
Primary Health Centres	Nil	Nil	-	2,800	1:70,000^

**Goals to be achieved by 1961. **Goals to be achieved by 1971. ***Population served by a hospital/dispensary. ^Population Actually Served by a PHC.*

Source: Mudaliar Committee, Vol. I.

However, PHCs continued to expand, even against the recommendation of the Mudaliar committee. In fact, the Fourth FYP expressed its dissatisfaction with the tardy progress of the PHC programme and stressed the need to strengthen it. It aimed to set up primary health centres in 351 community blocks, which could not be completed under the Third FYP. It was also decided to strengthen PHCs with staff, equipment, medicine, and buildings to provide basic health services in rural areas (GoI, 1969). For the first time, the Fourth FYP made a separate allocation for PHCs (17.5 per cent of the total health outlay). Separate allocations were also made for water supply under the sector of housing and regional development (Duggal, 2001).

The epidemiological trend reversed with malaria cases beginning to rise again from the early 1960s[2] (Sharma, 1996; Kumar *et al.*, 2007). The Fifth FYP recognised that, despite improvements in the infant mortality rate and life expectancy, the number of medical institutions, functionaries, beds, healthcare facilities were still inadequate in rural areas. Thus, it recognised that the urban health structure had expanded at the cost of rural sectors (GoI, 1974). Therefore, increasing the accessibility of health services in rural areas through the Minimum Needs Programme (MNP) and correcting regional imbalances was made one of the objectives of the Fifth FYP. It was also articulated that the MNP would receive higher priority and be the first charge on development outlays in the health sector (GoI, 1974). One of the important objectives in the MNP was to provide adequate drinking water to all villages (GoI, 1974).

A National Smallpox Eradication Programme was launched in 1962-63. The programme was expected to end after three years. However, the expectation was not realised, as a large proportion of the population remained unprotected from re-vaccination (GoI, 1969). In 1967-1968, the smallpox eradication strategy was reframed with a greater focus on surveillance, epidemiological investigation of outbreaks and their rapid containment drives (Lahariya, 2014).

The broad objectives of the health programmes during 1961-69 continued to be to control and eradicate communicable diseases, and a sizable health budget (29.0 per cent of total health budget) in the Fourth FYP was earmarked for the control of communicable diseases (GoI, 1969). The National Malaria Eradication programme, originally scheduled to end in 1967-68, was later expected to be completed by 1975.

3.1 Immunisation Programme—1978-1983

By mid-1973, efforts were broadly successful in containing smallpox mainly to Uttar Pradesh, Bihar, West Bengal, and a few other states (Lahariya, 2014). In 1974, the WHO launched the Expanded Programme on Immunization (EPI) to develop and expand immunisation programmes throughout the world. As soon as India was declared smallpox-free in 1977, the country decided to launch the National Immunisation programme, also called the Expanded Programme on Immunisation (EPI), in 1978 with the objective of reducing morbidity and mortality from diphtheria, pertussis, tetanus, poliomyelitis, and childhood tuberculosis. This was to be achieved by providing immunisation services to all eligible children and pregnant women by 1990 (Sokhey, *et al.*, 1989). The target of EPI was to achieve at least 80 per cent coverage in infancy.[3] The typhoid-paratyphoid vaccine was dropped from EPI in 1981, while Tetanus toxoid vaccine for pregnant women was added in EPI in 1983 (GoI, 1986; GoI, 2005a; GoI, 2005b). The EPI was rechristened and accelerated with some major changes in focus as the Universal Immunization Programme (UIP) in November 1985 (UNICEF, 1990; DGHS, 2012; Tamil Nadu State Archive, 1950). The measles vaccine was included in UIP. The key objective of UIP was to quickly expand the immunisation coverage and reduce mortality and morbidity due to six vaccine-preventable diseases (VPDs).

In 1983, the National Leprosy Eradication Programme was introduced as a continuation of the National Leprosy Control Programme. Health experts argued that it was one of the largest leprosy eradication programmes in the world.

3.2 Health for All by 2000 AD

In September 1978, the International Conference on Primary Health Care was held in Alma-Ata, then in the USSR (now Almaty, Kazakhstan), and recommended "Health for All by 2000 AD." The Alma-Ata Declaration, co-sponsored by the WHO, identified

[2] Malaria cases rose from around 0.1 million in the early 1960s to 6.4 million in the mid-1970s.

[3] With effect from 1990-91, vaccination programme became universalised in geographical coverage and the target of UIP was increased to over 100 per cent of the infants (Lahariya, 2014).

Table 2: Communicable Diseases: Status in the Early 1980s vis-à-vis 1950s

Diseases	Status around Independence	Status
Tuberculosis	Active cases: 4/1000 population (1955-58)	1.13/1000 (1981)
Smallpox	Cases: 410,819 (1950) Deaths: 105,781 (1950)	Cases: 188,000 (1974) Deaths: 31,000 (1950)
Malaria	Cases: 75million (21.8% of the population in 1947)	Cases: 2.9 million (1980)
Polio	2,00,000-4,00,000 annual cases during the 1950s	1,50,000 cases in 1980 (43% of worldwide cases)

Source: NHP-1983, Report.

primary healthcare[4] as key to the attainment of the goal of 'Health for All'. The Declaration of Alma-Ata exhorted all governments "to formulate national policies, strategies, and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with another sector." It also called for "urgent and effective national and international action to develop and implement primary health care throughout the world and particularly in developing countries."

India also signed the Alma-Ata Declaration, following which health moved into the mainstream of issues that concerned the entire community (Sapru, 1986).

The Sixth FYP, influenced by the Alma-Ata Declaration, reiterated the neglect of public health and the rising disparities between urban and rural areas. It is, therefore, emphasised the creation of a comprehensive and well-structured rural health service and increased the allocation for this purpose.

By the early 1980s, the burden of major communicable diseases had declined sharply, though they were still not fully under control (Table 2). This afforded an opportunity for the authorities to shift the focus from managing communicable diseases to providing healthcare for the public, which was attempted to be done within the overall framework of healthcare policies, as explained in the following sections.

4. Healthcare Policies–1983 onwards

The period from the early 1980s onwards saw some major initiatives in the health sector. However, these lacked the appropriate thrust, financial resources, and any concrete strategy or roadmap, leading to outcomes that fell well short of expectations, as explained in this and the following sections. The period from 1983 onwards can be further divided into three sub-periods: (i) 1983-2002; (ii) 2003-2017; and (iii) 2018 onwards.

4.1 Sub-period I: 1983-2002

This period was marked by two healthcare policy initiatives, which led to some improvement in healthcare indicators, though the overall performance fell far short of expectations. A major failure in this period was the continuing rural-urban imbalances in healthcare services.

National Health Policy (NHP), 1983

NHP-1983 was framed in the context of the Government of India's commitment to the Alma-Ata Declaration to achieve "Health for All by 2000." This policy expressed dissatisfaction with the disproportionate emphasis on the establishment of curative centres largely concentrated in urban areas. The key focus of the policy was on restructuring health services to provide, in a time-bound programme, a well-dispersed network of comprehensive primary healthcare services. Other noteworthy elements of restructuring health services included: (i) large-scale transfer of knowledge, simple skills, and technologies to health volunteers, selected by the communities themselves (GoI, 1983); (ii) establishment of a well-worked-out referral system; (iii) establishing a nationwide chain of sanitary and epidemiological stations with well-equipped staff to provide preventive, promotive, and

[4] With the launch of the Community Development Programme in October 1952, a modest beginning was made to implement a programme of setting up of Primary Health Centres (PHCs) as an integral component for all-round development of rural areas. A PHC with three sub-centres for every Community Development Block covering approximately 60,000 people was designed to provide integrated curative, preventive and promotive services to rural population. The PHCs were envisaged as the focal point from which primary healthcare services would radiate through sub-centres under each PHC (GoI, 2017).

mental healthcare services; (iv) locating curative centres near the population to ensure maximum utilisation; and (v) establishing centres equipped to provide speciality and super-speciality services.

NHP-1983 intended to reduce government spending on health, suggesting increased investment by non-governmental agencies in establishing curative centres and offering organised logistical, financial, and technical support to voluntary agencies active in the field of health.

The policy also emphasised other important inputs required for improved healthcare such as (i) adequate nutrition for all segments of the population; (ii) prevention of food adulteration and maintenance of the quality of drugs; (iii) provision of safe drinking water and adequate sanitation; (iv) environmental protection; (v) organised, nationwide immunisation programme; (vi) launch of special programmes to improve maternal and child health, with a special focus on the less privileged sections of society; (vii) school health services; and (viii) launching schemes to prevent and treat diseases and injuries arising from occupational hazards (GoI, 1983).

NHP-1983 provided a long-term framework to steer healthcare services for the first time in India. However, it did not give an account of the then-prevailing health status in the country or the rationale for the goals it set. Its key focus of 'health for all' access through primary healthcare was laudable. However, the policy did not lay down a roadmap for reaching the goal of 'health for all' by 2000. The most intriguing part of the policy was its silence on the public health expenditure required to meet the ambitious goal of 'health for all'.

Though the policy mentioned a time-bound programme for setting up a well-dispersed network of comprehensive primary healthcare services, it specified neither the timeframe nor the roadmap for achieving this. Between 1981 and 2000, the country expanded its network of health infrastructure in the form of primary healthcare. However, at the same time, the curative health infrastructure in the form of hospital/dispensaries and hospital beds also expanded, against which the policy had argued (Table 3).

The policy also set several demographic and epidemiological goals, along with a time path for their achievements (Table 4). However, the policy did not detail the measures or the action plan needed to achieve those goals. Consequently, by the end of 2000, many health indicators fell short of the targets (Table 4). The levels of morbidity and mortality in the country remained at an unacceptably high level (NHP, 2002). It is significant that the share of health outlay in the total plan outlay gradually declined from 4.7 per cent in the First FYP to 1.9 per cent by the Sixth FYP. However, from the Sixth FYP onward, the outlay for health and family planning was combined, with the allocation to health gradually increasing. The share allocated for health in the total plan outlay under the seventh FYP and eighth FYP was 1.7 per cent (Appendix I).

Table 3: Health Infrastructure – 1981 *versus* 2000

Indicator	1981	2000	Percentage variations (2000 over 1981)
SC/PHC/CHC	57,363	1,63,181	184.5
Dispensaries & Hospitals (all)	23,555	43,322	83.9
Beds (Private & Public)	569,495	8,70,161	52.8
Doctors (Allopathy)	2,68,700	5,03,900	87.5
Nursing Personnel	1,43,887	7,37,000	412.2

Note: SC: Sub-Centres, PHC: Primary Health Centre, CHC: Community Health Centre.

Source: NHP-2002, Report.

Table 4: Goals of NHP-1983

Sr. No.	Indicator		Goals			Status in 2000
	Year	Position in 1981	1985	1990	2000	
1.	Infant mortality rate (per 1000)	110	106	87	below 60	70
2.	Maternal mortality rate	4-5(1976)	3-4	2-3	below 2	7[5]
3.	Life expectancy at birth (yrs.)	54 (Total)	55.1 (Male) 54.3 (Female)	57.6 (Male) 57.1 (Female)	64 (Male) 64 (Female)	62 (male) 64 (Female)
4.	Deliveries by trained birth attendants (%)	30-35	50	80	100	43

Source: NHP-1983 report (for position and goals).

National AIDS and STD Control Programme

The first case of HIV in India was detected in April 1986. India's initial response to the HIV pandemic involved servo-surveillance, awareness generation, and screening of blood units for HIV infection. In 1992, an institutionalised response to the HIV/AIDS epidemic was established in India with the launch of the National Acquired Immune Deficiency Syndrome (AIDS) and Sexually Transmitted Diseases (STD) Control Programme (NACP). It has evolved into one of the largest programmes of the world across the prevention-detection-treatment continuum. Since 1992, five NACPs have been launched as detailed in Appendix II.

National Health Policy, 2002

NHP-2002 was formulated against the backdrop of an admission of three major weaknesses in the then health scenario: (i) limited success of the public health system; (ii) low public health investment; and (iii) uneven health status between rural and urban areas. NHP-2002 acknowledged that the financial resources and administrative capacity marshalled by NHP-1983 were far short of what was necessary to achieve an ambitious and holistic goal of health for all by the year 2000 AD.

The main objective of the NHP-2002 was "*…to achieve an acceptable standard of good health amongst the general population of the country*." The focus of the policy was on increasing access to the decentralised public health system by establishing new infrastructure in deficient areas and upgrading the infrastructure in the existing institutions.

The key focus of NHP-2002 was to ensure more equitable access to health services across the social and geographical expanse of the country. In fact, it stated that any future evaluation of its success or failure should be measured against this equity norm. Other key elements of the policy included: (i) increasing health sector expenditure to 6 per cent of GDP, with 2 per cent of GDP contributed by public health investment by 2010; (ii) exhorting state governments to allocate 7 per cent of their budget to the health sector in the first phase by 2005, and 8 per cent in the second phase by 2010; (iii) reducing various types of inequities and imbalances, and facilitating preventive and early-stage curative initiative; (iv) allocating 55 per cent of total public health expenditure to the primary health sector, with the secondary sector receiving 35 per cent and the tertiary sector 10 per cent; (iv) gradually converging all health programmes under a single field administration; (v) kick-starting the revival of the primary health system by providing some essential drugs; (vi) enforcing a mandatory two-year rural posting before awarding graduate degrees; and (vii) increasing government-funded health research to 1 per cent of total health expenditure by 2005, and thereafter to 2 per cent by 2010.

NHP-2002 acknowledged some of the serious deficiencies from which the then healthcare system suffered. However, it lacked clarity about the role of the Central Government versus States in health, emphasising that public health was the responsibil-

[5] Maternal Mortality Ratio as of January 2000.

ity of States and that the principal contribution for funding public health services should come from state resources, with some supplementary input from central resources. However, the policy then advocated for an increased role of the Centre, citing reduced allocations for health from state budgets. It argued that to significantly improve centralised public health services in the country, there was a need for substantial resource injection into the health sector from the Central Government's budget. Despite this muddled approach, NHP-2002 did well to articulate the need to raise public health expenditure and government-funded health research. It also emphasised the need to address inequities and imbalances and suggested kick-starting the revival of primary health centres. However, like NHP-1983 policy, it did not provide a roadmap for achieving the objectives/targets it set.

The policy failed to address the problems or offer solutions to many of the issues it pointed out. Public investment in health was 0.9 per cent of GDP (0.6 per cent by States and 0.3 per cent by the Centre) in 2010, against the target of 2.0 per cent of GDP, which was far lower than the target of 5.0 per cent recommended by the WHO. In 2019-20, public investment in health was 1.0 per cent of GDP. In 2021-22, public health expenditure shot up to 2.1 per cent of the GDP, but this was due to Covid-related healthcare packages, *viz.*, Emergency Covid Response Plan-I (ECRP-I) and ECRP-II[6] (Table 5). However, it remains to be seen whether this level of expenditure will be sustained.

Table 5: Expenditure on Covid-19 Management under ECRP (in Rs. Crore)

	Centre's share	State's share	Total
ECRP-I	*	-	15,000
ECRP-II	15,000	8,132	23,132[7]

**ECRP-I was funded by the Centre and some multilateral financial institutions such as the World Bank and ADB. However, the breakup is not available.*

Source: PIB Report dated 4th Jan, 2022: Covid-19 – Myths vs. Facts.

As against the target of 8 per cent, state government spending on health was at 5 per cent of their total spending even in 2019-20, *i.e.*, even after 10 years of the deadline. In fact, many States spent less than 5 per cent. Only Delhi and Puducherry spent more than 8 per cent of their budget on health. Many targets set under the policy were not achieved, even after many years, while others were met but with a considerable delay (Table 6).

The key question is how effectively it was able to address inequities and imbalances, against which NHP-2002 itself stated its success or failure should be judged. The share of hospital beds in rural areas as percentage of total hospital beds in the country hardly changed between 2005 and 2017. The share of rural hospital beds was only 28.9 per cent, even though more than 70 per cent of India's population lives in rural areas (Chart 1).

However, large disparities exist between hospital beds when normalised to population, considering that a large proportion of the population resides in rural India. In 2017, there were 9.36 hospital beds per 10,000 population in urban areas, compared to only 2.32 hospital beds per 10,000 population in rural areas. What is even more distressing is that the gap in health infrastructure between rural and urban areas, particularly in terms of hospital beds, widened from 2005 and 2016, before narrowing down somewhat in 2017 (Chart 2).

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[6] Emergency Response and Health Systems Preparedness Package – Phase I and Phase-II were centrally sponsored schemes introduced to prevent, detect and respond to the threat posed by the Covid-19 pandemic and strengthen the national health systems for emergency response and preparedness across the country. These packages were implemented through the NHM. The total amount approved under ECRP-I was Rs. 15,000 crore. For ECRP -II, a total budget of Rs. 23,132 crore was approved with a centre share of Rs. 15,000 crore.

[7] Under the scheme, Rs 20,308.70 crores are to be spent by states out of which Rs 12,185.70 crore is to be provided by the Central Government and Rs 8,123 crore is to be provided by state governments.

