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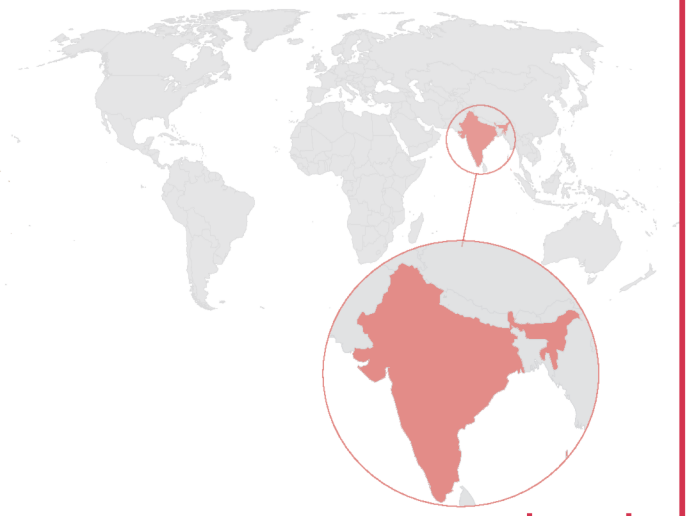
# Social Policy Country Briefs

India



Soumitra Ghosh

# The Health Care System in India

Global Dynamics of Social Policy CRC 1342

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**Soumitra Ghosh**
The Health Care System in India
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Contact: crc-countrybrief@uni-bremen.de

Postadresse / Postaddress:
Postfach 33 04 40, D - 28334 Bremen

Website:
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Soumitra Ghosh

# The Health Care System in India

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# The Health Care System in India

Soumitra Ghosh*

*Content*



* soumitra@tiss.edu

## 1. Country overview


*Source:* AdobeStock 364042801

- Sub-Region: Southern Asia
- Capital: New Delhi
- Official Language: Hindi, English
- Population size: 1.43 billion (2023)
- Share of rural population: 63.6 % (2023))
- GDP: 3,550 billion US-$
- Income group: Lower middle income
- Gini Index: 32.8 (2021)
- Colonial period: India was under the direct rule of the British Crown from 1858 and gained independence in 1947.

*Source:* World Bank (2024), https://data.worldbank.org/country/india (last access 28.09.2024)

## 2. Selected health indicators

| Indicator | Country | Global Average |
|---|---|---|
| Male life expectancy | 69.2 years (2017) | 69.8 years (2017) |
| Female life expectancy | 71.9 years (2017) | 75.0 years (2017) |
| Under-5 mortality rate | 30.5 (2023) | 36.2 (2023) |
| Maternal mortality rate (per 100,000 live births) | 103 (2020) | 223 (2020) |
| HIV prevalence | 0.2 (2019) | 0.7 (2022) |
| Tuberculosis prevalence | 210 (2021) | 134 (2021) |

*Source:* World Bank (2024), https://data.worldbank.org/country/india (last access 28.09.2024)

## 3. Legal beginning of the system

| | |
|---|---|
| Name and type of legal act | The Constitution of India |
| Date the law was passed | 26th November 1949 |
| Date of *de jure* implementation | 26th January 1950 |
| Brief summary of content | The Constitution of India implicitly recognises the right of everyone to have good health and access to health care. Note that Article 39 (E) directs the State to secure the health of workers, and as per Article 47, the State is duty-bound to raise the nutritional level and standard of living of the people and improve public health. In line with the above-mentioned health goals, the Constitution of India, under its seventh schedule, fixed the responsibilities of state (sub-national) and union (central) governments in a federal framework. These responsibilities are specified in the union, state and concurrent lists. The following items are included in the state list: "public health, sanitation, hospitals and dispensaries". The following items are included in the concurrent list: 'population control and family planning', 'adulteration of foodstuff', 'prevention of the extension from one state to another of infectious or contagious diseases', 'medical education' and governance matters related to medical profession. Seamen's and marine hospitals meant for quarantine are the sole responsibility of the Union Government. Besides, policy and regulatory aspects of commercial health insurance are also the exclusive domains of the Union (federal) government. However, social health insurance is under concurrent list, giving powers to both the centre and states to legislate in this regard. |
| Socio-political context of introduction | The Bhore Committee (1946) report, which is the only comprehensive review of the health situation in British India, revealed the dire state of health and nutritional status of the Indian population and the insufficiency of health services including the availability of medical personnel. The majority of doctors were in private practice and concentrated in urban areas. Worded differently, access to health services was mainly determined by how much money people had and where they lived. Also, people were largely dependent on private providers for outpatient care.<br>After 1949, the newly independent India made a conscious attempt to invest in health, especially in building the government health service system. The latter was in part based on the Bhore committee's recommendations, which emphasised laying out a three-tiered pyramidal structure of public facilities to address the unmet health needs of the vast majority of the Indian population and especially for the provisioning of basic medical care and maternal and child health services (Qadeer 2021). |

