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# How to Strengthen the Foundations of India's Health System

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*Decades after Independence, we are yet to provide health care for all. Insurance is no answer. We need to identify strategies to bolster the foundation of India's health system based on equality and justice, which would guarantee health care to everyone in need and provide free primary health care.*

Socially, India continues to be one of the most fractured societies, where caste, gender, region, and class determine the boundaries of our existence. Birth continues to decide how long one will live and what opportunities one will have. For example, a poor Scheduled Caste (SC) woman in Uttar Pradesh (UP) has a life span that is 10 years lower than that of a poor woman in Kerala. Likewise, the difference in the average age at which women die during childbirth is about 15 years between women in SC communities and women in other social groups.

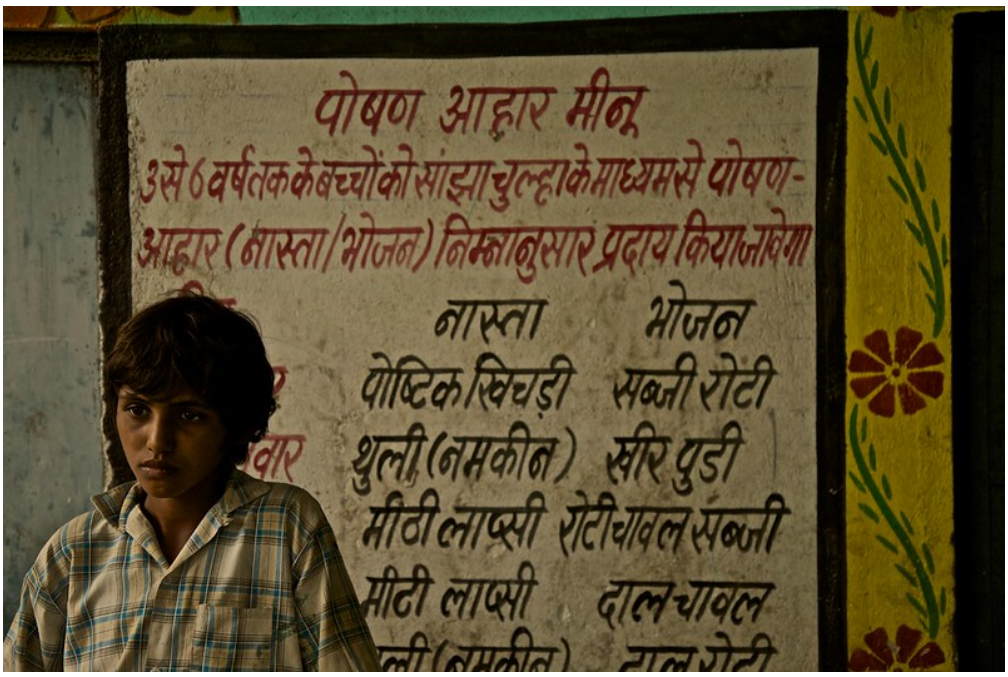
Clearly, ideas of equality and individual freedom — of liberty and opportunity — have failed to gain much political traction in the country. It is not just about welfare for the poorest but the idea that every human being counts and is worthy of respect and a life of dignity. If we do not believe in this basic idea, we need to ask ourselves what our assumptions are and what political values should drive our politics.

Such reflection is critical because it is the foundation for building a health system that every citizen can access when they need it, without the ability to pay being a barrier. In short, a health system is a social construct, reflecting and mirroring the values and cultural beliefs of the society it is embedded in. It is an arena of competing interests calling on the political system to make policy choices, and the choices are made in accordance with our values.

## Public values

The values of right and wrong and justice are at the foundation of countries that believe in the rule of law and have the resilience to take risks. An example of the moral strength of righteousness was seen in the United Kingdom at the end of the Second World War when the country, though economically battered, set up the National Health Service. All citizens were entitled to good quality healthcare at no cost. This was based on the belief that no one should be denied healthcare for want of ability to pay for it. Similarly, Canada and most European countries have political philosophies based on the values of equality and fairness, which make it implicit that the state has the obligation to provide every citizen equal access to healthcare, education, and all other public goods that are essential for them to live optimally.