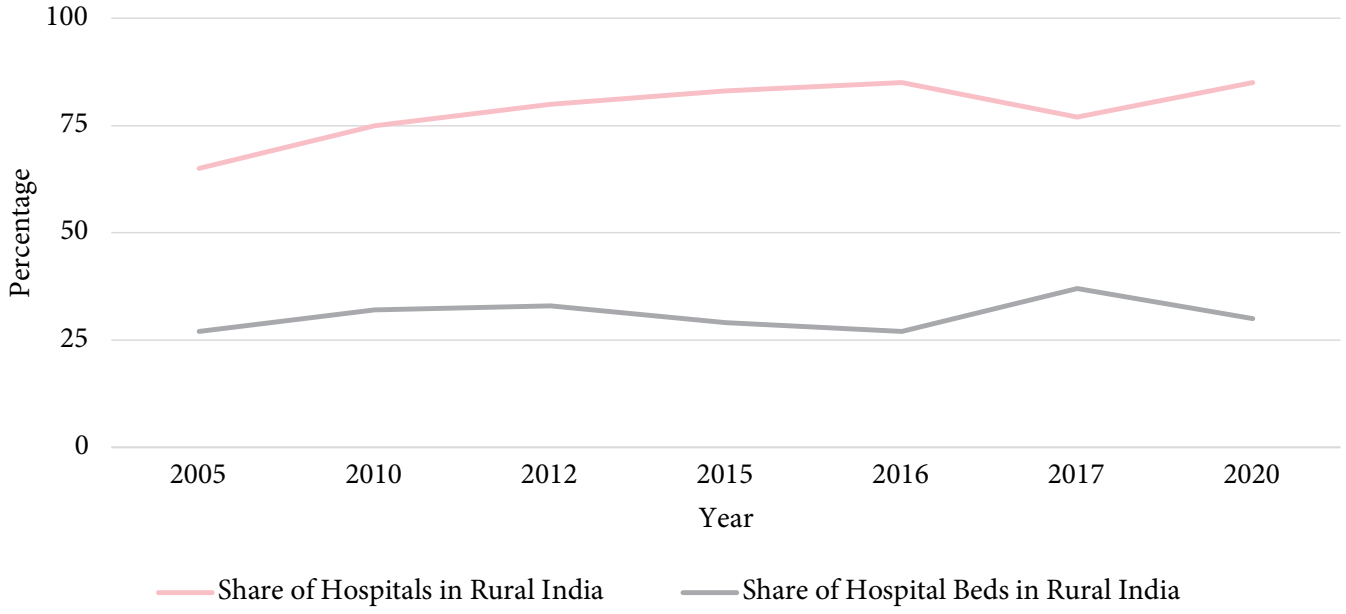
Table 6: NHP-2002 Goals and Status

Goal	Target year	Status	Remarks
Eradicate Polio and Yaws	2005	Achieved, but with a lag	Yaws was eradicated in 2015, and polio in 2011. India achieved the lowest ever polio transmission levels in 2010, especially during the high transmission season. Also, a sharp decline was seen in number of polio cases, with only 42 polio cases reported in 2010 compared to 741 cases in 2009.
Eliminate Leprosy	2005	Achieved, but with a lag	Leprosy prevalence rate was reduced to 0.71/10,000 by 2010 from 57.8/10,000 in 1983. 32 States/UT's (except Bihar, Chhattisgarh and Dadra & Nagar Haveli) eliminated leprosy by March 2010. In all, 81% of districts and 77% of Block PHC eliminated leprosy by 2010 in the country.
Eliminate Kala-azar	2010	No	Kala-azar has still not been eliminated. Of the 633 kala-azar endemic blocks, kala-azar was eradicated in 625 blocks by 2021.
Eliminate Lymphatic Filariasis	2015	No	The goal was extended till 2021, but it still has not been achieved so far.
Achieve zero level of growth HIV/AIDS	2007	No	Adult HIV prevalence at the national level declined from 0.41% in 2000 to 0.31% by 2009. The estimated number of new annual HIV infections declined by more than 50% over the decade ended 2010.
Reduce Mortality by 50% on account of T.B., Malaria and other vector and water borne diseases	2010	-	TB mortality in the country was reduced from over 420/million population in 1990 to 230/million population in 2009. The prevalence of TB in the country was reduced from 3380/million population in 1990 to 2490/million population by the year 2009 as per the WHO global TB report, 2010.
Reduce IMR to 30/1000 and MMR to 1000/million	2010	Achieved, but with a lag	Achieved in 2020, when the IMR declined to 28/1000 and MMR declined to 970 per million.
Establish an integrated system of surveillance, National Health Accounts and Health Statistics	2005	Achieved, but with a lag.	National Health Accounts was established in 2006-07.

Source: Reports published by National Health Mission.

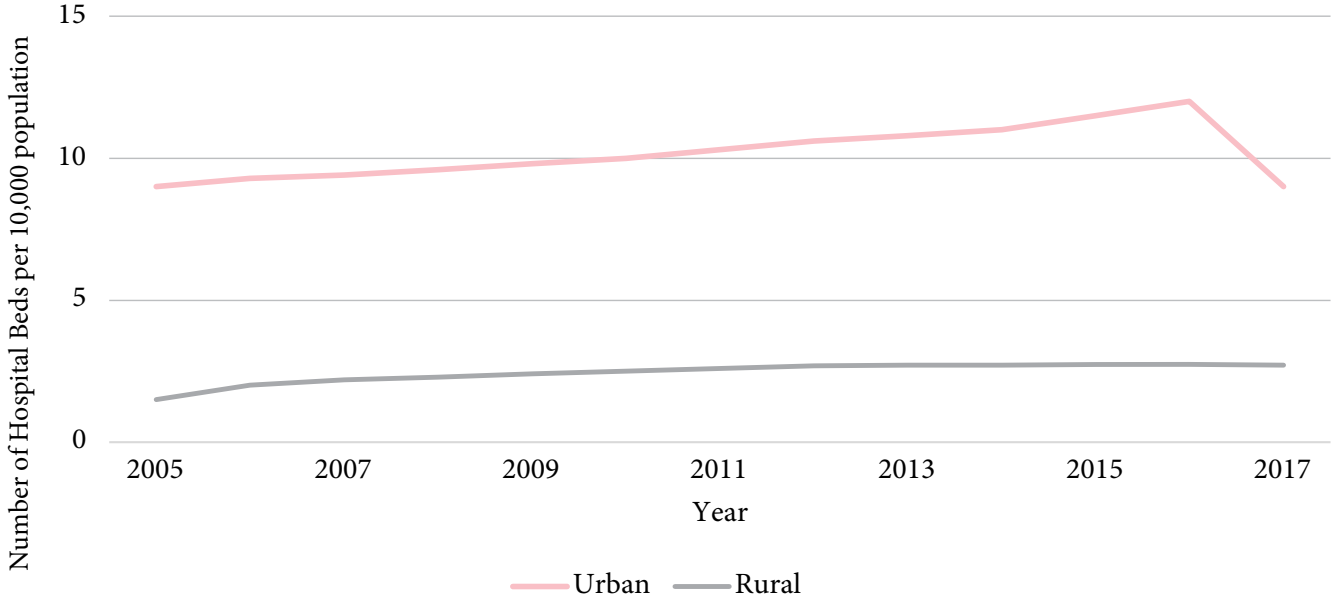
However, large disparities exist between hospital beds when normalised to population, considering that a large proportion of the population resides in rural India. In 2017, there were 9.36 hospital beds per 10,000 population in urban areas, compared to only 2.32 hospital beds per 10,000 population in rural areas. What is even more distressing is that the gap in health infrastructure between rural and urban areas, particularly in terms of hospital beds, widened from 2005 and 2016, before narrowing down somewhat in 2017 (Chart 2).

Chart 1: Share of Rural Hospital and Hospital Beds in India



Source: Rural Health Statistics 2016-17 and World Bank.

Chart 2: Hospitals Beds in Urban and Rural areas per 10,000 population (2005-2017)



Source: Rural Health Statistics 2016-17 and World Bank.

By 2017, the primary health sector infrastructure in the country continued to be deficient based on population norms (Table 7).

Table 7: Primary Healthcare System – 2017

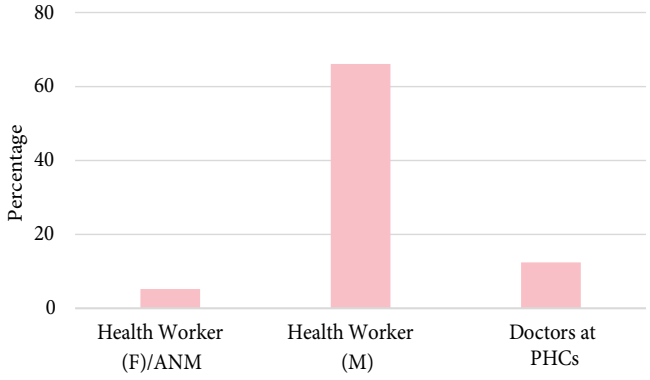
Indicator	National Norm*		Status (End-2017)		Status (2021)	
Population covered by:	Rural	Tribal Area	Rural Area	Tribal Area	Rural Area	Tribal Area
Sub Centre	5,000	3,000	5,337	3,327	5,734	3,839
Primary Health Centre	30,000	20,000	32,505	23,315	35,602	25,507
Community Health Centre	120,000	80,000	148,248	91,264	163,298	103,756

**National norms set under the NRHM by Directorate General of Health Services, in 2011.*

Source: Rural Health Statistics 2016-17.

However, more than the lack of physical infrastructure, it is the large-scale shortage of human resources (relative to the positions already sanctioned) managing the primary healthcare system which was distressing.There was a 66 per cent shortage of health workers and more than 10 percentage shortage of doctors in rural sub-centres (SCs) and primary health centre (PHC) (Chart 3). The expansion of PHC infrastructure does not serve much purpose if it is not adequately equipped with necessary facilities and resources.

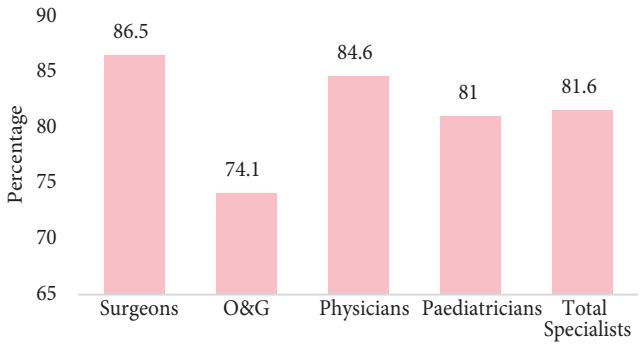
Chart 3: Shortfall in Rural SCs and PHCs



Source: Rural Health Statistics 2016-17.

There was a significant shortage of specialists such as surgeons, obstetricians and gynaecologists, physicians, and paediatricians in rural CHCs (Chart 4).

Chart 4: Shortfall of Specialists in Rural CHCs



Source: Rural Health Statistics 2016-17.

Thus, the provision of healthcare infrastructure in India is skewed in favour of urban areas. While some imbalances in healthcare services between rural and urban areas are to be expected, the scale of these imbalances remains a matter of concern.

4.2 Sub-period II: 2003-2017

The thrust of the healthcare policy framework in this period was on addressing regional imbalances by providing affordable and reliable tertiary healthcare services and improving the quality of medical education in the country.

Pradhan Mantri Swasthya Suraksha Yojana (PMSSY)

The *Pradhan Mantri Swasthya Suraksha Yojana* (PMSSY/Scheme) is a central sector scheme announced in August 2003 to augment facilities for quality medical education in the country. This included establishing institutions like the All India Institute of Medical Sciences (AIIMS) and upgrading certain state government hospitals (GoI). In March 2006, the government sanctioned Phase-I of the PMSSY, comprising two main components: (i) the establishment of six institutions akin to the All-India Institute of Medical Sciences (AIIMS), which were later referred to as new AIIMS; and (ii) the enhancement of 13 existing State Government Medical Colleges/Institutions (GMCIs). The enhancement of GMCIs was aimed at bolstering health infrastructure through the construction of super-speciality blocks/trauma centres and acquiring medical equipment for certain GMCIs.

The Government of India has been setting up new AIIMS to create advanced tertiary healthcare infrastructure, medical education, and research facilities in different parts of the country. To facilitate creation of these important institutions, the Government of India legislated the AIIMS (Amendment) Act, 2012, under which these AIIMS are established. As

per the provisions of the Act, these new AIIMS are called Institutes of National Importance and function as autonomous institutions under the Ministry of Health and Family Welfare (MoHFW). Over the years, the scheme has expanded to cover 20 new AIIMS and 71 GMCIs in six phases.

Though well-intentioned, the implementation of the scheme was tardy. First, there were considerable time and cost overruns in setting up the new AIIMS. Despite good intentions, the execution of the initiative encountered significant delays. Notably, the establishment of new AIIMS experienced extensive time and financial overruns. The Comptroller and Auditor General (CAG) highlighted in its 2018 Report that the completion timeline for all new AIIMS exceeded the initial estimates by approximately five years. Similar postponements were noted in the enhancement of state government hospitals, accompanied by financial overruns. Specifically, the Ministry of Health and Family Welfare (MoHFW) initially projected the capital expenditure for constructing six new AIIMS under Phase 1 at Rs. 332 crore per institution. This estimate was later adjusted to Rs. 820 crore per institution after four years, due to deficiencies in planning and evaluating necessities (Government of India, 2018). The Standing Committee on Health and Family Welfare, in its 2017 and 2018 reports, observed inadequate assessment of time and costs, resulting in the non-utilisation of allocated funds and significant delays in the construction activities of Government Medical College Institutions (GMCIs) in the first three phases of the PMSSY.

The new AIIMS faced significant human resource shortages, with vacancies in various faculty and non-faculty positions ranging from 55 to 83 per cent and 77 to 97 per cent, respectively. These shortages hindered the operation of several departments, led to an increased reliance on contracted staff, placed additional burdens on doctors during outpatient department (OPD) hours, and ultimately compromised the quality of patient care. Delays in filling these positions were linked to challenges such as establishing recruitment guidelines, legal disputes, the scarcity of qualified candidates, and a lack of coordination between recruitment processes and infrastructure development (GoI, 2018).

An essential aspect of delivering adequate service and ensuring quality care for patients is the availability of sufficient beds. Nonetheless, the shortfall in bed availability across the new AIIMS was between 43 and 84 per cent, a situation exacerbated by construction delays of hospital complexes and the aforementioned faculty shortages (GoI, 2018).

National Rural Health Mission (2005)

The National Rural Health Mission (NRHM) was launched in 2005 against the backdrop of the poor state of primary healthcare in rural areas and the decline in public investments in health, which had severe consequences on the health and economic outcomes of the population. The National Commission on Macroeconomics and Health (NCMH), which submitted its report in August 2005, identified three broad factors responsible for the failure of the public health system: (i) poor governance and the dysfunctional role of the state; (ii) lack of a strategic vision; and (iii) weak management. The NCMH emphasised five core elements for improving health in India: (i) promoting equity by reducing household health expenditure; (ii) increasing the accountability of the primary healthcare system; (iii) reducing disease burden; (iv) establishing institutional frameworks to improve governance of health; and (v) investing in technology and human resources (GoI, 2005a). The findings of the NCMH report played a significant role in the development of the NRHM.

The key focus of the NRHM was to provide accessible, affordable, and quality healthcare to the rural population, especially the vulnerable sections. Though the scheme was launched throughout the country, it focused on 18 states with weak public health infrastructure. These were Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand Jammu and Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Odisha, Rajasthan, Sikkim Tripura, Uttaranchal, and Uttar Pradesh. The major objectives of the scheme were: (i) reduction in child and maternal mortality; (ii) universal access to public services for food and nutrition, sanitation and hygiene and universal access to public healthcare services with emphasis on services addressing women's and children's health and universal immunisation; (iii) prevention and control of communicable and non-communicable diseases, including locally endemic diseases; (iv) access to integrated comprehensive primary health care; (v) population stabilisation, gender and demographic balance; (vi) revitalisation of local health traditions and mainstream *Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy* (AYUSH); and (vii) promotion of healthy lifestyles.

Key elements focused on in the scheme were (i) strengthening the public health delivery system by revitalising existing infrastructure and correcting manpower planning; (ii) integrating drinking water, nutrition, sanitation, female literacy, and women's empowerment as they also significantly impact health indicators as much as functional health facilities; (iii) ensuring accountability at every level through community-based monitoring, external surveys, and stringent internal monitoring. The scheme aimed to push the public health expenditure to nearly 3 per cent of GDP. The NRHM comprised four sub-schemes (Appendix III). Human resources provided and other activities undertaken by the NRHM during the period 2005-2013 are detailed in Appendix IV.

NRHM was the first comprehensive initiative targeted at the healthcare needs of the rural population. However, it suffered from some deficiencies. NRHM did not create an institutional mechanism to meet the demand of training a large number of public health professionals that such a programme required (Bajpai and Sarya, 2015). As a result, the overall progress of the NRHM in achieving its targets was mixed (Table 8). The programme successfully reduced the malaria mortality rate, made significant progress in eliminating leprosy, and maintained the TB cure rate above the target. The programme also increased human resources such as auxiliary nurse midwives (ANMs), staff nurses, medical officers, and specialists, though their numbers remained below the targets. However, the programme fell considerably short of its IMR and MMR targets, among others (Table 8). One area where it exceeded the target was in the deployment of accredited social health activists (ASHAs), as explained subsequently.

Table 8: Physical Outcomes: Targets & Achievements under NRHM

Sr. No.	Targets (2005-12)	Achievements (up to 2012)
1	Reduce IMR to 30/1000 live births	IMR reduced from 58 in 2005 (SRS) to 42 in 2012 (SRS).
2	Reduce maternal mortality to 100/100,000 live births	MMR reduced from 254 in 2004-06 to 178 in 2010-12 (SRS).
3	Reduce TFR to 2.1	TFR reduced from 2.9 in 2005 (SRS) to 2.4 in 2012 (SRS).
4	Reduce Malaria mortality to 60% relative to 2005	Malaria mortality reduced by 70% (from 1707 deaths in 2006 to 519 deaths in 2012).
5	Reduce Kala-azar mortality to 100% relative to 2005	Kala-azar mortality reduced to 85% (from 187 deaths in 2006 to 29 deaths in 2012).
6	Reduce Filaria/Microfilaria rate to 80% relative to 2005	Filaria/Microfilaria rate reduced by 60% (from 1.02 in 2005 to 0.41 in 2012)
7	Reduce Dengue mortality by 50% relative to 2005	Dengue mortality reduced by just 8% (from 184 deaths in 2006 to 169 deaths in 2011).
8	Cataract operations - Increase to 4.6 million per year	Cataract operations of more than 6.4 million were reported in 2012.
9	Reduce Leprosy prevalence rate to less than 1 per 10,000	Leprosy prevalence rate reduced from 1.34 per 10,000 in 2005 to 0.68 per 10,000 in 2012.
10	Tuberculosis Control - Over 70% case detection & 85% cure rate	The case detection rate of Tuberculosis was 71% in 2012 and the cure rate was 88%.

Source: Report of July 24, 2015, PIB.

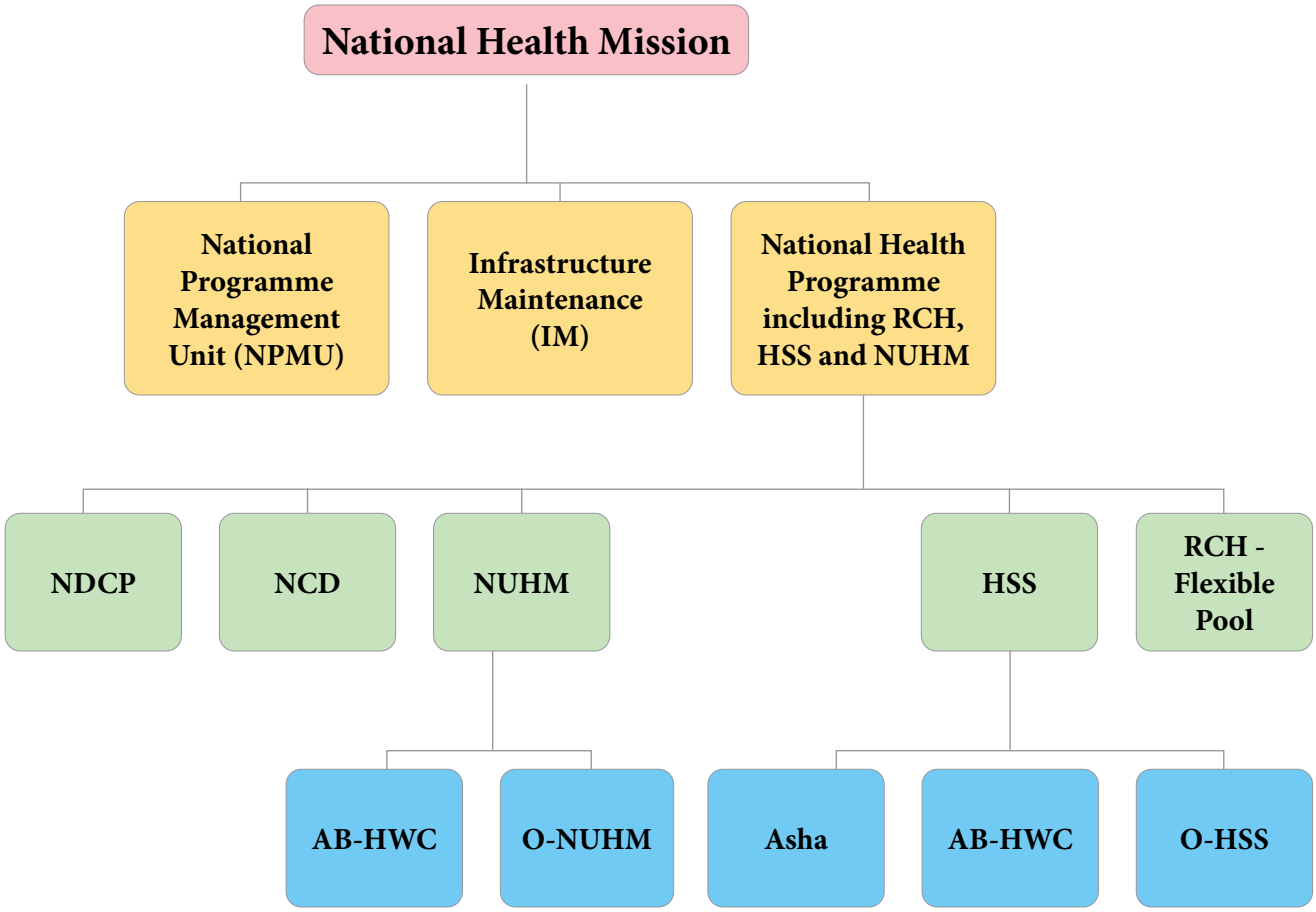
National Health Mission

In response to the stagnation and even worsening of key health indicators in urban areas, the National Urban Health Mission (NUHM) was launched on May 1, 2013. It functions as a sub-mission of the overarching National Health Mission (NHM), with National Rural Health Mission (NRHM) as the other sub-mission of NHM.