## 4. Characteristics of the system at introduction

### a. Organisational structure

While India, post-independence, adopted a decentralized approach towards health to provide the necessary decision space to states (sub-national governments) to build responsive and people-centred health care systems, in practice, the financial power enabled the union government to shape health policies and planning and guide policy actions through Five-Year Plans (FYP, i.e., centralised economic programmes to achieve social and economic development). The urban or rural local bodies, the lowest layer of the government, did not have much say in matters related to health at that time, except for a few municipal corporations which had a long history of local governance. For example, at the time of Independence, the Brihanmumbai Municipal Corporation (BMC) was significantly engaged in organizing health services, with the majority of hospitals in Mumbai being in the hands of BMC (Duggal 2021).

### b. Coverage

Alongside building a decentralized, universal, publicly funded, and publicly provided healthcare system, there were also developments of another kind. A handful of health schemes were introduced for small population groups belonging to the organized sector. The most notable and largest among them is the Employees State Insurance Scheme (ESIS), 1948, for industrial workers. This social insurance scheme with statutory payroll deduction was first implemented in Delhi and Kanpur, and then it was progressively scaled up to other regions of the country (Mehta, 1961).

Besides ESIS, the Central Government Health Scheme (CGHS) was started in 1954 in Delhi for its serving and retired employees and their dependent family members. Instead of a nominal monthly contribution, the CGHS beneficiaries were entitled to a generous health service package. The limited availability of private hospitals then was one of the primary reasons for starting CGHS. Furthermore, employees of public sector enterprises were also granted some measure of health protection. Similarly, plantations and mine owners were mandated to provide medical care to the workers, in line with the provisions of the Plantation Labour Act of 1951 and the Mines Act of 1952.

According to an estimate, 3.5% of India's population were additionally covered by ESIS at that time (Roemer 1997). It is worth noting that private health insurance was not used for financing health services for several decades. In fact, the majority of Indians, at that time, did not have any other public or private coverage, meaning that they mostly relied on the tax-funded universal health care system, which was being set-up. In other words, theoretically, the entire population was entitled to access services from the public healthcare facilities free of charge, in practice, the reach of this public health service system remained limited.

*Coverage*

| | |
|---|---|
| Percentage of population covered by government schemes | 100% * |
| Percentage of population covered by social insurance schemes | 3.5% * |
| Percentage of population covered by private schemes | None |
| Percentage of population uncovered | None * |

* Coverage rates are "de jure coverage" or merely theoretical – in practice, access to healthcare was severely restricted by the inability to enforce legal claims and the (un-)availability of healthcare infrastructure and services.

### c. Provision

In 1951, there was only one doctor (modern system) for every 5,841 persons, and the ratio of nurses to the population was about 1:20. Further, the total number of beds across public and private health facilities stood at 117,198. Put differently, India had just one bed per 3,080 people in 1951 (GOI 2004). It is worth noting that while inpatient care was largely provided by public hospitals, the private sector was the dominant provider of outpatient care during the

colonial period and this trend continued even after Independence (Bhore 1946; Duggal 2001). In fact, the majority of allopathic physicians were either in independent practice or attached to private hospitals.

The importance of providing comprehensive care was stressed upon in FYPs, leading to the allocation of financial resources to preventive and public health programmes as well as curative care. A close scrutiny of the budget data suggests that curative care accounted for more than 50 % of the combined state and central expenditure on health. As mentioned above, historically, the private sector principally operated in the sphere of curative care. As far as social protection schemes are concerned, the benefit package of ESIS, in the initial years, included outpatient care, selected drugs, vaccinations and home visits by panel doctors as well as inpatient care from government and empanelled private hospitals. And CGHS beneficiaries had access to inpatient and outpatient treatment from government hospitals, CGHS dispensaries and empanelled facilities. Besides, reimbursements for prescription drugs were also included. On the other hand, only primary care was provided to workers from plantations and coal mines. Clearly, the civil servants covered under CGHS had the most generous service coverage right from the beginning, while ESIS beneficiaries and those working in plantations and coal mines, by design, were provided with least generous benefit package. What is worth noting is, that the coverage of ESIS did not translate into utilisation for the majority of the insured population. One of the studies reported that in the initial year (1952-53), the benefits the workers derived from the scheme was a mere 7.44 lakhs rupees against the premium contribution of 162.14 lakhs rupees (Savur 1967).