Values enshrined in the public policies of these countries are, however, outcomes of a culture of knowledge, debate, and intellectual discourse that over decades has given rise to several postulates on the relationship between the state and citizen, and the state and society. Ideas such as John Locke's social contract theory, which states that governments are created with the consent of the people to protect their rights and promote the common good; Jeremy Bentham's utilitarianism, which promotes the greatest happiness of the greatest number; and John Rawls' definition of justice as fairness, have had profound effects on the politics of these countries. A strong belief in the importance of ensuring that all citizens enjoy freedom of speech and freedom to access healthcare and education made these countries invest their political and financial capital in these areas.




Considering that India was under British rule for 200 years and exposed to such thinking, it was natural to assume that India too would imbibe these values. It is, therefore, quite inexplicable how India ignored the two cornerstones of democratic societies — health and education — while seeking to build a nation. Besides Western influence, India had its own intellectual traditions that held a state responsible for ensuring the welfare of its people as seen in the edicts of Ashoka and in the concept of social equality in the teachings of almost all reformers, beginning with the Buddha to Basavanna in the 11th century, and from Guru Nanak in the 16th century to the Constitution of India in the 20th century.

Yet, in 2022, 75 years after Independence, India was ranked 129 out of 146 countries in the World Inequality Report. According to this report, in 2022–23, the top 1% of India's population received 22.6% of the country's national income, the highest level since 1922. The top 1% also held 40.1% of the country's wealth, the highest level since 1961. While the top 10% of the population had 57% of the total national income, the share of the bottom half was 13%.

> Poor nutrition, poor housing, inadequate water, poor hygiene, and polluted air are all causative factors of ill health.

Levels of income, education, sanitation, nutrition, environmental hygiene, and social relations are important components of a health system. They are referred to as the social determinants of health as opposed to a medical definition of health, which includes doctors, drugs, hospitals, patients, disease, and sickness. Though the World Bank classifies India as a lower-middle-income country based on its gross national income (GNI) per capita, we have more than 200 million people below the poverty line and a third of our children are stunted due to chronic hunger.

Poor nutrition, poor housing, inadequate water, poor hygiene, and polluted air are all causative factors of ill health. They also explain our inability to eliminate tuberculosis, respiratory infections, and other diseases, even as access to good quality healthcare is increasingly becoming a privilege. How did we come to such a pass? An understanding of the evolution of India's health system since Independence may be useful.

## Eliminating diseases

When we became independent, healthcare professionals comprised about 25,000 medically qualified doctors and an equal number of licentiates. Some urban hospitals had been established to cater for the elites and the British, while rural areas remained largely in the hands of practitioners of traditional medicine. Since sexually transmitted diseases and cholera affected soldiers, the colonial government had paid some attention to improving sanitation and inculcating notions of hygiene among them. Infectious diseases such as malaria and small pox were rampant. Combined with malnutrition and hunger, life expectancy in India was approximately 32 years in 1947.

In 1946, the Health Survey and Development Committee, under the chairmanship of Joseph Bhore, submitted its report, making wide-ranging recommendations on the architecture of the health system in India, which even today hold good. The committee recommended the establishment of a primary healthcare facility for every 40,000 people, which would be supervised by a secondary hospital. It clearly articulated the important principal of non-discrimination by emphasising that no one must be denied access to healthcare for want of money.

Despite the challenges a young India faced, a programme to build primary health centres across the country was launched, in tandem with focusing on reducing the incidence of infectious diseases such as malaria, tuberculosis, and small pox. Over the years, by the mid-1970s, we eradicated small pox, reduced the incidence of malaria from 75 million to less than 2 million, and established a network of primary health centres by opening one in every block with a population of 100,000. We also had subcentres manned by auxiliary midwives for every 5,000 people.

> Our greatest achievement of which we can be rightly proud is polio eradication — a certificate that India was polio free was received from the World Health Organisation on 27 March 2014.