The NUHM aimed to provide comprehensive primary healthcare services to the urban population in general, particularly the poor and other disadvantaged sections. It sought to facilitate equitable access to quality healthcare through a revamped primary public healthcare system, targeted outreach services, and involvement of the community and urban local bodies. NUHM covered all state capitals, district headquarters, and other cities/towns with a population of 50,000 and above (as per census 2011) in a phased manner. Cities and towns with populations below 50,000 continued to be covered under NRHM. NRHM was implemented in 779 cities and towns, covering about 77.5 million people.

The NHM aims to attain universal access to equitable, affordable, and quality healthcare services that are accountable and responsive to people's needs. Under the NHM, support is provided to States/Union Territories (UTs) to facilitate the delivery of effective healthcare services up to the district hospital (DH) level, especially for the poor and vulnerable sections of the population. The interventions under the NHM also aim to bridge the gap in rural healthcare services by improving health infrastructure, augmenting human resources, enhancing service delivery, and decentralising planning. NHM comprises three broad components with sub-components (Chart 5).

Chart 5: National Health Mission



Notes: O-HSS – Other health system strengthening, AB-HWC: Ayushman Bharat Health and Wellness Centre, ASHA- Accredited Social Health Activist, O-NUHM- Other National Urban Health Mission, NDCP- National Disease Control Programme, NCD- Non-Communicable Diseases.

Source: Rajya Sabha report 134, Dated: 24th March 2022.

Reproductive-maternal-neonatal-child and adolescent health (RMNCH+A or RCH): This programme aims to improve maternal and child health, as their survival is central to the achievement of national health goals. It provides a strong platform for delivering services across the entire continuum of care, ranging from the community level to various levels of the healthcare system. It includes the Routine Immunisation Programme, Pulse Polio Immunisation Programme, and National Iodine Deficiency Disorders Control Programme.

Communicable Disease Control Programme (NDCP): This programme comprises: (i) the National Vector Borne Disease Control Programme; (ii) the Revised National Tuberculosis Control Programme; (iii) the National Leprosy Control Programme; and (iv) the Integrated Disease Surveillance Programme.

Non Communicable Disease (NCD) Control Programme: This programme includes: (i) the National Programme for Prevention & Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS); (ii) the National Programme for Control of Blindness & Visual Impairment (NPCBVI); (iii) the National Mental Health Programme (NMHP); (iv) the National Programme for Healthcare of the Elderly (NPHCE); (v) the National Programme for the Prevention & Control of Deafness (NPPCD); (vi) the National Tobacco Control Programme (NTCP); (vii) the National Oral Health Programme (NOHP); (viii) the National Programme for Palliative Care (NPPC); (ix) the National Programme for Prevention & Management of Burn Injuries (NPPMBI); (x) the National Organ Tissue and Transplant Organisation (NOTTO); (xi) the National Programme for Prevention and Control of Fluorosis (NPPCF); and (xii) the National Iodine Deficiency Disorder Control Programme.

Health System Strengthening (HSS): This includes (i) the adoption of the Indian Public Health Standards (IPHS); (ii) quality standards; (iii) addressing skill gaps and standard treatment protocols; (iv) Hospital Management Societies (also referred to as *Rogi Kalyan Samiti*—this committee acts as a group of trustees who look after the functioning of the hospital affairs) and untied funds; and (v) Quality Improvement Programmes.

Accredited Social Health Activists (ASHAs): As a key component of the National Rural Health Mission, ASHAs also play a key role in NHM, as alluded to before. The ASHA Programme has been particularly successful in bringing people back to the public health system for outpatient services, diagnostic facilities, institutional deliveries, and inpatient care. There are over one million ASHAs across the country in rural and urban areas under the NHM, acting as a link between the community and the public health system.

Ayushman Bharat Health and wellness centre (AB-HWC): This initiative aims to ensure the delivery of comprehensive primary health care (CPHC) services. Existing sub-centres (SCs) covering populations of 3000-5000 were to be converted into Health and Wellness Centres (HWCs), with the principle that "time to care" should be no more than 30 minutes. PHCs in rural and urban areas were also to be converted to HWCs, with care also provided/complemented through outreach services.

National Urban Health Mission (NPMU): This aims to provide comprehensive primary healthcare services to the urban population, particularly the poor and other disadvantaged sections, by facilitating equitable access to quality healthcare through a revamped primary public healthcare system, targeted outreach services, and the involvement of the community and urban local bodies. Infrastructure maintenance component has been supported over several plan periods. Support under this component is provided to States to meet salary requirements of schemes.

National Programme Management Unit (NMPU): Up to 0.5 per cent of the total NHM outlay is earmarked for Programme Management and Activities for Policy support at the national level through a NPMU.

Funding Pattern under the National Health Mission

The NHM is a major instrument of financing and support to the States to strengthen public health systems and healthcare delivery. The funding arrangement for NHM involves a 60:40 split between the Central Government and most State Governments and Union Territories (UTs) with a legislative assembly, specifically Delhi and Puducherry (GoI, 2020). In the case of Jammu & Kashmir, Himachal Pradesh, Uttarakhand, and the North-Eastern States, including Sikkim, the funding distribution is adjusted to a 90:10 ratio, favouring the states. For UTs without a legislative assembly, the Central Government assumes full financial responsibility, providing 100 per cent of the funds. The allocation of funds to states is determined by their respective Programme Implementation Plan (PIP).

Until 2022-23, NHM had five financing components: (i) RCH-HSS Flexi pool; (ii) NUHM Flexi pool; (iii) Flexible pool for Communicable diseases (DCP). (iv) Flexible pool for Non-communicable disease (NCD); and (v) Infrastructure Maintenance. The Central Government allocated a certain proportion of the total allocation of the fund to each component with a definitive basis for allocation to States (Appendix V). However, from 2022-23 onwards, RCH-HSS, DCP, NCD, and NUHM pools under NHM were merged to provide greater flexibility to States/UTs. This was done to improve administrative efficiency; minimise the human interface involved in multiple instances of funds withdrawal; and improve financial utilisation of the States/UTs (GoI, 2022) (Appendix VI).

Major initiatives undertaken under NHM are mentioned in Appendix VII, while the progress made in terms of some of the above referred initiatives is outlined in Appendix VIII.

As NHM has been extended up to 2026, the targets set under the NHM have also been revised (Table 9).

The NRHM/NHM (hereinafter referred to as NHM, which also includes NRHM) has been one of the most significant public health initiatives so far in India. NHM played a role in reversing the trend of health spending by States to 0.70 per cent of GDP in 2022, up from 0.47 per cent of GDP in 2004-05 (health spending of States was 0.70 per cent of GDP in 1990-91). However, NHM has often been criticised for 'one-size-fits-all' approach as it does not consider inter-state variations, limiting States' ability to adapt to local conditions and innovate. Additionally, several concerns have been raised regarding the operations of the scheme. Rao (2017) in his assessment of select centrally sponsored schemes, including NHM, found that the actual release of funds was significantly below the allocations. A study conducted for 29 states for years 2015-16 and 2016-17 found limited flexibilities in NHM's flexi-pools, restricting States from maximising fund utilisation (Choudhary and Mohanty, 2018). Incidentally, the Central Government eliminated the allocation for each pool from 2022-23 onwards, as previously mentioned. Some researchers reported that NHM failed to achieve inter-state parity and provide health equity within states such as Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh (Husain, 2011; Jeffery, 2021), defeating its basic assumption that people in all states would receive at least basic meritorious public services (Rao, 2018).

Table 9: NHM – Initial and Revised Targets

S.no	Targets of NHM (2012-17)	Targets of NHM by 2025
1	Reduce IMR to 25/1000 live births	Reduce IMR to 23/1000 from 32/1000
2	Reduce MMR to 100/100,000 live births	Reduce MMR to 90/100,000 from 113/100,000
3	Reduce TFR to 2.1	Sustain a TFR of 2.1
4	Reduce annual prevalence and mortality from Tuberculosis by half	Ending the TB epidemic from the country by 2025
5	Reduce prevalence rate of Leprosy to <1/10,000 population in all districts.	Reduce prevalence of Leprosy to <1/10,000 population and incidence to zero in all districts
6	Annual Malaria Incidence to be <1/1000	Annual Malaria Incidence to be <1/1000
7	**	Reduce U5MR to 23/1000 from 36/1000
8	Less than 1 per cent microfilaria prevalence in all districts	*
9	Kala-Azar Elimination by 2015, <1 case per 10000 population in all blocks	*

**There was no mention of leprosy and kala-azar in the NHM 2025 targets.*
***There was no mention of U5MR in NHM 2017 targets.*

Source: PIB Report dated September 28, 2022.

The 14th Common Review Mission report also highlighted some deficiencies in the scheme's implementation. First, while ASHAs play a crucial role at the community level, gaps in critical programme components affect ASHA functionality, such as variable training equality, inadequate supportive supervision, delays in payments, and insufficient attention to grievance redressal and safe working conditions. Second, there are gaps in the availability of human resources across the six major service delivery cadres universally across the states. Third, although secondary care services, including emergency care, are being provided, their performance monitoring is not adequate to assess the types and quality of services being provided at the public healthcare facilities. Most of the facilities visited across the 13 states were also not compliant with IPHS norms (GoI, 2022). Fourth, the Clinical Establishments (Registration and Regulation) Act, 2010, was enacted by the Central Government to facilitate the registration and regulation of all clinical establishments across the country, ensuring they meet the minimum standards of facilities and services. However, the enforcement of the Act remains weak in almost all States. Fifth, the framework of NHM envisions a health system which is accountable and responsive to needs of the population. This is also one of the key core principles of NHP framed in 2017. Although States have reported functional *Rogi Kalyan Samitis* (RKS) at facility level, the role of RKS in improving quality and patient amenities was found to be limited (GoI, 2022).

While there has been good progress in the targets fixed under the programme, in most cases, the progress has fallen well short of these targets. Some targets were not achieved even three years after the programme's initiation. For instance, the IMR is currently 26.6 per 1000 live births, compared to the target of 25 per 1000. The incidence and mortality from TB has risen over the years. Kala-azar was eliminated only in 2023, despite the target to do so by 2015. One of the primary goals of NHM has been to reduce out-of-pocket expenditure. Numerous initiatives to decrease OOPE under NHM, such as providing free essential drugs and diagnostics, have been implemented. However, a major failure of the programme is that health expenditure continues to be low, showing only a marginal improvement (0.05 per cent of GDP) in the last 10 years. As a result, OOPE has remained quite high, accounting for 62.7 per cent of current health expenditure (Table 10).

The burden of most infectious and associated diseases has reduced in India. However, there has been a sharp rise in non-communicable diseases. It has been estimated that the proportion of deaths due to NCDs in India rose from 37.9 per cent in 1990 to 61.8 per cent in 2016 (ICMR, 2017). The four major NCDs are cardiovascular diseases (CVDs), cancers, chronic respiratory diseases (CRDs), and diabetes, which share four behavioural risk factors – unhealthy diet, lack of physical activity, and use of tobacco and alcohol.

National Health Policy, 2017

Fifteen years following the implementation of the 2002 health policy, the situation had evolved significantly in four major ways. First, though maternal and child mortality declined rapidly, the burden due to non-communicable diseases and some other infectious diseases increased. Second, the emergence of a robust healthcare industry was estimated to be growing in double digits. Third, the growing incidence of catastrophic expenditure due to healthcare costs was believed to be one of the major contributors to poverty. Fourth, accelerated economic growth provided enhanced fiscal capacity. In response to these changes, a new health policy was formulated in 2017, with its primary aim being "*to inform, clarify, strengthen and prioritise the role of the Government in shaping health systems in all its dimensions.*"

For the first time, NHP-2017 prescribed ten key policy principles: (i) professionalism, integrity, and ethics; (ii) equity; (iii) affordability; (iv) universality; (v) patient-centred and quality of care; (vi) accountability; (vii) inclusive partnerships; (viii) pluralism; (ix) decentralisation; and (x) dynamism and adaptiveness (GoI, 2017).

The specific key objectives of NHP-2017 included: (i) progressively achieving universal health coverage through (a) free, comprehensive primary health care services, (b) improved access and affordability of quality secondary and tertiary care services, (c) significant reduction in OOPE and reduction in proportion of households experiencing catastrophic health expenditures and consequent impoverishment; (ii) reinforcing public trust in the public healthcare system; and (iii) aligning private healthcare sector growth with public health goals. NHP-2017 also set specific quantitative goals, including raising public health expenditure to 2.5 per cent of GDP in a time-bound manner, with some goals aligned with those of the NHM.

Table 10: NHM Targets and Achievements

Baseline Indicator	Baseline (2012)	NHM Target	Latest Position	% Improvement over baseline	Remarks
Demographic Changes					
MMR	1.78/1000 (2010-12)	1/1000 live births.	0.97/1000 (2018-20)	45.5%	The target achieved and India is now reportedly on the track to achieve the Sustainable Development Goals (SDG) target of MMR less than 700/ million live births by 2030.
IMR	42/1000	25/1000 live births.	26.62/1000	36.6%	**The IMR target was not achieved as of 2023; IMR stood at 26.62.**
TFR	2.4	2.1	2	16.6%	The target was achieved.
Epidemiological Effects					
Prevention and reduction of anaemia in women aged 15–49 years	53.1% of all women aged 15-49 years were anaemic (NFHS-4 2015-16)		57% of all women aged 15-49 years were anaemic (NFHS-5 2019-21)		Even after the government's efforts, prevalence of anaemia among women has risen over time.
Reduce annual incidence and mortality from Tuberculosis by half	Incidence (rate per 100,000) -176 Mortality (rate per 100,000) - 22	Reduce both the indicators by half their original amount.	Incidence (rate per 100,000) - 188 Mortality (rate per 100,000) - 37	Incidence - 6.2% Mortality - 6.8%	The incidence as well as the mortality from TB have risen over the years.
Annual Malaria Incidence	Total Malaria Cases (million)- 1.06	<1/1000	Total Malaria Cases (million)- 0.19	82%	Malaria cases fell to 0.7 per 1000 of population. Malaria deaths also declined sharply by 82% between 2012 and 2020.
Microfilaria (MF) prevalence in all districts	0.43% of district population (national prevalence average)	Less than 1% microfilaria prevalence in all districts.	-		The target achieved. 222 districts reported MF rate less than 1% in 2016.
Kala-azar Elimination by 2015	Cases - 19,068 Deaths - 23		Cases – 2052 Deaths - 6	89.2% 4.9%	The target has been extended up to 2023. Out of 633 kala-azar endemic blocks, 625 blocks successfully eliminated the kala-azar in 2021.
Reduce prevalence of Leprosy	Total New Cases – 127,295	<1/10000 population	Total New Cases – 464	99.6%	The NHM target was achieved in 2021.Prevalence rate of 0.4 per 10,000 of population (WHO, 2021)
Health Infrastructure					
PHCs	24,049		30,813	28.1%	-
CHCs	4,833		5,649	16.9%	-
Sub Centres	148,366		157,921	6.4%	-
AMN's	664,453		934,583	40%	-
Health Financing					
Public Health Expenditure as % of GDP	0.93%		0.98% (2019)	5.3%	It was the Covid 19 pandemic which helped reach the target of over 2% of GDP spent on health in 2021-22. Adjusted for Covid, health spending was less than one per cent.
Reduce household out-of-pocket expenditure in total healthcare expenditure	63% (of current health expenditure)		54.78% (2019) (of current health expenditure)	13%	-

Source: PIB Report dated September 28, 2022.

Table 11: NHP-2017 Policy - Targets & Achievements

	Indicator	Latest Position	Remarks
	Demographic Indicators		
1	Reduce MMR from current levels to 100 by 2020.	MMR was 97 in 2020	Achieved.
2	Reduce infant mortality rate to 28 by 2019.	IMR 30 in 2019, but reduced to 27 in 2020	Achieved with a lag.
3	Reduce Under Five Mortality to 23 by 2025	U5-MR was 32 in 2020	-
4	Reduce TFR to 2.1 at national and sub-national level by 2025.	TFR was 2 in 2020	Achieved.
5	Increase Life Expectancy at birth from 67.5 to 70 by 2025.	70 in 2020	Achieved ahead of time.
6	Reduce neonatal mortality to 16 and still birth rate to "single digit" by 2025.	Neo-natal mortality rate was 19.1 in 2021.	-
7	Antenatal care coverage to be sustained above 90% and skilled attendance at birth above 90% by 2025.	Antenatal care coverage was 58% according to NFHS 2019-21 and the births attended by skilled professionals was 89.4% in 2021.	Achieved.
8	More than 90% of the new-born to be fully immunised by one year of age by 2025.	67% of the total new-born were fully vaccinated in their first year in 2021.	-
9	Meet the need of family planning above 90% at national and sub national level by 2025.	Family planning was at 87.6% in 2021.	-
10	Access to safe water and sanitation to all by 2020 (Swachh Bharat Mission).	99% and 95% of urban and rural households have access to safe drinking water. 83% have access to a toilet.	Not achieved but significant improvement made.
11	Decrease in proportion of households facing catastrophic health expenditure from the current levels by 25%, by 2025.	OOPE was 49.8 per cent of health expenditure in 2021.	-
	Epidemiological Effects		
12	Elimination of: Leprosy by 2018, Kala-Azar by 2017 and Lymphatic Filariasis in endemic pockets by 2017.	(a) Prevalence rate of leprosy was at 0.4 per 10,000 of population in 2021. (b) The target of elimination of kala-azar was extended till 2023. (c) Lymphatic Filariasis prevalence rate in endemic pockets declined to less than 1% prevalence by 2016.	Not achieved. Not achieved in 2017, Deadline extended till 2023. Not achieved in 2017, the deadline was further extended twice—first till 2021 then till 2027.
13	A cure rate of >85% in new sputum positive patients for TB and reduce incidence of new cases, to reach elimination status by 2025.	TB incidence and mortality rose 6.2% & 6.8%, respectively, between 2012 and 2020.	-
14	Reduce the prevalence of blindness to 0.25/1000 by 2025	Prevalence of blindness reduced to 0.3% (2020).	-
	Health Financing		
15	Increase health expenditure by Government as a percentage of GDP from the existing 1.15% to 2.5 % by 2025.	Increased from 1.15% in 2013-2014 to 1.28% in 2019.	Not achieved.
16	Increase State sector health spending to > 8% of their budget by 2020.	Average spending on health was 5 per cent of state budgets.	Not achieved.