### d. Financing

The information on total spending on health for the financial year 1950-51 is not available, owing to the difficulties in obtaining the estimate on private health spending at that time. The public spending on health was a mere 0.22% of GDP in 1950-51 (Duggal 2001). In the initial decades, states accounted for the largest share of total public health spending, with a figure approaching 90% of the total public expenditure on health (Jeffery 1988).

### e. Regulation

Regulations related to health can be broadly divided into four categories, the regulation of drugs, social health insurance, medicine, and healthcare providers.

#### *Regulation of drugs*

The Central Drugs Standard Control Organisation (CDSCO), which falls under the Directorate General of Health Services, Ministry of Health and Family Welfare (MOHFW), plays a pivotal role in drug regulation in India. The Drugs & Cosmetics Act of 1940 and Rules 1945 provided the regulatory framework concerning drugs. It has entrusted responsibilities on both central and state regulators to oversee the regulation of drugs. In other words, they are mandated to ensure safety, efficacy, and quality of drugs available to the public. As far as specific roles of CDSCO are concerned, it is responsible for drug approval, setting the standards for drugs, conduct of clinical trials, control over the quality of imported drugs into the country, and liaising with State Drug Control Organisations for uniform enforcement of the provisions of the Drugs and Cosmetics Act 1940. Furthermore, CDSCO together with its state counterparts are responsible for grant of licenses of a specific set of critical drugs like blood and blood products, I.V. Fluids, Vaccine and Sera.

#### *Regulation of Social Health Insurance*

As mentioned earlier, ESIS is India's first social health insurance (SHI) scheme, primarily governed by the Employees' State Insurance Act of 1948. The Employees' State Insurance Corporation (ESIC), created by this act, was tasked with delivering medical care to employees in all factories employing ten or more individuals, including those owned or controlled by the government. However, it is not applicable to establishments whose employees have social security benefits quite similar or superior to the benefits provided under this Act. In terms of providing policy directions to ESIS, besides ESIC, two more committees, namely Standing Committee and Medical Benefits Council are responsible. These structures comprise of nominees from employers and employees of covered

industries and sectors, apart from government and ESIC representatives. Representatives of insured workers and registered enterprises participate in the overall stewardship of the scheme and in significant policy decisions impacting the structure and operations of the ESIS. Another SHI scheme, namely the CGHS, is administered by a dedicated department under the MOHFW.

*Regulation of systems of medicine (Allopathy)*

The Medical Council of India (MCI) was first established in 1934 under the Indian Medical Council Act (IMCA), 1933. The MCI was constituted with the aim to set uniform minimum standards of medical education across provinces. In addition to designing the curricula of higher qualifications in medicine, MCI also established the infrastructural standards for medical colleges. It is worth noting that, as per the legislation, MCI's approval was needed for starting a new medical college or introducing a higher course of study by a medical college. Even the 'admission capacity' or student intake for specific courses offered by a college was determined by the MCI. The Indian Medical Council Act (IMCA) of 1933 was amended in 1956, extending its reach to all states with the exception of Jammu and Kashmir. This amendment was carried out to also reconstitute MCI to include licentiate members from the medical profession, many of whom were active practitioners then. Furthermore, the act sought to regulate the registration of qualified medical practitioners in India by establishing an all-India medical register containing the names of all practitioners with recognized medical qualifications.

*Regulation of health care providers*

Like IMCA, 1933, the Indian Nursing Council Act, 1947 was enacted to constitute an Indian Nursing Council with the purpose of setting a uniform standard of training for nurses, midwives and health visitors across states. The act also aimed to regulate the registration of the above-mentioned health professionals. Under INCA 1947, nurses, midwives and health visitors who had completed their training, qualified for the examinations and fulfilled the other conditions laid down in the Act were entitled to be entered on a national register.

The Bombay Nursing Homes Registration Act of 1949 was the first legislation to regulate private institutional care providers within the Bombay province, including the municipal boroughs of Ahmedabad and the Poona sub-urban area. In the years that followed, other states enacted similar legislations, mandating that all health service providers, including nursing homes and private hospitals, apply annually for registration or renewal with the local supervisory authorities.