India established the All India Institute of Medical Sciences (AIIMS) in New Delhi in 1956 to create the necessary faculty for opening more colleges, and launched five national health programmes, three for reducing and eradicating vector–borne diseases, tuberculosis, and leprosy, and one each for reducing maternal and infant mortality and population control. In the 1980s, India launched a universal immunisation programme, which was aimed at eliminating six diseases that could be prevented by vaccines: tetanus, diphtheria, polio, tuberculosis, measles, and whooping cough.

To provide greater focus, the immunisation programme was included as a technology mission under Prime Minister Rajiv Gandhi's watch. This got additional resources and political attention enabling the building up of the required cold chain and procurement systems. Barring childhood tuberculosis and measles, the other four preventable diseases have been eradicated.

Our greatest achievement, of which we can be rightly proud is polio eradication: a certificate that India was polio free was received from the World Health Organisation (WHO) on 27 March 2014. This was after a 25 year battle that started in 1994, with the Global Call to launch the Polio Pulse Programme for eradicating polio. The program meant vaccinating newborn babies and infants in two nationwide campaigns and seven focused campaigns in high-risk pockets. It meant mobilising more than 2.3 million volunteers and organising a massive exercise to administer polio drops in over 700,000 vaccine booths, which were under 180,000 supervisors. It meant reaching out to every infant every infant in every single household and to monitor the millions of infants on an individual basis.

## Primary healthcare for all

In health, there is a concept called epidemiological transition, which can be used to describe the shift in disease burden as countries develop. Diseases of underdevelopment and poverty were the more infectious or communicable diseases, while diseases of development were referred to as non-communicable lifestyle diseases. Thus, as a country develops, incomes rise and living conditions improve, its disease profile changes, witnessing higher incidence of the non-communicable diseases just as when longevity increases, geriatric care becomes important.

India made this transition in 2010. The southern states, however, made it a decade earlier. So, in India, we have a clear epidemiological divide between the north and the south: 60% of the disease burden in the south is because of non-communicable diseases, while it is the opposite in the north.

> Improved incomes, better living standards, and higher expectations saw cases of non-communicable diseases multiply, raising a demand for services that were not all available in government facilities.

The world over, health systems have a pyramidical structure, with the base called primary care, the middle secondary care, and the apex tertiary care. Such a structure enables patient flows to be aligned with patient needs. So common colds and minor ailments, that form almost 90% of patient needs, are handled in primary care facilities. District hospitals, which are secondary care institutions, take care of 6% of the total cases, including surgeries for appendicitis or cataract. Tertiary care hospitals handle the remaining 4% of patients with diseases such as cancer knee or liver transplants and cardiac diseases etc that require sophisticated diagnostic facilities and super specialists.

The nature of morbidities at each level determines the skills, competencies, and levels of knowledge and expertise to be deployed. Besides, the financial implications are real, with a three-fold increase in unit cost at each level. So, for sustainable and affordable healthcare, the priority should be on providing excellent primary healthcare free of cost to all citizens.

India began its development story with such an understanding. But the 1990s changed it all. Improved incomes, better living standards, and higher expectations saw cases of non-communicable diseases multiply, raising a demand for services that were not all available in government facilities.

In 1990, economic conditions forced India to take International Monetary Fund (IMF) loans that imposed stiff conditions, mainly reducing the fiscal deficit and cutting down on all 'non essential' expenditure. Health and education suffered, as did nutrition and other welfare programmes. With health budgets just enough to provide salaries, and little left for maintenance, drugs or equipment, the delivery of healthcare services in public facilities suffered.

Nudged by the World Bank and the IMF, India was forced to turn to the private sector for investment in the health sector. The government offered land and custom duty exemptions for importing equipment in exchange for a providing free care to the poor, a condition that was never enforced. Private hospitals mushroomed. Since then, the private sector has emerged as the dominant player in the health sector – running hospitals and clinics, bringing in modern technology, and manufacturing drugs. It has also establishing more than half of the 730 medical colleges in the country, and treats nearly three quarters of all those needing outpatient care and more than half of those who require inpatient care.