Source: Report dated September 28, 2022, PIB and NHP-2017 report.

Key elements of the policy included: (i) aligning state resource allocations with development indicators, absorptive capacity, and financial metrics; (ii) fostering inter-sectoral coordination at both national and sub-national levels to enhance health outcomes; (iii) adjusting healthcare service organization strategies, such as (a) transitioning primary care from selective to assured comprehensive care with connections to referral hospitals; (b) shifting secondary and tertiary care from input-driven to output-oriented strategic purchasing; (c) transforming public hospitals from user fee and cost recovery models to providing free drugs; diagnostics; and emergency services for everyone; (d) evolving infrastructure and human resource development from a norm-based to a targeted approach for underserved regions; (e) upgrading urban health from minimal to comprehensive assured interventions; (f) integrating National Health Programs with health systems to improve program effectiveness; and (g) mainstreaming AYUSH services from stand-alone operations to an integrated three-dimensional approach.

NHP-2017 articulated allocating up to two-thirds or more of the budget to primary care, followed by secondary and tertiary care, the view which was also echoed by the Fifteenth Finance Commission (FC-XV). FC-XV also recommended grants of Rs. 70,051 crore over the period of five years (2021-2026) through local governments for strengthening the primary healthcare system. These grants were provided for: (i) conversion of rural SCs and PHCs to HWCs; (ii) support for diagnostic infrastructure for primary healthcare activities; and (iii) support for urban HWCs, SCs, PHCs, and public health units at the block level[8] (GoI, 2023).

NHP-2017 policy was a departure from NHP-2002 policy in at least two ways. First and foremost, it brought the focus back to UHC. Secondly, it proposed enhancing institutional frameworks for consultative decision-making and joint execution between the central and state governments as a progressive strategy, in contrast to the National Health Policy 2002 (NHP-2002), which explicitly designated public health as a state responsibility.

Like earlier policies, NHP-2017 failed to outline a road map to raise public spending on health. As a result, even five years after the rollout of NHP-2017, public expenditure on health remained broadly unchanged at around one per cent of GDP. Several other quantitative targets for 2020 have not been met, even though many years have elapsed after the timeline set for the targets (Table 11).

4.3 Sub-period III: 2018 Onwards

The primary focus during this period was on managing the Covid-19 pandemic and addressing the inadequacies in public health infrastructure for any future pandemics and outbreaks.

National Digital Health Mission (2020)

Following the NHP's 2017 specific goals for adopting digital technologies, the MoHFW constituted a committee (Chairman: Shri J. Satyanarayana) to develop an implementation framework for the National Health Stack. This committee produced the National Digital Health Blueprint (NDHB), laying out the building blocks and an action plan to implement digital health comprehensively and holistically. Since the implementation was envisioned to be in a mission mode, the initiative was referred to as the National Digital Health Mission (NDHM), which was later renamed as the Ayushman Bharat Digital Mission (ABDM).

Some of the key objectives of ABDM are: (i) establishing digital health systems for managing digital infrastructure; (ii) creating registries with credible data of clinical establishments, healthcare professionals, health workers, drugs, and pharmacies; (iii) standardising personal health records; and (iv) national portability of healthcare services. The goal is to create a holistic health ecosystem for all.

ABDM was piloted on August 15, 2020 in six Union Territories—Andaman & Nicobar, Chandigarh, Dadra & Nagar Haveli and Daman & Diu, Ladakh, Lakshadweep, and Puducherry. Three key registries of NDHM—Health ID, Health Professional Registry (HPR), Health Facility Registry (HFR) and digital infrastructure for data exchange—were developed and implemented in these UTs. On September 27, 2021, the national rollout of the ABDM was announced. Over 290 million citizens have gener-

[8] The FC-XV also recommended that Centrally Sponsored Schemes (CSS) in health should be flexible enough to allow states to adapt and innovate, and the focus of these schemes should shift from inputs to outcomes. It also recommended strengthening local governments in terms of resources, health infrastructure and capacity building which would enable them to play an enhanced role in health care delivery, including in crisis times (GoI, 2023).

ated their unique Ayushman Bharat Health Accounts (ABHA) so far. Over 40 million digital health records have been linked to the ABHA accounts of individuals. ABHA, a 14-digit number, allows citizens to access and manage their medical records digitally. With their health records linked to their ABHA accounts digitally, citizens can access and manage these records based on their convenience. This enables citizens to create a comprehensive medical history across various healthcare providers, thereby improving clinical decision-making. Further, the citizens can also digitally share relevant health records with ABDM registered healthcare providers. However, ABDM faces challenges, particularly in ensuring data security and privacy of patient records.

Managing the Covid-19 Pandemic

The Covid -19 pandemic caught the world by surprise, challenging the healthcare system like never before in the recent human history. India was the second most affected country in the world, accounting for 1/7th of the world's Covid burden. With the emergence of the highly transmissible Delta variant (1.617.2), India registered over 0.5 million cases every day for consecutive three weeks (April–May 2021) (Dhar, *et al.,* 2021). The surge in Covid cases of such a large magnitude required unprecedented policy responses on multiple fronts, including two lockdowns in the country to contain/suppress the transmission of the virus. The Government of India constituted 11 empowered groups in March 2020 on different aspects of Covid-19 management in the country to take informed decisions on issues such as medical emergency planning; availability of hospitals; isolation and quarantine facility; disease surveillance and testing; and ensuring availability of essential medical equipment. Location-enabled app *Aarogya Setu* was launched to help monitoring of Covid-19 cases and contact tracing of people who had tested positive or had been in contact with a Covid-19 positive individual.

The India Covid-19 Emergency Response and Health Systems Preparedness Package— ECRP I and II—were launched. ECRP-I, as a central sector scheme, was aimed at building resilient health systems to support preparedness and prevention functions. This initiative was designed to address not only the current Covid-19 outbreak, but also to prepare for similar future outbreaks within the country. The interventions in this package were implemented under the NHM, supplementing the available resources for health systems strengthening and ensuring complementarity.

The objectives of ECRP I, which was implemented from January 1, 2020 to March 31, 2024, were to (i) slow and limit the spread of Covid-19 in India as much as possible; (ii) strengthen national and state health systems to support prevention and preparedness; and (iii) enhance surveillance activities, including setting up of laboratories.

The total package of Rs. 15,000 crore was financed with support from the World Bank and other multilateral financial institutions, such as the Asian Development Bank. The package, sanctioned in April 2020, was required to be utilised in three phases. An amount of Rs. 7,774 crore was allocated for immediate Covid-19 emergency response, while the remainder was provided for medium-term support (1-4 years) under mission-mode approach.

Most of the expenditure was required for mounting a robust emergency response and strengthening both national and state health systems. This was followed by enhancing pandemic research, and strengthening multi-sector national institutions and platforms for One-Health, community engagement, risk communication, implementation, management, capacity building, monitoring, and evaluation components.

In July 2021, Phase Two of the package (ECRP-Phase-II) was launched, amounting to Rs. 23,123 crore, spanning from July 2021 to March 2022. This scheme aimed to prevent, detect, and respond to the continuing threat posed by Covid-19 and strengthen national health systems for preparedness in India. This scheme is a centrally sponsored scheme (CSS) with some central sector (CS) components, comprising a central share at Rs.15,000 crore and a state share of Rs.8,123 crore. To ensure the implementation of critical activities at the state/district levels and strengthen the public healthcare system's preparedness in response to the evolving pandemic, 15 per cent of the Centre's share of resources was released in advance to the States/UTs.

The Covid pandemic exposed serious deficiencies in India's health infrastructure. The country faced a huge shortage of hospital beds, especially oxygen-supported beds and isolation beds. Therefore, efforts were made to strengthen the health infrastructure (Table 12).

Table 12: Covid-19 Health Infrastructure Strengthening

Category	As on April 1, 2020	As on August 2, 2020	No. of Fold increase
Dedicated COVID Hospitals	163	4,416	27
Dedicated COVID Health Centres	0	8,485	-
Dedicated COVID Centre	0	10,150	-
Oxygen supported beds	50,583	435,077	9
Total isolation beds (excluding ICU beds)	41,000	1,808,040	44
Total ICU beds	2,500	124,755	50

Source: State/UT-wise and Hospital-wise Covid Beds/ICU Beds/ventilator Beds in ESIC Covid Dedicated Hospitals (in reply to Unstarred Question on 11 August, 2021).

Table 13: Number of Persons Vaccinated in India (by age group) (As on 12.01.2023) Doses (millions)

12-14 Years		15-18 Years		18+ Population		Precaution Dose		Total Doses
1st Dose	2nd Dose	1st Dose	2nd Dose	1st Dose	2nd Dose	18-59 Years	60+ Years, HCW, FLW	
4.1	3.2	6.2	5.4	92.2	86.4	15.4	6.9	220.1

Source: WHO database.

Table 14: Number of Persons Vaccinated in India (Dose I, II and Booster) (As on 27.06.2023)

Doses of vaccines	Persons Vaccinated 1Plus Dose*	Persons Last Dose**	Persons Booster Add Dose	Total Vaccinations
Number of doses (millions)	1026	952	229	2207

Source: WHO database.
*Note: *: Cumulative number of persons vaccinated with at least one dose;*
***: Cumulative number of persons vaccinated with a complete primary series.*

About 2.2 million health workers, including ASHAs, were insured to fight Covid-19, and additional human resources were deployed in the States/UTs, including specialists (3,720), medical officers (7,030) and nursing staff (36,303). One of the highlights of Covid-19 pandemic management was the vaccination drive covering all age groups. In all, 2.2 billion doses were administered as of January 12, 2023 (Table 13). This was the largest ever vaccination drive in the world.

Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM)

After the breakout of the Covid-19 pandemic, our public health infrastructure was found grossly inadequate to handle it. To strengthen the public health infrastructure and effectively manage any future pandemics and outbreaks, PM-Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) was launched in October 2021 (renaming the *Prime Minister Atmanirbhar Swasth Bharat Yojana* (PMASBY) announced in February 2021). It is a centrally sponsored scheme (with some Central Sector component) spread over five years from 2021-22 to 2025-26. This mission aims to enhance the capabilities of health systems and institutions at the primary secondary, and tertiary levels of healthcare, preparing them to effectively address both current and prospective pandemics.

The scheme's centrally sponsored component is designed to promote the early detection of diseases through HWCs, which will offer medical consultations, testing facilities, and medicines at no cost. Additionally, it plans to augment the healthcare

infrastructure by adding 35,000 new critical care beds across 600 districts and improving referral services in 125 districts to facilitate the transfer of patients between healthcare facilities. The total budgetary allocation for this mission during its operative period from 2021-2022 to 2025-2026 is Rs. 64,180 crore. Of this total investment, Rs. 54,205 crore (84 per cent) is dedicated to the execution of Centrally Sponsored Scheme components, while Rs. 9,340 crore (16 per cent) is reserved for the execution of Central Sector scheme components.

Two Centrally Sponsored Components of PM-ABHIM:

Rural Health and Wellness Centres: Under PM-ABHIM, there is a provision for necessary infrastructure support for the construction of 17,788 building-less Sub-Health Centre (SHC) level AB-HWCs in rural areas. This will be in seven high-focus states (Bihar, Jharkhand, Odisha, Punjab, Rajasthan, Uttar Pradesh and West Bengal) and three North-eastern states (Assam, Manipur and Meghalaya) cumulatively over a five-year duration from 2021-22 to 2025-26.

Urban Health and Wellness Centres: To ensure the provision of comprehensive primary health care to the urban population, 11,024 urban HWCs are envisaged to be established across all the States and UTs, cumulatively over a five-year duration from 2021-22 to 2025-26.

Centre Sector Component

Under the second component, integrated public health laboratories will be established in 730 districts. Block-level public health units will be created in 3,000 blocks. Additionally, the network for diagnostic facilities will be strengthened through five regional National Centres for Disease Control, 20 metropolitan units, and 15 bio- safety level labs (GoI, 2023).

The Mission was allocated Rs. 5,846 crore for 2022-23, which is more than 5.5 times the allocation of Rs. 1,040 crore made in 2021-22 (RE).

Pradhan Mantri Swasthya Suraksha Nidhi (PMSSN)

PMSSN was established in March 2021 as a single non-lapsable reserve fund, created by allocating a share of health from the proceeds of the Health and Education Cess levied under Section 136-B of Finance Act, 2007. Accruals into the PMSSN will be utilised for the flagship schemes of the MoHFW, *viz.*,

- *Ayushman Bharat - Pradhan Mantri Jan Arogya Yojan*a (AB-PM-JAY)
- Ayushman Bharat - Health and Wellness Centres (AB-HWCs)
- National Health Mission (NHM)
- *Pradhan Mantri Swasthya Suraksha Yojana* (PMSSY)
- Emergency and disaster preparedness and responses during health emergencies
- Any future programme/scheme that aims to achieve progress towards SDGs and the targets set out in the NHP-2017.

The responsibility for the administration and upkeep of the PMSSN falls on the Ministry of Health and Family Welfare (MoHFW). In a given fiscal year, funding for the MoHFW's schemes will first be provided by the PMSSN, followed by support from the Gross Budgetary Support (GBS). A major benefit of this fund is that it enhances access to universal and affordable healthcare through the availability of earmarked resources, while also ensuring that the funds do not lapse at the end of the financial year.

5. Health Insurance Schemes in India

Despite the expansion of health facilities, illness remains one of the most prevalent causes of human deprivation in India. Health insurance is one way of providing protection to poor households against the risk of health spending that can lead to poverty. For Central Government employees, a health insurance scheme was launched as early as 1954. However, there was also a recognised need for health schemes for the underprivileged sections of society. From time to time, the Central Government has attempted to provide health insurance coverage to select beneficiaries. A noteworthy initiative in this regard was the *Rashtriya Swasthya Bima Yojana (*RSBY) in 2008, which was replaced by the Prime Minister Jan Arogya Yojana (PM-JAY) in 2018.

5.1 Central Government Health Scheme

The Central Government Health Scheme (CGHS) was initiated in 1954 for serving Central Government

employees and their families, who faced difficulty in getting reimbursements for OPD medicines. Another reason for CGHS was that there were not many private hospitals then. However, the scheme was later extended to retired government employees and their families. The scheme started in Delhi, and it was not envisaged to be an all-India scheme. However, the scheme was gradually made operative at an all-India level. CGHS dispensaries now also provide OPD medicines.

Through 331 wellness centres and an extensive network of wellness centres, polyclinics, and laboratories, medical services and medications are made available to 3.85 million beneficiaries in 74 cities. Additionally, the Central Government Health Scheme (CGHS) has included private hospitals and diagnostic centres across various cities to facilitate investigations and inpatient treatments. The facilities and eligibility for CGHS scheme are detailed in Appendix IX.

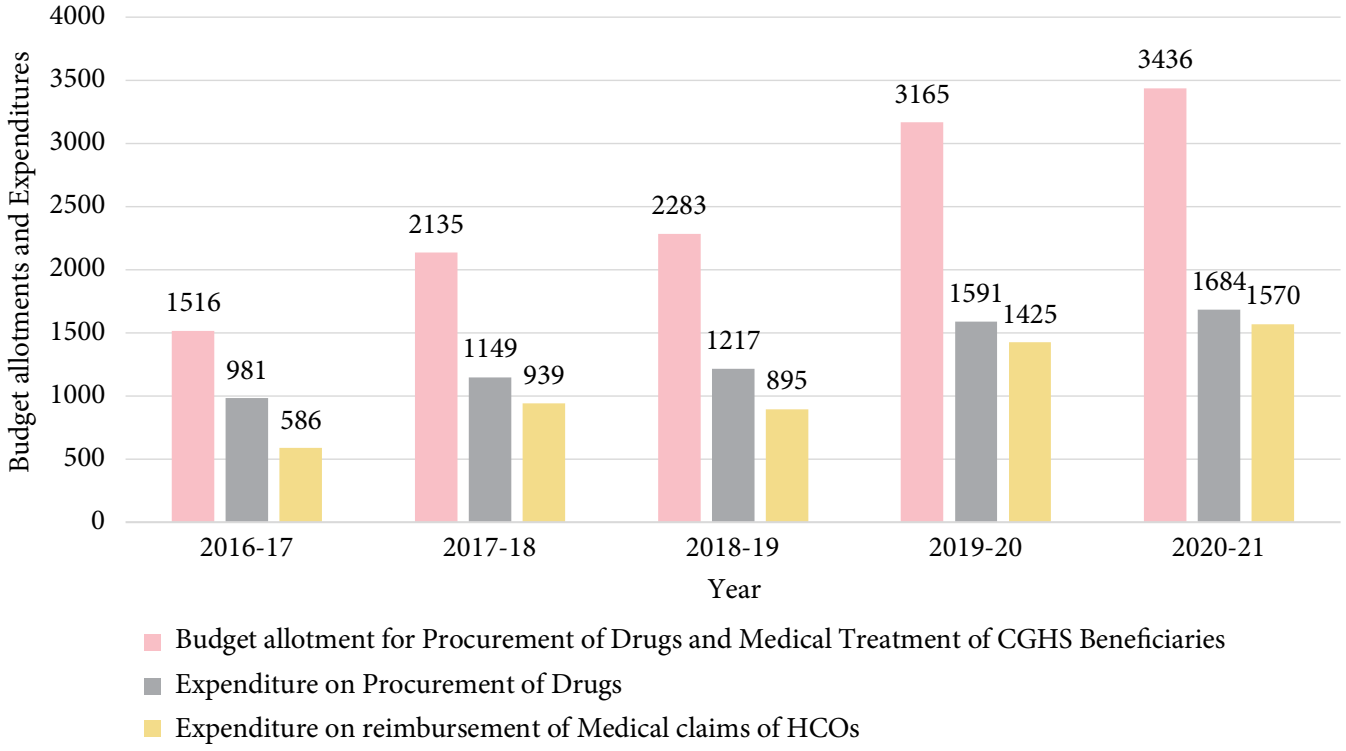
CGHS is fully funded by the Central Government. Budget allocations for CGHS have been raised over the years. However, within these allocations, the share dedicated to the reimbursement of medical claims for healthcare beneficiaries has gradually increased, while that allocated for the procurement of drugs has declined (Chart 6).

Although outpatient claims dominated in terms of the number from 2016 to 2021, inpatient claims were significantly higher than those of outpatient claims. About 87 per cent of the total claims were for outpatient services, yet 85 per cent of the total claim amount was attributed to inpatient claims.