## 5. Subsequent historical development of public policy on healthcare

### a. Major reform I

| | |
|---|---|
| Name and type of legal act | National Health Policy 1983;<br>National Health Policy 2002 |
| Date the law was passed | N/A |
| Date of *de jure* implementation | N/A |
| Brief summary of content | The National Health Policies (NHP) of 1983 and 2002 have shaped the development of the healthcare system in India and are subsumed here as a major reform.<br>The NHP of 1983 pledged the goal of "Health for all by the year 2000 AD" through universal provisioning of comprehensive primary health care services, a promise also made by the Alma Ata declaration of 1978. After the NHP of 1983, there was considerable expansion of preventative health care infrastructure in the country, although the majority of these primary health care facilities lacked the capacity to provide minimum acceptable quality services because of issues ranging from lack of supplies to shortage of human resources. It is worth noting that the NHP of 1983 stressed the need for private investment to reduce the government burden on curative care, particularly in specialty and super-specialty areas (GOI 1983). |

| | |
|---|---|
| Brief summary of content (continued) | In 2002 the NHP adopted a selective primary health care approach, only recommending access to universal immunization services. It prescribed policy actions to ensure equitable access to health services through a decentralized public health system, the convergence of major disease control programmes under one umbrella field, and committed to increasing public health spending from a meagre 0.9 % to 2 % of GDP by 2010 with 55 % allocation for primary health. The NHP of 2002 also envisaged a greater role for the private sector in all areas of health care, and expanding the scope of private health insurance plans to include more comprehensive coverage for secondary and tertiary care. The NHP of 2002 initiated the National Rural Health Mission (NRHM) in 2005 and the National Rural Health Mission (NUHM) in 2013, both subsequently subsumed under the National Health Mission (NHM). As a flagship central government programme, the NRHM aimed to strengthen the basic public health service delivery system in rural areas. The strategies included creating and deploying human resources for health closer to the community to improve accessibility and acceptability. Another important target was to strengthen or establish 175,000 Sub Health Centres and 30,000 Primary Health Centres (PHCs) as part of the service guarantees under Indian Public Health Standards by 2010. The NHM aimed to achieve these targets in a mission mode, underscoring their policy significance (GOI 2005).<br>Finally, the NHP of 2002 also envisaged the establishment of a social health insurance scheme for the underprivileged, with subsidies provided by the government and utilizing private sector services to complement public healthcare services (GOI 2002). Recognizing that hundreds of millions of poor working in the unorganized sector, often forgo treatment because of financial reasons and end up spending disproportionately on healthcare services, RSBY (which translates to National Health Insurance Scheme) was launched in 2008. This was done to create supplementary arrangements for secondary and tertiary services by partnering with private health service providers, marking a shift from India's traditional reliance on public health facilities. The RSBY had the following design features. The state paid the insurance premium to the commercial health insurance companies for covering the BPL families ('Below Poverty Line' households, identified by means tests). Once the families were enrolled, theoretically, the insured people could then obtain selected inpatient care packages from the empanelled health facilities, and the costs associated with those services would be reimbursed by the insurance companies as per the predetermined rates. The empanelled hospitals were supposed to provide cashless services to the beneficiaries. The existing literature on RSBY suggests that the scheme had very limited impacts in terms of enrolment, utilization, and financial risk protection (Ghosh and Gupta 2017). There are several plausible explanations. Both qualitative and mixed-method studies attributed the failure of this scheme to supply-side factors, including the scheme's design features (Ghosh 2014a; Ghosh 2014b). |
| Population coverage | In theory, the National Health Plans and the National Health Mission address the whole population. The RSBY specifically targets households below the poverty line (about 55 million families, or about 300 million people, by 2012.) |
| Type of benefits | The NHP of 1983 promised the provision of universal primary care services, but the implementation was restricted due to the lack of supplies and human resources.<br>The NHP of 2002 proclaimed only universal immunization services and selective primary care services.<br>The RSBY included secondary and tertiary care, e.g. hospitalization up to 30,000 Rs. (about 353 US-$) |
| Socio-political context of introduction | The NHP of 1983 was implemented in a context of national population policies that prioritized activities like "family welfare" and "maternal and child health services" in government health spending. The economic reforms and macroeconomic adjustments that took place in the mid-1980s and 1990s percolated into the health sector, too. During this time, the government's involvement in health lessened, and policies were adopted to promote healthcare privatization. It is worth noting that the National Health Policy of 1983 stressed the need for private investment to reduce the government burden on curative care, particularly in specialty and super-specialty areas (GOI 1983). One of the watershed policy developments that helped the private sector to expand was the passing of the Insurance Regulatory and Development Authority (IRDA) Act in 1999. This allowed foreign and domestic firms to enter the private health insurance market. Additionally, the hospital sector was granted industry status, paving the way for the establishment of India's first corporate hospital in 2000. |