The near reversal of the earlier policy framework, where public facilities were the main sources of free care, compelled citizens to resort to the private sector. This has ended up impoverishing a large number of people, as shown in the National Sample Survey's (NSS) 55th Round Consumption Expenditure Survey conducted during the period July 1999 to June 2000. In UP, 22% of rural poverty was reported to be due to medical expenses.

In response to the deterioration of public healthcare, the National Rural Health Mission (NRHM) was launched in 2005 as a flagship government programme to revitalise the primary health system in rural areas. It was a landmark development. With three times the usual budget, within five years, the government was able to appoint a million trained community workers, one for every 2,000 population. It also expanded and strengthened primary healthcare facilities by recruiting and appointing more than 25,000 doctors and nurses and ensuring a steady supply of drugs. Footfalls increased in government hospitals, and trust was restored, albeit slowly.

> Guinea worm and tetanus have been eradicated, and leprosy is nearly there, followed by tuberculosis. HIV/AIDS has been contained by providing free treatment and propagating preventive strategies.

Continued public investment did yield some results. Compared with 1990, when the infant mortality rate was 80 per 1,000 live births, it was 27 in 2023. Likewise, maternal mortality has also fallen to 97 now from a high of 556 per 100,000 births in 1990. Guinea worm and tetanus have been eradicated, and leprosy is nearly gone, followed by tuberculosis. HIV/AIDS, which had seen India sitting on an explosive situation, has been contained by providing free treatment and propagating preventive strategies. Today, communicable and infectious diseases account for about 28% of India’s disease burden, and they are disproportionately higher in the northern states.

## Moving towards comprehensive care

Once born, all have to die — if not of malaria or tuberculosis, then of heart attacks or respiratory infections. Causative and contributive factors of non-communicable diseases are sedentary lifestyles, rapid urbanisation, shifts in dietary habits (increased intake of junk foods, alcohol, tobacco and other addictive substances), and the aging of the population. They are responsible for 60% of the deaths in India, with cardiac problems, cancers, chronic obstructive pulmonary disease, and diabetes topping the list.

These diseases are expensive to treat but can be checked by appropriate laws and regulations. Since patients with chronic diseases such as diabetes and hypertension need longitudinal attention, health systems need to be revamped to shift from episodic care to long-term care. They also need resilience and different skill sets, besides a culture of accountability. Accordingly, many countries have reworked their public health policies and established community-based primary healthcare systems manned by family doctors and public health specialists.

> Close to 350 million cards have been issued under Ayushman Bharat, and nearly 68 million hospitalisations have been authorised so far. The scheme has been recently extended to cover all the elderly above the age of 70.

In recognition of this and inspired by the vision of leaving no one behind, in 2018, India launched the Ayushman Bharat programme in an attempt to move from a sectoral and segmented approach to health service delivery to a comprehensive need-based healthcare service. It aims to holistically address the healthcare system (covering prevention, promotion and ambulatory care) at the primary, secondary and tertiary levels, and adopt a continuum of care approach.

The Ayushman Bharat programme consists of two components — first, strengthening primary care facilities, and second, expanding social health insurance to cover the poor.

Under the first component, all the 164,000 subcentres (rural and urban, including 23,744 primary health centres) manned by an auxiliary midwife and assisted by two accredited social health activists (ASHAs) were renamed as Health and Wellness Centres (now further renamed as Ayushman Arogya Mandirs). They were strengthened by appointing as community health officers either a fully qualified nurse or a practitioner of ayurveda, yoga and naturopathy, unani, siddha, or homoeopathy. Better availability of drugs was ensured while bridging gaps in basic diagnostics and infrastructure.

These centres are mandated to provide 12 services for conditions ranging from reproductive and child health to non-communicable diseases, including mental health. Screening and referrals are done free for all the people residing in their jurisdiction.

The second component of Ayushman Bharat is the Pradhan Mantri Jan Arogya Yojana (PMJAY) under which 120 million families, defined as poor under the socio-economic caste census of 2011, are eligible for a sum Rs. 5 lakh for 1,929 procedures and secondary and tertiary hospitalisation in 30,870 accredited hospitals across the country, both public and private.