Status of Drug Availability and Quality of Service - Wellness Centres

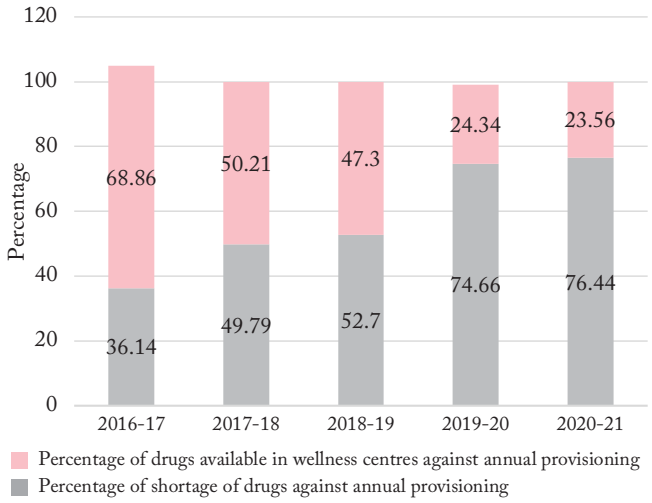
A significant shortage of drugs, as high as 76 per cent, was noticed against approved provisioning in 2020-21 at select wellness centres in Delhi (Chart 7). The increase in drug shortages at select wellness centres in Delhi during 2019-20 and 2020-2021 was attributed to inadequate steps in purchasing the drugs. There was a delay of six to nine months between the rate finalisation by MSO and the supply of the drugs.

Chart 6: Budget Allocation and Expenditure (in Crore)



Source: CGHS Database.

Chart 7: Shortage of Drugs – Select Centres at Delhi



Source: CAG Audit Report no 17 (2022).

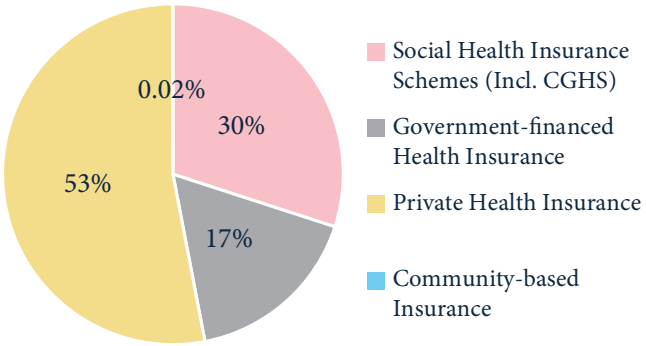
From 2016 to 2021, the Central Government Health Scheme (CGHS) settled a total of 7.5 million claims, with 4.3 million of these claims coming from the Delhi NCR region. Other cities with significant numbers of settled claims included Kolkata, Hyderabad, Chennai, and Pune, ranking highest in terms of hospital claims processed.

Issues were identified in procurement and supply chain management, such as the lack of regular updates to the drug formulary, delays and failures in finalising rate contracts for drugs, leading to inefficiencies in drug supply chain management. A review of the claim reimbursement procedures for Health Care Organisations (HCOs) under CGHS highlighted problems including delayed submissions, processing, and approval of claims, excessive billing by HCOs, and overpayments made to them. As a result, CGHS's goal, as stated in its Vision Statement to become the preferred provider of quality healthcare services and ensure the comprehensive well-being of its clients throughout their lives, was not achieved (Government of India, 2022).

An audit of the procurement process uncovered significant flaws at each stage, such as the lack of defined timelines, failure to follow established timelines, deviations from standard procedures, and insufficient monitoring, adversely affecting the drug procurement process. This impacted the timely availability of services to beneficiaries and the quality of the drugs supplied.

In terms of drug distribution, 36 per cent of patients experienced delays in receiving their medications, with 35 per cent facing delays of three to seven days, and 1.4 per cent waiting for more than seven days between 2016-17 and 2020-21. Besides CGHS, there are other social health insurance schemes such as the Employee State Insurance Scheme (ESIS) and the Ex-Serviceman Contributory Health Scheme, in addition to state government-financed health insurance schemes and private health insurance options. In terms of health insurance expenditure, private health insurance constitutes the largest share, followed by social health insurance schemes and state-government financed health insurance schemes (Chart 8).

Chart 8: Health Insurance Schemes



Source: National Health Accounts.

A recent press report suggests that the National Health Authority (NHA) is in the process of integrating the CGHS with Ayushman Bharat Digital Mission (ABDM) (Sharma, 2023). It is aimed at creating digital health identification of CGHS beneficiaries and storing their digital health records, thus ensuring quick treatment to the needy.

CGHS, a significant healthcare scheme for active/retired government officials and their dependents, caters to around 4 million beneficiaries in 74 cities. Though the budget allocations have increased over the years, the share of reimbursement of claims has increased, while that of procurement of drugs has declined. Major deficiencies in procurement and supply chain management have been identified, leading to delays in the issuance of drugs.

The strategic allocation of increased healthcare expenditure in India can effectively address the deficiencies in drug procurement and supply chain management, thus reducing delays in drug issuance. By investing in advanced procurement technologies and supply chain logistics, the process can be streamlined, ensuring efficient and transparent operations. Enhanced training for personnel, coupled with the adoption of public-private partnerships, can introduce best practices and innovations. Furthermore,

regulatory reforms can minimise bureaucratic delays, while newer technologies can improve demand forecasting and traceability. Altogether, these measures can significantly improve the availability and timely delivery of essential medications, directly benefiting patient care. Additionally, with more financial resources, the government and healthcare institutions can focus on research by fostering collaboration between the government, pharmaceutical companies, and research institutions. Thus, strategically increasing healthcare expenditure in India can not only strengthen the overall healthcare infrastructure but also specifically address and alleviate the delays in the drug issuance process, making critical medications more swiftly available to the population.

5.2 Rashtriya Swasthya Bima Yojana (RSBY)

RSBY was rolled out from April 1, 2008, after critically reviewing the then existing and earlier health insurance schemes and other successful models of health insurance in the world in similar settings. The scheme was meant for the unorganised sector workers belonging to below poverty line (BPL) category and their family members (a family unit of five). The beneficiary was eligible for such inpatient healthcare insurance benefits as were designed by the respective State Governments based on the requirement of the people/geographical area. The unorganised sector worker and his family (unit of five) were covered. Total sum insured was Rs. 30,000/- per family per annum on a family floater basis. It was a centrally sponsored scheme with 75 per cent of the estimated annual premium of Rs. 750, subject to a maximum of Rs. 565 per family per annum, and cost of the smart card was also borne by the Central Government. State Governments contributed 25 per cent of the annual premium, as well as any additional premium. The beneficiary paid Rs. 30 per annum as registration/renewal fee. The administrative and other related cost of administering the scheme were borne by the respective State Governments. The key features of the scheme are summed up in Table 15.

Table 15: Key Features of RSBY

Parameter	Description	Additional comments/caveats
Benefits covered	Cost of hospitalisation for 725 + procedures at empanelled hospitals up to INR 30,000 per annum per household.	Pre-existing conditions are covered; minimal exclusions; day surgeries covered; outpatient expenditure is not covered.
	INR 100 per admission up to INR 1000 for transport cost per annum per household.	
Eligibility criteria	Must be on the official state BPL list	All enrolled members must be present at enrolment to be enrolled; infants are covered through mother.
	Limited to five members of the household including household head, spouse and three dependents.	
Premium and fees	INR 30 registration fee per household per annum paid by household.	Average premium for participating districts is around INR 560, funded by the government.
Financing	75%/25% Government of India/State government.	The ratio is 90%/10% in Northeast states and Jammu & Kashmir.
Policy period	One year from month of enrolment.	Enrolment can take place over four months each year and can vary across states.
Management	Both public and private insurance companies can bid to work in a district or more than a district recommended by state governments.	In each district only one insurance company is finally selected for a particular tier.
Service provider	Both public and private providers can apply to join the network of providers empanelled under the scheme.	Minimum eligibility criteria on quality of services have been laid down by the MoL&E.

Source: Ministry of Labour and Employment, 2008b.

RSBY was a government initiative aimed at reducing OOPE and preventing catastrophic health expenditures among the poor. However, actual implementation of the scheme was not so encouraging because of its complex design. Out of 59 million eligible households, only 36.3 million (61 per cent) were covered by RSBY. In Assam and Bihar, two states with notably poor health and educational outcomes, coverage of BPL households ranged from 50 to 60 per cent, based on government statistics (IndiaSpend, 2017). A significant barrier to higher enrolment was a lack of awareness about the policy among those eligible. A study by the Tata Institute of Social Sciences, Mumbai, in 2013 revealed that 35 per cent of eligible households were unaware of the program. Among the 150 million registered, only about 14 million (9.94 per cent) utilised hospital services. Additionally, although beneficiaries received smart cards, many did not know how to use them, and hospitals were often hesitant to accept these cards, further complicating access to benefits.

The scheme's rigidity also posed challenges. The National Sample Survey Office's (NSSO) health survey for the first half of 2014 showed that the average hospitalisation cost was Rs. 14,935 in rural areas and Rs. 24,435 in urban areas. From the decade up to 2014, hospitalisation expenses rose by 10.1 per cent in rural regions and 10.7 per cent in urban areas. Despite these increases, the insurance coverage amount under the RSBY remained the same throughout its nine-year duration. A 2013 study in the British Medical Journal detailed the costs for common surgeries as ranging from Rs. 2,469 to Rs. 41,087 for a lower abdomen caesarean, Rs. 4,124 to Rs. 57,622 for a hysterectomy, and Rs. 2,421 to Rs. 3,616 for an appendectomy. The relatively low coverage limit of the scheme may have led some households to utilise hospital services beyond the RSBY cap. The survey data showed that in 2012, among households incurring inpatient out-of-pocket expenditure, approximately 9 per cent reported paying more than Rs. 30,000. The average annual expenditure ranged from Rs. 75,000 to Rs. 80,000 (Chatterjee and Laxminarayan, 2013).

5.3 Ayushman Bharat Yojana

The RSBY focused primarily on hospitalisation for secondary care, while various state-level schemes provided coverage for tertiary care conditions. These schemes operated in isolation from the broader national healthcare system, contributing to the division of risk pools, and lacked any integration with PHCs. In response, the Government of India adopted a dual strategy within the Ayushman Bharat, or "Healthy India," initiative launched in April 2018 as part of the National Health Policy 2017, aiming for UHC in line with the Sustainable Development Goals (SDG) and the principle of leaving no one behind.

The initiative's first aspect involved disease prevention and health promotion to combat the rising tide of non-communicable diseases by transforming existing sub-centres and PHCs into Health and Wellness Centres (HWCs). The plan was to establish approximately 150,000 HWCs nationwide in the ensuing years to lessen the disease burden and the need for hospitalisation among the populace. These centres would offer comprehensive primary healthcare services, including maternal and child health, non-communicable diseases, and provision of free essential medicines and diagnostic services. The second aspect entailed the introduction of the Pradhan Mantri-Jan Arogya Yojana (PM-JAY). This scheme aimed to foster a demand-driven healthcare reform system that provides eligible families with immediate hospitalisation coverage in a cashless manner, thereby protecting them from severe financial hardships due to health expenses.

PM-JAY is one significant step towards the achievement of UHC and Sustainable Development Goal 3 (SDG 3). The scheme subsumed two centrally sponsored schemes, namely, the RSBY and the Senior Citizen Health Insurance Scheme. The key features of the scheme areexplained in Table 16.

PM-JAY provides financial protection (S*wasthya Suraksha*) to 107 million poor, deprived rural families. PM-JAY has defined 1,350 medical packages covering surgery, medical, and day care treatments, including medicines, diagnostics and transport.

With a view to ensuring that nobody is left out (especially girl children, women, children, and elderly), there is no cap on family size and age. The scheme is cashless and paperless at public hospitals and empanelled private hospitals. The beneficiaries are not required to pay any charges for hospitalisation expenses. The scheme provides coverage for 1,573 procedures, and pre- and post-hospitalisation expenses as well. When fully implemented, the PM-JAY will become the world's largest government-funded health protection mission. It is expected to significantly reduce out-of-pocket expenditure for hospitalisation, mitigate the financial risk arising from catastrophic health episodes, and consequently prevent impoverishment for poor and vulnerable families.

Table 16: Key Features of PM-JAY

Benefits & Coverage	Health insurance coverage of Rs. 5,00,000 per family annually for secondary and tertiary care hospitalisation. Covers 3 days of pre-hospitalisation and post hospitalisation charges up to 15 days. Unlike RSBY, PM-JAY has been designed in such a way that there is no cap on family size or age of members. Pre-existing diseases are covered from day one.
Eligible Beneficiaries	Enrolled Population falling under the following categories: Below the Poverty Line (BPL) in the Socio-Economic Caste Census (SECC) 2011. Existing *Rashtriya Swasthya Bima Yojana* (RSBY) beneficiaries. State notified categories.
Funding Pattern	The existing sharing pattern is in the ratio of 60:40 for States and Union Territories with Legislature. 90:10 for the North-eastern and Himalayan States. 100% coverage may be provided to UTs without Legislature by the Central Government.
Service Providers	Public- All public hospitals (including ESIC) equipped with inpatient facilities (Community Health Centre level and above) are empanelled by default. Private and not for profit hospitals–Hospitals meeting the minimum criteria established by National Health Authority (NHA).

Source: Empanelment of healthcare facilities under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in India.

Under PM-JAY, insurance cover has been provided to around 107 million poor and vulnerable families. For 2022-23, PM-JAY was allocated Rs. 6,412 crore, which is double the revised estimates of 2021-22 (Rs. 3,199 crore). A study by the FC-XV on Ayushman Bharat (2019) estimated the demand and expenditure on PM-JAY for the next five years. It stated that the total costs (centre and states) of PM-JAY for 2019 could range from Rs. 28,000 crore to Rs. 74,000 crore. This estimate considers: (i) the assumption that all targeted beneficiaries will be covered (approximately 500 million beneficiaries based on socio economic caste census 2011 data); (ii) hospitalisation rates over time; and (iii) average expenditure on hospitalisation. These costs could go up to between Rs. 66,000 crore and Rs. 1,60,089 crore in 2023 (accounting for inflation) (GoI, 2023).

A snapshot of Progress of HWCs and PM-JAY is outlined in Table 17.

Table 17: Status of Implementation of HWCs and PM-JAY (April 1, 2021, to November 28, 2021)

Indicator	All India
Total Footfalls	826 million*
Ayushman Cards Issued	172 million
Funds Dispersed to states /UTs for implementation	Rs. 2,544 Crore
Total Hospital admissions authorised	7.47 million
Claims paid towards authorised hospital admissions (Covid-19 and non-Covid-19)	Rs. 2,450 Crore*
Claims paid towards authorised hospital admissions for Covid-19 treatment	Rs. 1,056 Crore*
Health and Wellness Centres (HWCs)	1,50,000**

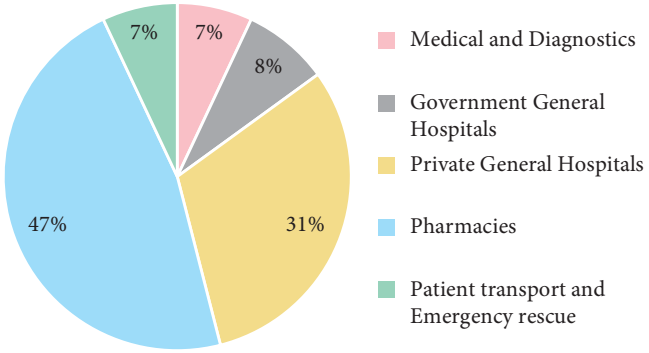
**denotes as on February 06, 2022, **denotes as on December 31, 2022.*

Source: Lok Sabha starred Question No. 95, answered on December 3, 2021; HWC Portal, Ayushman Bharat; PRS.

The overall out-of-pocket expenses in India on healthcare is 50 per cent of the total expense on public health—one of the highest in the world. One of the objectives of the PM-JAY is to reduce OOPE. PM-JAY allows access to secondary and tertiary healthcare services. However, of the health expenditure in 2017-18, 47 per cent was towards primary care (pharmacies), 39 per cent towards secondary care (private and government hospitals), and 14 per cent towards tertiary care, with the remaining percentage allocated towards governance and supervision (Chart 9). This implies that about 50 per cent of the healthcare expenditure is not covered under the PM-JAY. Therefore, the PM-JAY has inherent limitations in reducing OOPE.

It is claimed that to offer comprehensive health coverage to beneficiaries, free essential drugs and diagnostic services are provided through AB-HWCs. However, specific details about these medicines and tests, including their likely costs, are not readily available.

Chart 9: Health Expenditure - Major Components



Source: NITI Aayog (May 1, 2020).

In several cases, OOPE is covered through borrowings. As per the NSS Survey on Health in India (2018), in rural areas, 13.4 per cent of the hospitalisation cases were financed by individuals through borrowings. In urban areas, this share was at 8.5 per cent. Between 3–4 per cent people in both rural and urban areas required support from friends and relatives. Large OOPE, therefore, have serious consequences, especially for the lower rung of society. The FC-XV noted that about 55 million Indians are pushed into poverty each year due to out-of-pocket payments for health. This implies that health insurance or any kind of financial protection measures must cover expenses at all levels of healthcare. Increasing government spending on public health from 1 per cent of the GDP to 2.5–3 per cent of GDP will help in reducing out-of-pocket expenditure from 50 to 30 per cent. It also noted that Indian States that have higher per capita spending on health have lower out-of-pocket expenditure, which is also true at the global level (GoI, 2021).

The utilisation of the amount allocated to the scheme has also been poor. While 83 per cent of budget allocation was utilised in 2018-19, the utilisation decreased to 50 per cent in 2019-20, and to 42 per cent in 2020-21. In 2021-22, the allocation towards the scheme was halved at the revised stage. This could imply gaps in implementation of the scheme. The Rajya Sabha Committee (GoI, 2022), which went into the working of the PM-JAY, observed in its report that a large mismatch in allocation and actual expenditure reflected poor financial prudence and failure in judicious assessments of the needs of the programme. It also observed that the list of beneficiaries under AB-PM-JAY, which was based on the outdated socio-economic caste census 2011 data, may lead to the exclusion of many beneficiaries. The committee reiterated its recommendation that the MoHFW must make efforts to expand the list of beneficiaries under AB-PM-JAY. It was of the view that there was a direct correlation between the number of verified beneficiaries and demand for healthcare services under the scheme.

Like the erstwhile RSBY, people also lack awareness about the PM-JAY. This was also noted by the Rajya Sabha Committee, and it exhorted the MoHFW to conduct large scale awareness campaigns, especially in rural areas for wider dissemination of the provisions under the scheme and work towards increasing the beneficiary base.

6. Evolution of Health Spending–2005-06 Onwards

Having discussed health policies and various health schemes, it will be insightful to know how health spending on various schemes evolved over the years. This assessment is based on the overall health budget of the MoHFW of the Central Government. Though a comparison of scheme-wise health spending is strictly not possible as schemes have changed over the years, still some useful inferences could be drawn.