## b. Major reform II

| | |
|---|---|
| Name and type of legal act | Ayushman Bharat, National Health Policy 2017 |
| Date the law was passed | N/A |
| Date of *de jure* implementation | February-September, 2018 |
| Brief summary of content | To accelerate progress towards Universal Health Coverage (UHC), a major health sector reform, as recommended by the third National Health Policy of 2017, the Ayushman Bharat Mission (which translates to "long life") was launched in 2018. It consists of two components: Health and Wellness Centres (HWCs), which have been renamed as Ayushman Arogya Mandir, and PM-JAY (Pradhan Mantri Jan Arogya Yojana, which translates to "Prime Minister's People's Health Scheme").<br>The AB-HWC is a critical primary healthcare reform that builds on the work done by NHM from 2005 to 2018. The AB-HWC aims to make architectural corrections in the primary health care system to move from selective to comprehensive primary health care provisioning. To realize this goal, it set out a target of transforming 150,000 Sub Health Centres and Primary Health Centres into HWCs by the end of 2022. In India, SHCs are the first point of contact, and as per the IPHS norms, there should be one HWC-SHC for every 3,000-5,000 inhabitants in rural areas and 15,000 to 20,000 in urban areas. The AB-HWC is showing signs of hope and should be accorded the highest priority as, according to one assessment, 80% of the disease burden can be tackled at the primary level. Nevertheless, its performance has remained sub-optimal due to factors such as inadequate funds, non-availability of all essential medicines and diagnostics, lack of residential facilities and, most importantly, lack of staff (Almost all states failed to meet even half of the human resource norms set by IPHS for HWC-SC and HWC-PHC (GOI 2022a; Dreze, Khera & Malhotra 2024).<br>The PM-JAY subsumed RSBY and integrated with other state-sponsored health insurance schemes (SSHIS). The PM-JAY design features are not fundamentally different from RSBY or SSHIS. It is fully funded by the government, with costs shared between the central and state governments. The funding ratio is 100:0 for union territories, 90:10 for north-eastern and three Himalayan states, and 60:40 for the remaining states. |
| Population coverage | The PM-JAY is an entitlement-based scheme and not enrolment-based (which was partly responsible for the underperformance of RSBY). Registration (for issuance of PM-JAY card) is compulsory for PM-JAY, which often poses a challenge for the least resourceful beneficiaries. The target population comprises socioeconomically disadvantaged families as identified by the Socio Economic and Caste Census 2011, in addition to the population already identified by the states during SHIS implementation. As of August 2023, private providers account for 42% of the provider network in PM-JAY. The availability of PM-JAY hospital beds stood at 3.3 in 2023 at the national level, varying from 0.7 per 1,000 inhabitants in Bihar to 4.4 in Kerala. There are significant concerns regarding equity, efficiency, and sustainability of this scheme. As per the recent report on PM-JAY, several states have joined the programme by integrating their health insurance schemes with it. This expansion has increased the number of eligible families to 15.25 crore (or 59.74 crore people), much more than the original target of 12 crore families (bottom 40% of the economic pyramid) set by the scheme (NHA 2023). As of 12th January 2024, 30 crore PM-JAY cards were issued, covering only half of the target population. Furthermore, there are reports of the poorest individuals being excluded from the PM-JAY beneficiary list, indicating a significant misalignment of the programme's targeting (Ghosh 2024). |
| Available benefits | AB-HWC benefits: The primary healthcare centres (HWCs) are envisaged to offer an expanded range of services, increasing from six to twelve packages. These services include screening, prevention, control, and management of non-communicable diseases, as well as screening and management of basic mental health and oral healthcare, elderly and palliative healthcare services, and first-level care for emergencies and trauma. Additionally, an expanded range of essential medicines, diagnostics, and teleconsultation services are also to be provided free of charge.<br>PM-JAY benefits: PM-JAY not only targets a wider population coverage but also has a much higher reimbursement ceiling (Rs. 500,000 or US$5,988) than RSBY. The benefit package initially included 1393 procedures, which has increased to almost 2,000 medical/surgical procedures, including certain procedures under the speciality of oral and maxillofacial surgery. Having said that, the benefit package is not fixed, and states have the liberty to include or exclude packages as per the local needs. As a result, many states provide benefits, considerably less than what the national package contains. In essence, PMJAY covers only certain major hospitalisation risks. Like RSBY, the beneficiaries could |