The unique features of this social health insurance policy are that it is portable, which means that an insured person from UP can be compensated for hospitalization in Chennai; there is no restriction on family size; it covers three days pre-hospitalisation expenses and 15 days post-hospitalisation expenses; and it also covers all existing diseases. Close to 350 million cards have been issued, and nearly 68 million hospitalisations have been authorised so far. The scheme has been recently extended to cover all the elderly above the age of 70.

## Challenges

These are welcome developments. Yet, there is huge concern all around as the general perception is that the health system is too costly, too privatised, and lacks strong foundations. Considering that our achievements have been impressive, why this perception? Some reasons are :

1) India’s public spending on health has for the last seven decades been an average of about 1% to 1.2% of gross domestic product (GDP). This has at best gone up to 1.3% of GDP. The Economic Survey shows public health spending to be 1.8% of GDP but that includes expenditures on water, sanitation, and nutrition. What is more disturbing is that the last NSS survey showed a contraction in private spending on health because it is becoming unaffordable.

The general norm on total health spending in developed nations is 5% of GDP, of which government spending is at least 3% to make the system equitable. Against that broad norm, India’s total health spending is about 3.8% of GDP, and public spending is about 1.3% of GDP. This is very low because just revamping the primary healthcare system to provide comprehensive care to all will itself need an additional 1% of GDP. In other words, we are not spending enough, and much of what we spend is not necessarily in the right areas, which results in a very shaky edifice.

2) The PMJAY covers only inpatient treatment, and patients have to pay for outpatient treatment, which often means diagnostics and drugs. So, notwithstanding the impressive social health insurance programmes of the central and state governments, out of pocket expenses by patients continue to be high, ranging between 45% and 54% of total health spending as against the UN’s Sustainable Development Goal of 20%.

3) Lopsided incentive structures and the non-availability of appropriately trained and skilled personnel is a serious issue in India. The country has a million ASHAs, and over 160,000 subcentres with two qualified nurses. There are also 24,935 primary health centres in rural areas and 6,118 in urban areas, each with a doctor and support staff for a population of 30,000. Between 10% and 20% of these

facilities still have vacancies.

At the 100,000 population level, the government has 5,480 community health centres in rural areas and 584 in urban areas, each with 30 beds. Each one is also expected to have four specialist doctors, but 79.9% of these posts are unfilled. A Niti Ayog survey of 700 district hospitals showed that not one has been providing all the 14 services in its mandate, and that more than one third of the posts are vacant.

For tertiary care, the government has been feverishly announcing AIIMS-like hospitals. Starting with six in 2003, 22 have been announced so far. However, even the first six have severe problems with human resources. At least half of the 731 medical colleges in India, with nearly 112,000 MBBS students and 72,627 MD seats, have inadequate faculty and are liable to be shut down if National Medical Commission (NMC) regulations are enforced.

According to a WHO report, India's doctor density has fallen by 5 percentage points since 1991, to 7 in 2020. This means there is effective demand but the supply lines are clogged. Declogging cannot be done by shifting the responsibility to the private sector because it too dips in the same available pool of human resources.

4) India has a mixed health delivery system, with both the public and private sectors providing healthcare services. As mentioned earlier, the trend since the 1990s has been towards privatising healthcare delivery. Privatisation per se is not a problem as India has always had a private sector. The problem is the commercialisation and profiteering that have emerged as important characteristics of our private sector. This has increased multifold in the health sector because of the reluctance of states to frame laws and regulations and enforce them.

The government today also lacks clarity on what the architecture of the health system has to be. This is important to understand.

On the one hand, public budgets are not increasing. No state is spending more than 5% of its revenue budget on health. This means there are shortages at every level to keep up with demand. In the scheme of things, it is primary, preventive, promotive healthcare that suffers the most. Instead of increasing budgets and tightening governance, the government is doing two things. The first is the easy and lazy thing of announcing more health insurance schemes. Of what use is a Rs 5 lakh or even a Rs 10 lakh voucher in Shravasti or Bundelkhand or Adilabad if there is no hospital or doctor nearby?