In 2005-06, (i) medical education training and research (14 per cent); (ii) public health (9 per cent); and (iii) NRHM (63 per cent) constituted more than

80 per cent of health budget of the MoHFW. This pattern was broadly similar in 2010-11. By 2015-16, while the share of NHM (earlier NRHM) remained broadly the same, some other significant changes were observed. Autonomous bodies (13.1 per cent); establishment expenditure of the centre (9.4 per cent); Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) and National AIDS and STD Control Programme (4 per cent each) constituted other major items. In 2023-24, some further changes were observed. The share of NHM declined sharply to 33.8 per cent (from 59.7 per cent in 2015-16) and the decline in the share of NHM was offset by PM-JAY (8.4 per cent) and PM-ABHIM (4.9 per cent). The share of autonomous bodies increased (to 20.1 per cent from 13.1) (Table 18).

Table 18: Health Budget Allocations – MoHFW (as % of Total Expenditure)[9]

Category	2005-06	2010-11	2015-16	2023-24
Hospitals & Dispensaries	**2.61**	**4.17**	-	-
Medical Education Training & Research	**13.59**	**11.38**	-	-
Of which:				
PMSSY	2.4	6.7	-	-
Public Health	**8.67**	**13.52**	-	-
Of which:				
National AIDS Control Programme	4.6	6.7	-	-
National Rural Health Mission	**63.30**	**59.12**	-	-
Establishment Expenditure of the Centre	-	-	**9.37**	**9.37**
Central Sector Schemes/Projects	-	-	**11.33**	**11.33**
Of which:				
PMSSY[10]	-	-	4.76	3.90
National AIDS and STD Control Programme[11]	-	-	4.80	3.57
Other Central Sector Expenditure	-	-	**19.56**	**19.56**
Of which: Autonomous Bodies	-	-	13.1	20.1
Centrally Sponsored Schemes	-	-	**59.73**	**59.73**
Of which:				
National Health Mission	-	-	59.73	33.75
PM-JAY	-	-	-	8.35
RSBY	-	*	*	-
PM-ABHIM	-	-	-	4.87
Others	**11.82**	**11.80**	-	-
Total	**100.0**	**100.0**	**100.0**	**100.0**
Grand Total (Amount in Rs. crore)	**10281**	**23530**	**33121**	**86175**

*Note: Data in the table have been sourced from budget documents of the Central Government. The classification of healthcare data underwent changes as new schemes were introduced. *Break-up not available.*

Source: Union Budget documents of various years.

[9] This budget allocation is for the Department of Health and Family Welfare, *i.e.*, it does not include expenditure relating to Department of Health Research.

[10] PMSSY, which was earlier as a part Medical Education Training & Research, is now included under central sector schemes.

[11] National Aids and STD Control Programme, which was earlier a part of public health, is now categorised under central sector schemes.

7. Discussion

Health was an issue of intense discussion even before India's independence. The importance of health for the well-being of people and the economic growth of the country was also well recognised by various committees, five-year plans, national health policies, and even FCs. Health is vital not only as an end in itself, but also because it contributes to economic growth. One extra year of population life expectancy raises GDP per capita by 4 per cent (Raj, *et al.*, 2023). There is no denying that there has been considerable improvement in health indicators over the years such as life expectancy at birth, infant mortality rate, increase in institutional births, improvement in immunisation coverage, improved sanitation, and clean cooking. India is now a smallpox free country, and many diseases such as malaria and tuberculosis have also been contained. India's health delivery system has also improved with a large pool of physicians and the nursing staff. As a result, the gap in India's health index has narrowed with respect to both advanced and developing economies over the years (Raj *et al.*, 2023). Despite this progress, India continues to lag far behind its peers in some crucial indicators of health (Table 19).

In context of health, four major issues raise concerns: (i) universal health coverage goal remains elusive; (ii) low spending on health, with a relative neglect of primary health care, and consequently high OOPE; (iii) a massive shortage of human resources; and (iv) low spending on research.

Universal Health Coverage Goal remains Elusive

The Bhore Committee was a landmark development in that it was a step towards universal health coverage (UHC), which implies access to quality health services without incurring financial hardship. Moreover, the High-Level Expert Group on Universal Health Coverage constituted by the then Planning Commission in 2010 was also an example of a policy-level effort for achieving UHC. Despite some improvements, overall access to quality health services remains inadequate for the majority of the population. As a result, India continues to lag behind many of its peers in the UHC index. India is about 14 years behind China in UHC (Chart 10).

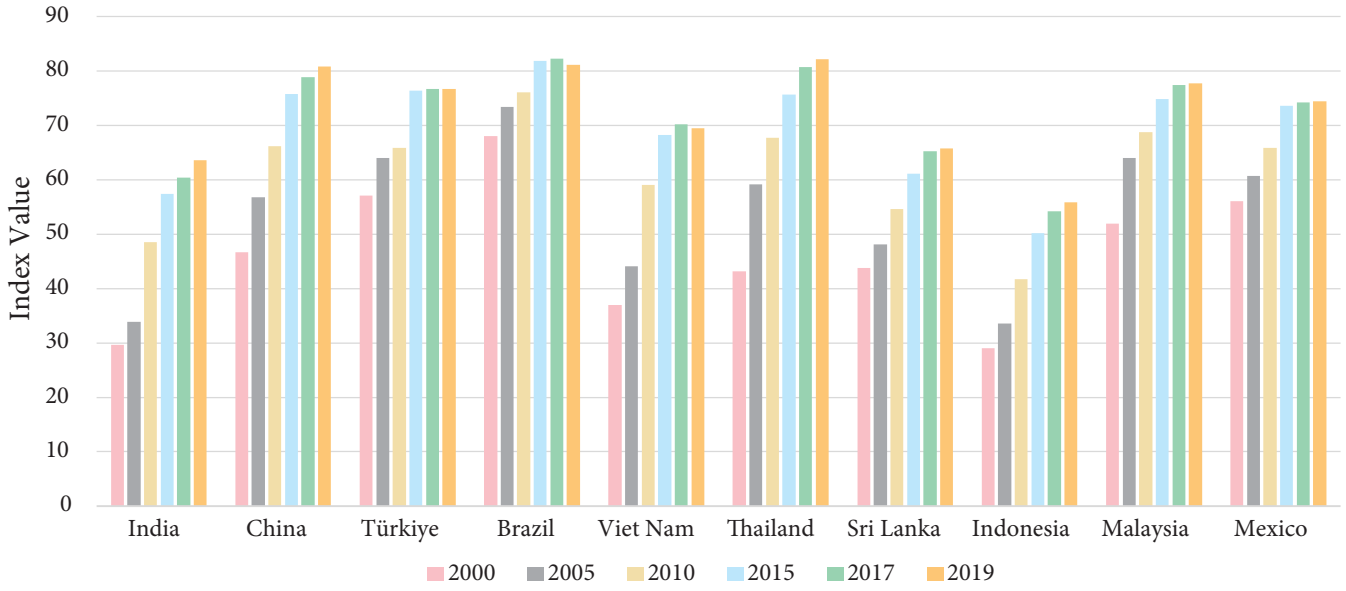
The ultimate test of India's healthcare system would be how quickly the country climbs up the ladder of the UHC index. Lack of universal healthcare, in fact, also represents large rural-urban divide in terms of health infrastructure, as has been alluded to before and also explained subsequently.

Table 19: Indicators of Health – India vis-à-vis its Peer Economies

Country	Life Expectancy		MMR (per 100,000 live births)		IMR (per 1,000 live births)		Health Expenditure (% of GDP)		OOPE (% of Current Health Exp)	
	1991	2021	1991	2021	1991	2021	2000	2021	2000	2021
Nepal	54.8	68.4	924	186	96.4	22.8	0.5	1.8	55.8	51.3
Bangladesh	54.2	72.4	589	173	101.0	22.9	0.5	0.4	61.8	73
India	59.1	67.2	487	133	88.8	25.5	0.8	1.1	71.7	49.8
Indonesia	63.2	67.6	348	177	61.8	18.9	0.5	2.2	45.2	45.9
Philippines	65.9	69.3	198	121	39.9	20.5	1.4	2.1	41.2	45.0
South Africa	63.3	62.3	162	119	47.8	26.4	2.7	5.0	14.5	5.5
Brazil	66.3	72.8	112	60	52.7	12.9	3.5	4.5	36.6	22.7
China	68.0	78.2	90	29	42.7	5.1	1.0	2.9	60.1	34.4
Sri Lanka	71.9	76.4	79	36	19.4	5.8	2.2	1.9	40.0	43.6

Source: World Development Indicators Database; WHO Global Health Expenditure Update, 2023.

Chart 10: UHC Service Coverage Index



Source: WHO database.

Low Spending on Health - A Key Concern

Better health outcomes, however, depend largely on public spending on health. The root of India's poor health performance is its abysmally low spending on health, which has resulted in a high OOPE relative to its peers. Post-Independence, India followed a model of planning in the form of Five-Year Plans (FYP), the focus of which was on industrial development to achieve commanding heights. As such, not much attention was paid to the social sector, including health. Economic services from the 1st FYP to 9th FYP were allocated over four-fifth resources to economic services, while the social sector, including health and education, and water supply, received the residual (Duggal, 2011).

One of the key features of NHP-2017 was to raise the share of States' expenditure on health to 8 per cent of their total expenditure. The FC-XV recommended unconditional grants amounting to Rs. 1 lakh crore for the health sector (for the time 2021- 26). In addition, it endorsed the NHP-2017 suggestion that by 2022, States should spend more than 8 per cent of their budget on health. However, on an average, States spend only 5 per cent of their budget on health with Delhi and Puducherry above the target, while some other States spend even less than 4 per cent of their budget on health. It is indeed distressing that States' health spending has remained unchanged over last 30 years.

Every health policy introduced shares the overarching goal of ensuring more equitable access to health services across the diverse social and geographical landscape of the country. However, this can only be achieved by strengthening the healthcare resources which, in turn, depend on the public health spending in the country.

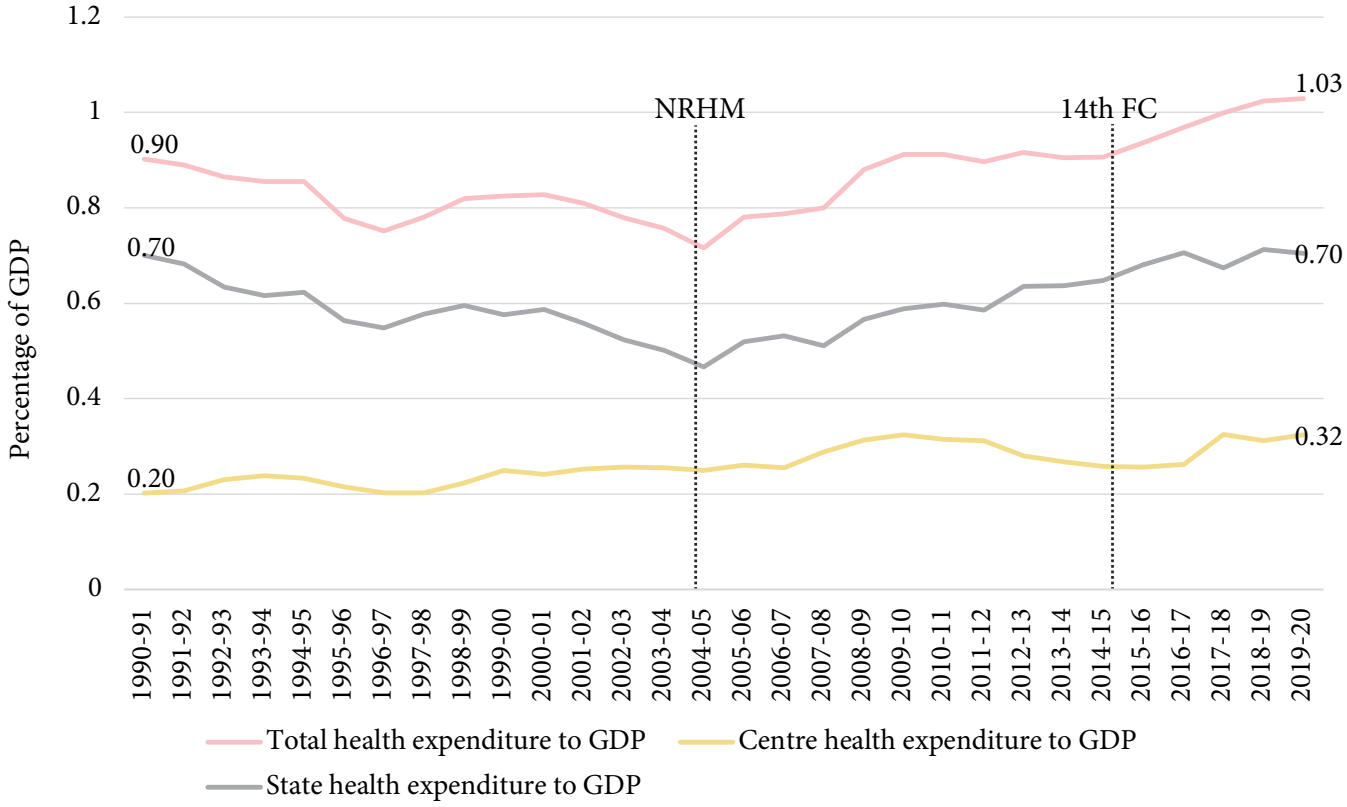
The NHP-2017 also aimed at increasing public health expenditure to 2.5 per cent of the GDP by 2025. The NHP-2017 noted that while general taxation would remain the largest means for financing healthcare, the government could consider imposing taxes on specific commodities such as tobacco, alcohol, and foods having negative impact on health, and also levy taxes on extractive industries and pollution cess. In 2018-19, the Central Government announced a 4 per cent Health and Education Cess in place of the 3 per cent Education Cess on Income Tax and Corporation Tax to cater to the education and health needs of the poor and rural families. In 2022-23, Rs. 62,519 (RE) was estimated to have been collected through the health and education cess, which was an increase of 18.5 per cent over the amount collected in 2021-22. In 2020-21, the Central Government also introduced a 5 per cent health cess which is imposed as customs duty on certain medical equipment. This was to be utilised for financing health infrastructure and services in aspirational districts. In 2022-23, Rs. 870 crore was estimated to have been collected under this health cess (customs) (GoI, 2021).

However, despite all the efforts, overall health spending remains low. Even 40 years after it was first articulated to be raised to 2.5 per cent of GDP, health spending is nowhere close to the target with the public expenditure on health at about 1 per cent of GDP. What is even more disappointing is that the share of 1 per cent

of GDP has remained stagnant for the last 30 years. Health expenditure as percentage of GDP declined from 0.90 per cent of GDP to 0.72 per cent of GDP in 2004-05, before it started inching up again from 2004 onwards following the launch of NRHM (Chart 11).

Public health spending has remained at a low level and compares unfavourable with health spending by other emerging market economies with the similar tax-GDP ratio (Chart 12).

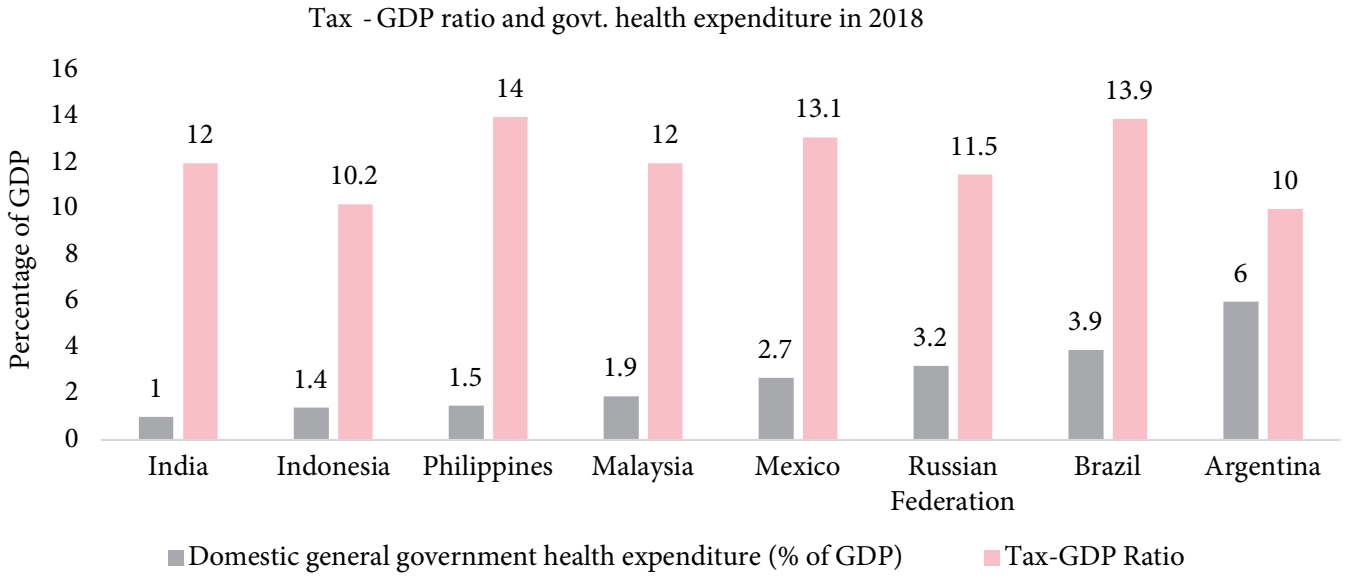
Chart 11: Health Expenditure – Centre *versus* State (1990-2019)



Source: RBI State Finances, A Study of Budget; Union budgets.

Note: Total health expenditure includes expenditure by the Centre and the States on Medical and Public Health and Family Welfare. Health expenditure by ministries other than the ministry of health has been excluded.

Chart 12: Tax-GDP ratio and Public Health expenditure in Select Emerging Market Economies



Source: World Bank.

One of Bhore committee's key recommendations was a national health system for delivery of comprehensive preventive and curative allopathic services through a rural-focused multi-level public system financed by the government, which all patients would be able to reap irrespective of their ability to pay. However, the newly independent country faced with multiple challenges such as (i) widespread poverty; (ii) high morbidity and mortality due to several communicable diseases such as malaria, smallpox, plague, tuberculosis, among others; (iii) and a fragile economy and could not afford the NHS recommended by the Bhore committee. Incidentally, around the same time that the Bhore committee submitted its report in India, the United Kingdom enacted the National Healthcare Service Act in 1946, with the aim of establishing a health service to improve the physical and mental health of the people and to enhance the prevention, diagnosis, and treatment of illnesses.

However, it needs to be underlined that NHS in the UK gave a huge boost to the healthcare spending. As a result, the gap between public health spending in the UK and India only widened over the years (Chart 13).

Apart from low spending on health in general, another major reason for inadequate health infrastructure in the country is the limited space for capital spending. This is because the bulk of the health budget of MoHFW is revenue in nature with capital budget constituting only 6.7 per cent. This does not augur well for developing adequate health infrastructure in the country.

In India, 'inverse care law' of Tudor (1971) is all pervasive, according to which "the availability of good medical care tends to vary inversely with the need of the population served." In other words, the individuals requiring the most medical attention receive the least. This phenomenon is due to wealth for two reasons. First, rich people can mitigate the burden of disease due to better nutrition, environment, education, and other favourable factors. Second, they also have access to high-quality healthcare throughout their life. It will be a huge challenge to reverse the Tudor law in India and it will not be possible unless public health spending is sharply stepped up. A study in the international context suggests that public spending on health would need to be raised to at least 5 per cent of GDP for progressing towards UHC or for meeting the basic healthcare needs (WHO, 2015, Mcintyre *et al.*, 2017). We, therefore, have a long way to go, especially because there has not been any noticeable increase in public health spending in last 30 years. Insufficient funding in public health hampers the government's capacity to invest in essential health infrastructure, cultivate a skilled workforce, and guarantee universal access to fundamental healthcare services. This underinvestment has led to a preference among citizens for private healthcare facilities over public ones. Furthermore, this situation has additional repercussions, particularly for the economically disadvantaged, who find themselves compelled to allocate a larger portion of their personal finances towards basic healthcare needs.

Chart 13: Public Healthcare Spending (% of GDP)– India *versus* the UK

Source: Ministry of Health and Family Welfare; IndiaStat. Data for UK has been taken from Our World in Data based on Lindert (1994), OECD (1993), OECD Stat and excludes capital investment.

Primary Healthcare - Not Receiving the Attention it Deserves

Primary healthcare, by providing services at the grassroot level, greatly reduces the chances of ailments requiring subsequent secondary or tertiary treatment. Therefore, primary healthcare becomes the key for providing adequate healthcare services, especially to underprivileged sections of society.

However, primary healthcare remains a neglected area even after 65 years. The need for primarily healthcare was first articulated by the Bhore Committee and its reiteration in/at various other reports such as Alma-Ata Declaration, NHP-2002, NHP-2017, and the recommendation of FC-XV. However, government spending on primary healthcare in 2018-19 was only 55 per cent (as against the target of two-thirds or more articulated in NHP-2017 policy endorsed by the FC-XV); the share of secondary healthcare was 30.5 and that of tertiary 5.9 per cent (National Health Systems Resource Centre, 2022).

Reflecting the inadequate spending on primary healthcare, significant deficiencies continue to plague the healthcare delivery services in the country. Despite a manifold increase in rural primary healthcare infrastructure in absolute terms, there continues to be a shortage in the number and distribution of Sub Centres, Primary Health Centres, and Community Health Centres in rural areas based on population norms. As per the Rural Health Statistics 2019, SCs, PHCs, and CHCs still do not meet the required coverage targets (Table 7).

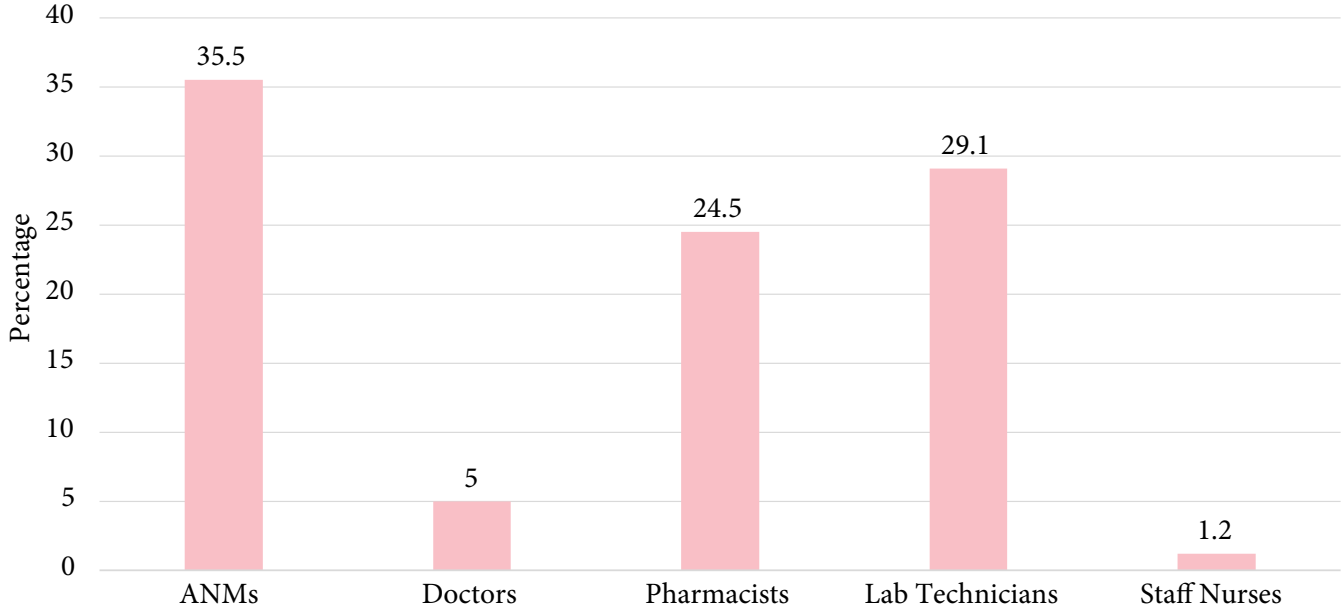
The Standing Committee on Health (2021) noted that there are shortfalls of 23 per cent in SCs, 28 per cent in PHCs, and 37 per cent in CHCs. FC-XV also noted that there are critical gaps with respect to sub-centres, PHCs, CHCs, and wellness centres in some states. It noted that as of March 31, 2020, 885 PHCs and 33,886 SCs did not have the necessary infrastructure to meet the targets of the NHP-2017.

Inadequate Medical Human Resources

Inadequate health spending has resulted in a significant shortage of human resources. As alluded to before, there was a large shortage of health workers, doctors, and specialists in rural SCs, PHCs, and CHCs at the end of March 2017. This shortage continued till the end of March 2022, though there was some improvement in shortfall (from 21 per cent to 3.1 per cent in the case of doctors in rural SCs and PHCs; and from 81 per cent to 79.5 per cent in the case of specialists in rural CHCs).

Apart from rural areas, there has also been a significant shortage of manpower such as ANMs, doctors, pharmacists, lab technicians, and nursing staff in urban PHCs (Chart 14).

Chart 14: Shortfall of Human Resources - Urban PHCs (2022)

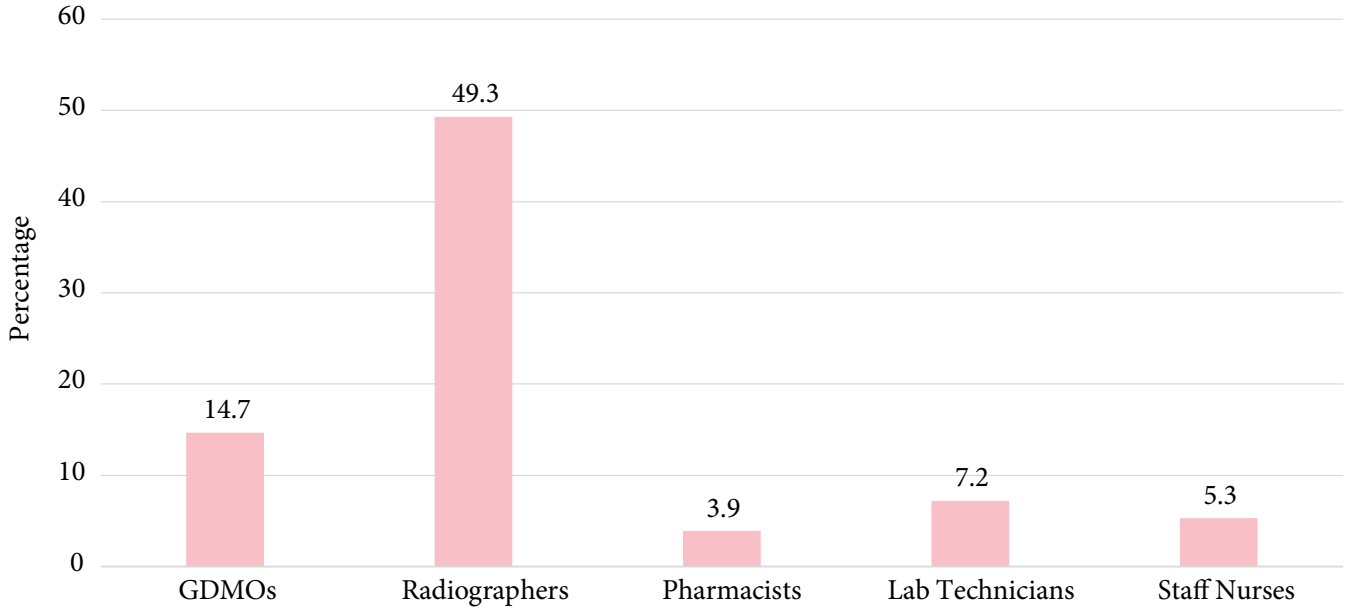


Note: ANM stands for Auxiliary Nurse and Midwife.

Source: Rural Health Statistics 2021-22.

Urban CHCs also faced shortages, though not as severe as those in urban PHCs or rural CHCs (Chart 15).

Chart 15: Shortfall of Specialists - Urban CHCs (2022)



Source- Rural Health Statistics 2021-22.

The acute shortage of healthcare workers, particularly in rural areas, is a matter of concern. Although 71 per cent of India's population resides in rural areas, only 36 per cent of India's health workforce is stationed in these areas. About 80 per cent of doctors and 70 per cent of nurses and midwives are employed in the private sector, which is heavily concentrated in urban areas.

Low Spending on Health Research

The Standing Committee on Health and Family Welfare, in its 2020 report, observed that the financial allocation for the Department of Health Research was insufficient when compared to the requisite funds for health research. The Committee advocated for a minimum allocation of 10 per cent of the Ministry of Health and Family Welfare's (MoHFW) budget specifically for health research purposes. Furthermore, it urged the MoHFW to elevate its investment in health research to align with the global average of 1.72 per cent of GDP within a two-year timeframe. For the fiscal year 2021, the Committee proposed that health research funding should constitute 5 per cent of the Ministry's total expenditure. Nonetheless, in the fiscal year 2023-24, the budgetary allocation for the Department of Health Research was recorded at Rs. 3,201 crore (BE), representing 4.0 per cent of the overall MoHFW budget.

8. Summing Up

Healthcare policies in India have evolved over time to meet various emerging challenges. At the time of independence, India's healthcare was bleak, lacking in infrastructure and human resources, as the focus of colonial rulers was on their army personnel and administrators, not the common masses.

Post-Independence, the blueprint for healthcare in India was ready, as just a year before, the Bhore committee had submitted its well-documented report covering almost all aspects of healthcare. However, for nearly 35 years after independence, the focus was first on controlling/eradicating serious communicable diseases and then on ensuring the population's immunisation. Country-wide mass campaigns were launched against tuberculosis, smallpox, malaria, leprosy, cholera, *etc.*

Until 1983, India's healthcare decisions were driven by various committees' recommendations and successive five-year plans. One area that consistently engaged policymakers was the primary healthcare system in rural areas, a key recommendation of the Bhore committee. In the early 1960s, though the Mudaliar committee recommended its discontinuation due to a lack of necessary infrastructure, PHCs continued to expand, and the Fourth five-year plan

emphasised strengthening them. Despite this, PHC infrastructure did not keep pace with the growing population and remained deficient, especially in rural areas.

Before the first formal NHP in 1983, significant progress was made in reducing child and maternal mortality and increasing life expectancy. Smallpox had been eliminated, and plague ceased to be a problem. Mortality from cholera and related diseases had declined, and malaria was largely under control. However, leprosy and tuberculosis continued to have high incidence rates. By the early 1980s, the incidence of major NCDs had declined, though not fully under control, allowing authorities to shift their focus to improving healthcare facilities. An extensive network of dispensaries, hospitals, and institutions providing specialised curative care had been developed, primarily in urban areas, neglecting rural areas. To correct these disparities, the Sixth Plan articulated that further linear expansion of curative facilities in urban areas be allowed only in exceptional cases. The NHP-1983, coinciding with the Sixth Plan, also focused on developing primary healthcare infrastructure. In the next 15 years, the primary healthcare infrastructure expanded, though it fell short of the requirement. Also, alongside, curative healthcare facilities in urban areas continued to expand, thus the gap in healthcare facilities in rural and urban areas remained wide.

The focus of the new NHP, rolled out in 2017, was on correcting all types of imbalances, including rural-urban, and to increase public health spending to 2 per cent of GDP. As a follow-up of this policy, two initiatives were undertaken, *viz.*, PMSSY and NRHM. These measures positively impacted healthcare in health indicators. A significant reduction was observed in child and maternal mortality rates. These measures also helped reverse the declining trend in health spending by States, though over last 30 years health expenditure (as percentage of GDP) in State budgets remained virtually unchanged. Over the years, the burden of non-communicable and some infectious diseases had increased. There was also no evidence of a narrowing gap in health infrastructure between rural and urban areas. In 2015, NRHM was rechristened as NHM, with NRHM and NUHM as its two constituents.

NHP-2017 brought back the focus to universal healthcare and articulated raising public health spending to 2.5 per cent of GDP. However, the situation on the ground has not changed much even seven years after the policy was announced. Health spending has continued to be low at around 1 per cent of GDP, and consequently, OOPE has remained one of the highest in the world. Health infrastructure also remains inadequate. More distressing than public health infrastructure is the massive shortage of health-related human resources, especially in rural areas, raising concerns. The inadequacy of health infrastructure and human resources was felt acutely during the Covid-19 pandemic, after which the Central Government initiated specific measures to strengthen health infrastructure.

A careful reading of a long history of healthcare in India clearly suggests two major disconcerting features. First, health has all along been a low priority in India. Policy after policy articulated to raise public health spending, but it has remained broadly unchanged in the last three decades. This has left the population, especially the poor and underprivileged, at the mercy of the private sector, resulting in one of the highest OOPE, causing impoverishment. One of the reasons for low health spending could be that health in India, in general, has never been a political or an electoral issue. Before the country embarked on economic reforms in the early 1990s, both physical and social infrastructure in general was ignored. Post economic reforms, the emphasis was laid on physical infrastructure, while social infrastructure continued to be neglected. It was a failure to justify health as an intrinsic value, which led to the relative neglect of the public health sector in the broader competition for support and resources (Rao, 2004). Policymakers always looked for some tangible benefits when it came to investing in health. For instance, much of the legitimacy of the malaria control and eradication programme in the 1950s rooted in the argument that malaria control would be beneficial for economic benefits. However, when it became hard to demonstrate or quantify benefits, the support for the programme diminished (Amrith, 2007).

Second, the focus of the healthcare system in India has been on curative health, while preventive health has been largely ignored. Since curative health infrastructure has been heavily concentrated in urban areas, this has created large rural-urban disparities in healthcare. These outcomes are all the more disappointing as various health policies articulated raising public health spending and correcting rural-urban imbalances. Low public spending on health has been at the root of many ills that the healthcare system

faces today. While enhancing investment is undoubtedly essential, the actual outcomes are influenced more by the way these funds are allocated and utilised. Therefore, it is crucial to focus not only on the scale of finance but also on the strategic deployment of these resources to ensure their most effective use by focusing on the sector's most pressing needs.

The only way to improve healthcare delivery in India is to step up public health spending in a time-bound manner. Both the central and state governments should commit that in every single year, the health spending as percentage of GDP ratio will rise by at least 0.2 percentage points. In order 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 reach the target of 3 per cent of GDP in the next 7-8 years, which is the average public health spending to GDP ratio of low- and middle-income countries. A certain percentage of health spending must also be committed for capital spending on health research. After reaching this stage, our next target should be to raise public health spending gradually to 5 per cent of GDP. Money, of course, would also need to be spent efficiently. It is only then we can achieve the goal of universal health coverage and close the gap with our peers (Raj, 2023).

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APPENDIX

Appendix I: Plan Outlay on Health and Family Planning (in Rs. Crore)

Plan Period	Overall Public Sector	Total Service Sector	Health	Distribution to Public Sector (%)	Family Planning	Distribution to Public Sector (%)
1st Plan (1951-56)	1,960	472	90	4.7	-	-
2nd Plan (1956-61)	4,672	855	146	3.1	2	0.4
3rd Plan (1961-66)	8,577	1,493	226	2.6	25	0.3
Annual Plan (1966-69)	6,625	976	140	2.1	71	1.1
4th Plan (1969-74)	15,779	2,987	336	2.1	278	1.8
5th Plan (1974-79)	39,426	6,017	761	1.9	492	1.2
6th Plan (1980-85)	1,09,292	15,917	3,412			3.1
7th Plan (1985-90)	2,18,730	34,960	3,689	1.7	3,121	1.4
8th Plan (1992-97)	4,34,100	79,012	7,576	1.7	6,500	1.5

Source: India, GoI, FYP 1996-97.

Appendix II: National AIDS and STD Control Programme

Since 1992, five National AIDS and STD Control Programme (NACPs) have been launched as detailed below:

National AIDS and STD Control Programme Phase-I (1992-1999)

Due to the persistent rise in the HIV epidemic, the main objective of the first phase of the NACP was to slow down the spread of HIV infections, and decrease the morbidity, mortality, and impact of HIV/AIDS in the country. Phase 1 also established institutional structures such as the National AIDS Control Board (NACB), the AIDS Control organisation (NACO), and the state-level Programme Management Units called the State AIDS Control Societies (SACS).

National AIDS and STD Control Programme Phase-II (1999-2007)

The second phase of the NACP was launched in 1999 with two objectives: (a) reduce the spread of HIV infection in India; and (b) increase India's capacity to respond to HIV/AIDS on a long-term basis. Two major initiatives in this phase were the establishment of facilities for Voluntary Counselling and Testing (VCT) and Prevention of Parent to Child Transmission (PPTCT); and constitution of National Parliamentarian Forum and National Council on AIDS.

National AIDS and STD Control Programme Phase-III (2007-2012)

In this phase, service delivery facilities were rapidly scaled up across India. HIV counselling and testing services were also offered to pregnant women as an essential component of ANC services.

National AIDS and STD Control Programme Phase-IV (2012-2017)

Major initiatives during this phase were (i) expansion of the reach of HIV screening services with facility integrated HIV counselling and testing Centres (FI-ICTC) as well as the launch of community-based screening (CBS) in the private sector; and the launch of the HIV and AIDS prevention bill in Rajya Sabha.

National AIDS and STD Control Programme Phase-IV Extension (2017-2021)

In this phase, the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (Prevention and Control) Act, 2017 was enacted. The bill ensured that people who are infected with HIV and AIDS do not have to face any type of discrimination in receiving treatment. Another initiative 'Mission *Sampark*' was launched to re-engage people living with HIV (PLHIV) who discontinued their treatment following the launch of antiretroviral therapy (ART).

National AIDS and STD Control Programme Phase-V (2021-26)

With an outlay of Rs. 15,472 crore, NACP phase V will build upon the systemised convergence with the existing schemes of the Central Government for ensuring resource optimisation. This phase has set the following goals: (i) reducing annual new HIV infections by 80 per cent; (ii) reducing AIDS related morbidity by 80 per cent; (iii) eliminating vertical transmission of HIV and Syphilis; (iv) promoting universal access to quality sexually transmitted infections (STI)/ reproductive tract infection (RTI) services to at risk and vulnerable populations; and (v) eliminating HIV/ AIDS-related stigma and discrimination (National AIDS and STD Control Programme, 2021-26).

Appendix III: Sub Schemes of National Rural Health Mission (NRHM)

ASHAs: The Accredited Social Health Activists (ASHAs) is the first port of call for any health-related demands by deprived sections of the population, especially women and children, who find it difficult to access health services in rural areas. ASHAs are volunteers who are selected from the village itself and accountable to the community. They are trained to work as an interface between the community and the public health system. More than 884,000 community health volunteers contributed to this mission.