The second is publicising the simplistic notion that the government can rid itself of all responsibility for healthcare by privatising public health facilities. As we speak, the country's two laggard states in health, UP and Madhya Pradesh, are selling or leasing out 20 district hospitals for 30 years in their most backward districts where the paying capacity of patients is poor. Ten district hospitals have been given away to private corporates to set up medical colleges on the promise that free care will continue to be made available to the poor.

> Increasingly, private corporates have been seeking funds from equity or venture capitalists who demand a 25% return on investment. Due to this, prices in hospitals have shot up.

Two thirds of tertiary care is provided by corporate hospitals, which are largely not accredited under the government's health insurance programmes. The cost of care is growing in these hospitals as most are being bought up by multinational corporations. For example, BlackRock has bought up the Manipal group, the Aster group, and the KIMS hospital network in Kerala. Blackstone, another global investment company, has bought a hospital chain in Hyderabad. IHH Healthcare, Temasek, and KKR are all international equity and investment companies with majority stakes in Max, Fortis, Medanta, and other top tertiary hospitals in India.

Increasingly, private corporates have been seeking funds from equity or venture capitalists who demand a 25% return on investment. Due to this, prices in hospitals have shot up. Getting care in these high-cost hospitals now mean either incurring out of pocket expenses or paying a very high premium for commercial insurance. The situation is getting worse with Indian hospitals being aggressively marketed to medical tourists. Thailand earns more from medical tourism than India but only a few selected services are on offer, such as plastic surgery and sex change procedures. In other words, we have still not figured out the dynamics between the state-citizen and markets in the health sector.

5) Technology is going to be a huge disruptor in the health sector. Technology like call centres or telemedicine and the range of diagnostics have enhanced quality of care. Artificial intelligence (AI) is now being seen as beneficial as it enables access to critical information for doctors in real time.

But can healing and medical care be left to machines? Is there no role for intuition? Is it not true that every individual's response to disease is unique? Can AI and robots really replace doctors and other human health workers?

Today, the health sector is an employment intensive sector. But technology can disrupt this, in addition to demanding a new set of skills. Do we not need to think hard and carefully about the implications of these technologies and undertake a social cost benefit analysis? Elon Musk said in a recent interview that AI will render millions jobless but that the loss of employment can be addressed by providing a basic minimum income. The greater worry is what will these humans do? How will they gain a sense of worth? These are critical questions.

> It is argued here that they are the values of equality and justice, and a political system or state that acknowledges its responsibility by doubling the health funding to provide free, comprehensive, community-based primary healthcare to all citizens.

6. Finally, centre-state relations in India. States are not spending enough, and in most cases do not have the capacity to do so. Recent policies of the central government have destabilised the economic base of states, which have to provide the bulk of healthcare services. The central government has to step up and share in areas of concurrent jurisdiction. For example, infectious disease is a concurrent subject and the central government needs to put in much more money to ensure a Covid pandemic-like situation never happens again. Without a strong consultative relationship among communities, states, and the central government, the health scene in India will become more chaotic if everyone pulls in different directions.

## Conclusions

What are the foundations of a health system? I argue that they are the values of equality and justice, and a political system or state that acknowledges its responsibility by doubling the health funding to provide free, comprehensive, community-based primary healthcare to all citizens. It must also include addressing the social determinants of health and strengthening the system's governance and regulatory capacity.

In other words, strengthening the foundations of the health system is clearly not just building health centres. It is about every individual in need being guaranteed care. It is about an actively interventionist state protecting patients from market distortions and ensuring they have access to a health system founded on strong primary healthcare and a well-regulated private sector, which together are accountable to them. Given this background, can India aspire for a just and fair health system that guarantees universal health coverage? If yes, how and by when?

*(This is an edited version of the Dr. Y. Chandramouli Memorial Lecture delivered at the Administrative Staff College of India in Hyderabad on 18 November 2024.)*

*An earlier version had incorrectly edited the text to state that the immunisation programme had been set up under Prime Minister Narendra Modi. The programme was established during the prime ministership of Rajiv Gandhi. The error is regretted. Ed.*

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