Rogi Kalyan Samiti (Patient Welfare Committee)/Hospital Management Society: It is a registered society that acts as a group of trustees to manage hospital affairs. A united fund looks after the funding and other financial assistance for these communities that are involved in patient welfare activities.

The Untied Grants to Sub-Centres (SCs): Untied grants to sub-centres have been used to fund grassroot improvements in healthcare. These include: (i) improved efficacy of Auxiliary Nurse Midwives (ANMs) in the field, who can now provide better antenatal care and other healthcare services, as they are better equipped with blood pressure monitors, stethoscopes, weighing machines; (ii) village health sanitation and nutrition committees (VHSNCs), which work at the grassroots levels to monitor the services provided by the Anganwadi Worker (Anganwadi is a type of rural child care centre in India), ASHAs, and sub-centres. They act as a sub-committee or statutory body of the Gram Panchayat.

Health Care Service Delivery: Health care service delivery requires intensive human resource inputs. NRHM has sought to address human resource shortages by deploying nearly 170,000 health service personnel to States on a contractual basis. This service includes 8,871 Doctors, 2025 Specialists, 76,643 ANMs, 41,609 Staff Nurses, etc. Many unserved areas were covered through mobile medical units (MMU) (National Rural Health Mission Document, 2005-12).

Appendix IV: Activities under the National Rural Health Mission (2005–2013)

Human resources (new providers)	9,31,239 Accredited social health activists
	27,421 Doctors at PHCs, 4078 specialists at CHCs
	40,119 Staff nurses
	72,984 ANM
Human resources (programme management)	618 District Programme Managers and 633 District Accounts Managers deployed
Ambulance	More than 30,000 ambulances deployed nation-wide
Community participation structure	4,99,210 Village level Health Sanitation and Nutrition Committees (VHSNCs) created
	29,063 Patient Welfare Committees created at public facilities
Web-based mother and child tracking system	Tracking 105 million mother-baby dyads
Finances provided	A total of 21 billion USD invested (2005–2015) by the Central Government
Other	Between 2009 and 2013, graduate medical capacity increased by 54 per cent and post graduate medical seats by 74 per cent.

Source: Mission Document, National Rural Health Mission (2005-2012).

Appendix V: Flexi Pools: Basis of Allotment

Flexi Pool	Basis of Allocation	GoI Share	State share
RCH-HSS	75% total population & 25% rural area	20%	40%
DCP	Disease burden basis	10%	
NCD	75% total population & 25% rural area	10%	
NUHM	50% weightage on urban population & 50% on slum population	10%	
Infrastructure Maintenance		10%	0
Total		**60%**	**40%**

Source: MoHFW, NHM Finance.

Appendix VI: National Health Mission: Allocations

National Health Mission (NHM)					
					(Rs. In Crore)
Sl.No.	**Pools**	**BE (2021-22)**	**RE (2021-22)**	**Pool**	**BE (2022-23)**
1	RCH Flexible Pool including RI,PPI and NIDDCP	6,273.32	5,650.00	Flexible Pool for RCH & Health System Strengthening, National Health Programme and Urban Health Mission	22,316.73
2	Health System Strengthening under NHM Flexible Pool	11,931.28	10,931.00		
3	AB-HWC (NRHM)	1,650.00	1,550.00		
4	ASHA Benefit Package (ABP)	836.99	500.00		
5	Flexible Pool for National Disease Control Programmes (NDCPs)	2,178.00	1,750.00		
6	NCD Flexible Pool	717.00	367.00		
7	National Urban Health Mission (NUHM)	1,000.00	500.00		
8	AB-HWC (NUHM)				
9	Pilot Project	20.00	12.00		
10	Infrastructure Maintenance (IM)	6,343.41	6,950.00	Infrastructure Maintenance (IM)	6,343.00
11	Strengthening of National Programme Management Unit (NPMU)	150.00	140.00	Strengthening of National Programme Management Unit (NPMU)	200.00
	Total	**31,100.00**	**28,350.00**		**28,859.73**

Source: MoHFW, NHM Finance.

Appendix VII: NHM – Major Initiatives

Addressing Shortage of Human Resources: The delivery of healthcare services requires intensive human resource inputs. There has been an enormous shortage of human resources in the public healthcare sector in the country. NHM has attempted to address shortages in human resources by providing nearly 2.40 lakh additional health workers to the States on a contractual basis[12]. In addition to supporting health personnel, the NHM has also emphasised the multi-skilling of medical professionals, such as doctors, at strategically situated facilities designated by the States. Similarly, due importance is given to capacity-building of nursing staff and auxiliary workers such as ANMs. Additionally, NHM supports the co-location of AYUSH services in PHCs, CHCs, and district hospitals.

***Janani Shishu Suraksha Karyakram* (JSSK):** To promote universal health care, the government started the *Janani Shishu Suraksha Karyakram* (JSSK) initiative under NRHM. This scheme entitles all pregnant women delivering in public health institutions to free delivery, including caesarean operations, along with complimentary transportation, drugs, diagnostics, blood tests, and meals. This service can be accessed through a toll-free call to a dedicated call centre.

Janani Suraksha Yojana: is a safe motherhood intervention under the National Health Mission. The objective is to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women.

Free Drugs: An initiative has been launched to ensure provision of quality free essential drugs such as facility-wise essential drug list (EDL); robust procurement system; IT backed logistics and supply chain management; proper warehousing; and necessary drug regulatory and quality assurance mechanism.

Free Diagnostic Service Initiative: To improve the quality of care, support is provided to states for offering essential diagnostics free of cost in public health facilities. Three types of diagnostic services have been implemented: (i) free diagnostics laboratory; (ii) free diagnostics CT Scan services; and (iii) free tele-radiology services.

Biomedical Equipment Maintenance and Management Programme (BMMP): This initiative was established to tackle the challenge of malfunctioning equipment in public health facilities. Through the BMMP, diagnostic services have seen significant improvement, with a 95 per cent equipment uptime, leading to reduced healthcare costs and enhanced quality of care in these facilities.

National Ambulance Services (NAS): Provision of basic transport to patients has been one of the components of NRHM. The ambulance service operating under Dial 108 or 102 is a part of this initiative. Dial 108 predominantly serves as an emergency response system, primarily designed to attend to patients requiring critical care, trauma care, and support for accident victims, among others. Meanwhile, Dial 102 services focus on basic patient transport, catering primarily to the needs of pregnant women and children. However, these services are not limited to the aforementioned groups can be availed by other categories of patients as well.

National Mobile Medical Unit (MMU): The objective of the MMU is to facilitate access to public healthcare, particularly for people living in remote, difficult, underserved, and unreachable areas. It provides a wide range of healthcare services, including treatment for minor ailments, communicable and non-communicable diseases, reproductive and child health, family planning services, etc.

Emergency Response Service Vehicles (ERSV): Currently, there are several ESRVs and empanelled vehicles available for transporting patients—particularly pregnant women and sick infants—from their home to public health facilities and back.

My Hospital / MeraAspataal Initiative: '*Mera Aspataal*' is a patient-centric initiative featuring a simple, intuitive, and multilingual ICT-based system. It quickly captures feedback from patients regarding the services they receive at both public and private empanelled health facilities. This is achieved through user-friendly multiple channels such as Short Messaging Service (SMS), Outbound Dialling (OBD), a mobile application, and a web portal.

[12] These includes 11,028 GDMOs, 3144 Specialists, 54,414 Staff Nurses, 82,512 auxiliary nurse mid-wives (ANMs), 39,605 Paramedics, 429 Public Health Managers, 17,179 Programme Management staffs, etc.

Untied grants for Healthcare: This includes ANMs and VHSNC at the rural level as part of the NRHM, as previously mentioned. The same institutional mechanism is mandated in urban areas as well. VHSNCs receive an annual untied fund of Rs. 10,000, which may be increased based on the previous year's expenditure. As of December 2018, more than 5.40 lakh VHSNCs had been established across the country. In many states, capacity-building activities for VHSNC members about their roles and responsibilities are also being conducted to maintain the health status of the villages.

Rashtriya Bal Swasthya Karyakram (National Child Health Scheme): This initiative, launched in 2013, provides child health screening and early intervention services. It focuses on the early detection and management of the 4Ds: Defects at birth, Diseases, Deficiencies, and Development delays, including Disability. Additionally, it offers free management of 30 identified health conditions. Children between 0-18 years of age are expected to be covered in a phased manner across the country.

District Hospital as Knowledge Centre for Clinical Care & Training: Under this scheme, district hospitals are strengthened to provide multi-specialty healthcare, including dialysis care, intensive cardiac care, cancer treatment, mental illness treatment, emergency medical and trauma care, etc. These hospitals provide knowledge and support for clinical facilities down the line through a telemedicine centre located in the district headquarters. They also serve as training centres for paramedics and nurses.

24 X 7 Services and First Referral facilities: To ensure service provision for maternal and child health, 24x7 services at the PHCs have been made available. A total of 9,698 PHCs have been made operative 24x7. Additionally, 3,135 facilities (including 714 DH, 737 SDH and 1684 CHCs and other level) have been operationalised as First Referral Units (FRUs).

Kayakalp Scheme: A Kayakalp Scheme was launched in 2015 with a view to: (i) maintain a higher level of hygiene and sanitation in public hospitals through various methods, including outsourcing; and (ii) change the mindset and perception about public hospitals.

National Quality Assurance Programme: National Quality Assurance Programme aims at providing quality health services at public health facilities. Launched in November 2013, the initiative has been implemented in all the States and UTs. Under the programme, there are National Quality Assurance Standards (NQAS) for various facilities: district hospitals, community health centres, primary health centres, and urban-primary health centres. The quality standards and assessor training programme have received international accreditation from the International Society for Quality in Healthcare (ISQUA). Currently, 310 health facilities have received national quality certification, while 509 are quality certified at the state level (Ministry of Health and Family Welfare, 2018-19).

Appendix VIII: Key Initiatives under the NHM- Progress Made (up to 2021-22)

As of March 31, 2022, 1,17,440 Ayushman Bharat-Health & Wellness Centres were operationalised, surpassing the cumulative target of 1,10,000.
As of March 31, 2021, a total of 5,34,771 ASHAs, 1,24,732 Auxiliary Nurse Midwife (ANMs), 26,033 Staff Nurses and 26,633 Primary Health Centre (PHC) Medical Officers had been trained on non-communicable diseases (NCDs).
Around 6.58 crore doses of Rotavirus vaccine were administered in all States/UTs.
Around 204.06 lakh doses of Pneumococcal Conjugated Vaccine (PCV) were administered in six states.
Around 3.5 crore adults have been vaccinated with adult Japanese Encephalitis Vaccine.
National Ambulance Services (NAS).
As of March 31, 2021, there is a total pool of 10.69 lakh ASHAs across the country.
24x7 Services and First Referral facilities: During 2020-21, 1,140 facilities were added as FRUs operationalisation.

Source: MoHFW, Government of India.

Appendix IX: Facilities available under CGHS

i. OPD Treatment including issue of medicines

ii. Specialist Consultation at Government Hospitals

iii. Hospitalisation at Government and Empanelled Hospitals

iv. Investigations at Government and Empanelled Diagnostic Centres

v. Cashless treatment facilities in empanelled hospitals and diagnostic centres for pensioners and other identified beneficiaries

vi. Reimbursement for emergency treatment in private unrecognised hospitals

vii. Reimbursement for expenses incurred for purchase of Hearing Aid, Artificial Limb, etc.

viii. Family Welfare & MCH Services

ix. CGHS Beneficiaries can avail medical facilities in any Wellness Centre across cities covered by CGHS

x. Tele-consultation services through e-Sanjeevini application started in August 2020

xi. Restricted Drugs (Life Saving Medicines): Now delivered at CGHS Wellness Centres in Noida, Faridabad, Ghaziabad, and Gurugram of NCR region. Previously available only at CGHS, MSD, Gole Market, New Delhi.

xii. The myCGHS mobile app for services like appointment booking, medical history, card details, medical reimbursement details, etc., with SMS alert system (CGHS, 2020).

Eligibility for CGHS

- All Central Government employees and their dependant family members in CGHS covered areas.
- Central Government Pensioners and their eligible family members getting pension from Central Civil Estimates
- Sitting and Ex-Members of Parliament, Ex-Governors & Lt Governors, Freedom Fighters
- Ex-Vice Presidents
- Sitting and Ex-Judges of Supreme Court & High Courts
- Employees and pensioners of certain autonomous organisations in Delhi.
- Journalists (in Delhi) accredited with PIB (for OPD & hospitalisation facilities at Dr RML Hospital, New Delhi)
- Delhi Police Personnel in Delhi only
- Railway Board employees
- Central Government Servants who (through proper channel) got absorbed in Central Public Sector Undertakings/Statutory Bodies/ Autonomous Bodies and receive pension from Central Civil Estimates (CGHS, 2020).

About the authors

Janak Raj leads the macroeconomic segment in the Growth, Finance, and Development vertical. His areas of interest are health, climate finance and MDB reforms. He has worked with the Reserve Bank of India, the International Monetary Fund, and Ministry of Finance. Dr. Janak Raj served as an Executive Director in the Reserve Bank of India and as a member of its Monetary Policy Committee. In the IMF, he was Senior Advisor to the Executive Director for Bangladesh, Bhutan, India and Sri Lanka. He holds a Ph.D in Economics from IIT Bombay.

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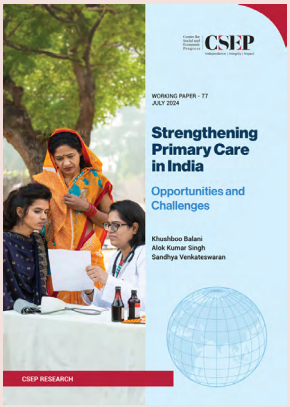
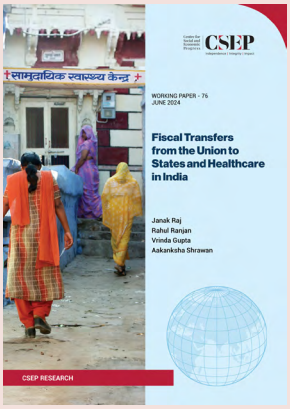
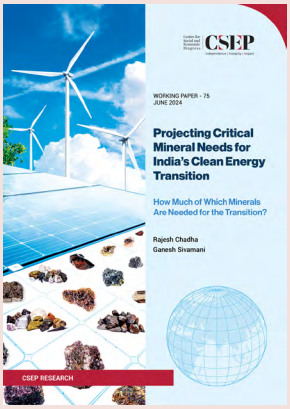
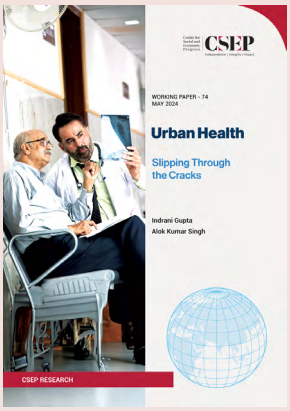
His interests lie in reading and researching about macroeconomics and trade theories.

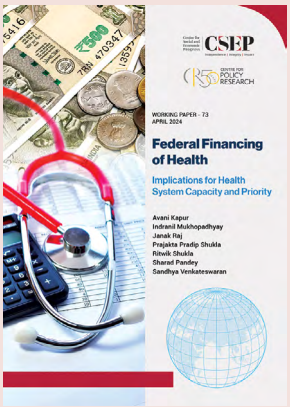
Other publications

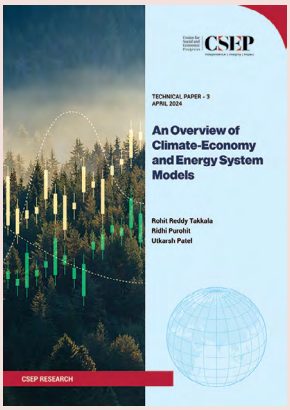


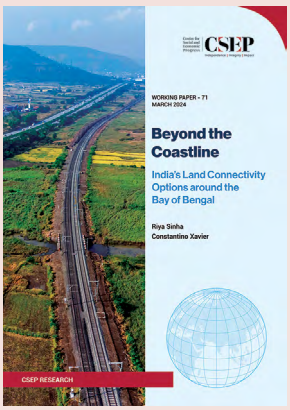


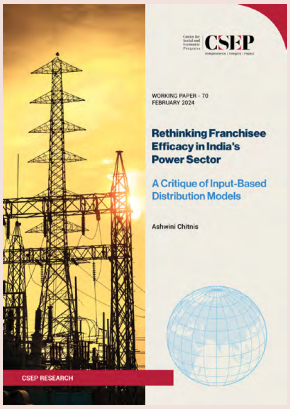


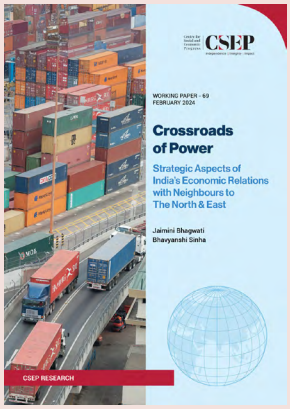


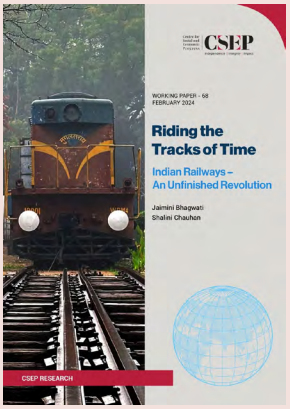


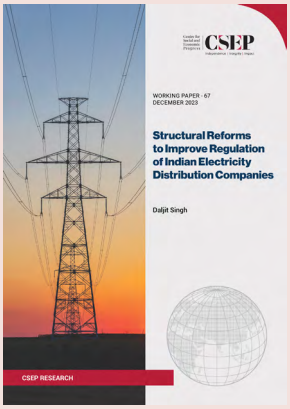


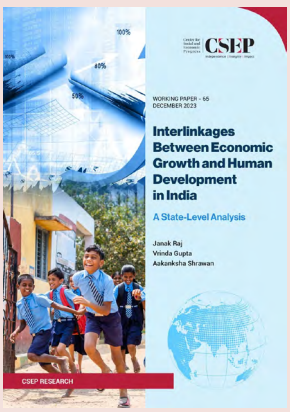


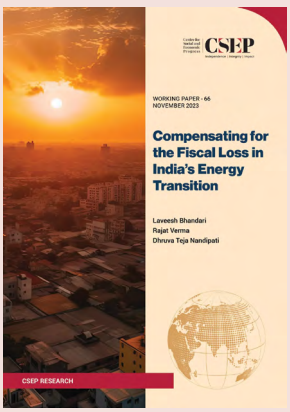


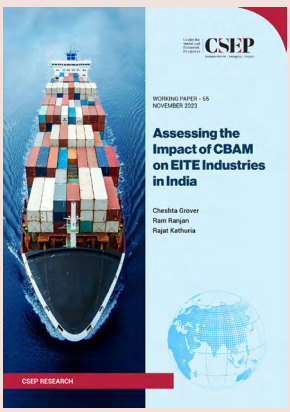












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