| | |
|---|---|
| Available benefits (continued) | procure these services free of charge, i.e., cashless at the listed hospitals. Importantly, it does not cover outpatient care or medicine, which is the largest contributor to out-of-pocket health spending in India. The inpatient care rate for PMJAY varies widely across states. Advanced states with better healthcare infrastructure and long experience in implementing such schemes, particularly those in the south, have accounted for a disproportionately large share of total claims, while populous states could only capture a small portion of the total PMJAY claims. In addition to regional disparities in use, there are also significant disparities within states, particularly between rural and urban areas. The lack of hospitals in rural areas has been a major barrier to accessing services. Besides, private providers often deny admissions to PMJAY beneficiaries, citing prolonged delays in claim reimbursement. According to a survey conducted in Chhattisgarh, the insurance cover of PMJAY has not prevented families from catastrophic health spending, nor has it reduced the incurrence of out-of-pocket expenditure (Garg, Bebarta & Tripathi, 2024). The promise of free hospital care under PMJAY did not quite materialise, as patients are frequently subjected to "extra billing" (Garg, Bebarta & Tripathi, 2020). |

## 6. Description of current health care system

### a. Organisational structure

The government has a constitutional obligation to ensure access to free healthcare for all in India. The nation's power structure has undergone a process of decentralisation since its adoption in 1949. The 72nd and 73rd constitutional amendments in 1992 further advanced decentralization by transferring power from the state to local self-government. In line with the constitutional scheme, the primary responsibility for organizing health services lies with the state and local level authorities, namely PRI in rural areas and municipalities in urban areas. The federal government plays a stewardship role, formulating policies and programmes, and transferring some funding drawn from central taxes to states through centrally-sponsored programmes.

The primary health care system in each state is well-structured, consisting of three tiers: sub-health centre (rural and urban), primary health centre (rural and urban), and community health centre (rural and urban). The sub-centre is the initial point of contact between the health care system and the community, serving a population of 3,000 to 5,000. The primary health centre serves a population of 20,000 to 30,000, while the community health centre is designed for a population of 80,000 to 120,000. The population norms and facility types vary based on the topography and rural-urban location. While these facilities focus on preventive, promotive, and curative care, district hospitals and medical colleges mainly offer secondary and tertiary care.

India's healthcare system is diverse, fragmented and highly commercialised. The poorly functioning network of public health facilities coexists with a thriving but exploitative private sector. It can also be described as a two-tiered system where the majority, including those with low income, use private sector services (at all levels) and pay for them directly. Meanwhile, the poorer segment of the population relies on public facilities. The private sector operates with minimal oversight from state and local authorities and includes a wide range of healthcare providers, from small clinics to quaternary hospitals and from informal providers to highly qualified specialists. It was estimated that traditional healers or informal providers constituted 71.3% of the 1.4 million healthcare enterprises in 2010-11 (Hooda 2015). According to one study, up to 75% of primary care visits are handled by these unqualified and "self-declared" doctors in rural India (Das et al. 2016).

Importantly, the country's healthcare system is gradually transitioning to an insurance-based model. The two main schemes are CGHS and ESIS, catering to employees of the national government and salaried workers of private (formal) enterprises. A recent government-sponsored scheme, AB-PMJAY, covers lower-income groups, including self-employed and informal sector workers. PMJAY is currently implemented across India, and Odisha (an Indian state) is the latest state to join the programme. However, West Bengal (estimated population is 104.2 million in 2024) remains outside PM-JAY and implements a state-sponsored universal scheme called *Swasthya Sathi* (translates to Health Partner).

The first two SHI schemes-CGHS and ESIS, are funded through contributions from employees and employers and subsidies from the national and state governments. The benefits vary significantly depending on an individual's affiliation with different insurance schemes. Currently, all these schemes, including those for the employees of public sector enterprises, operate independently, meaning that there is no pooling of funds into a common kitty.

However, recently, the health facilities of ESIS and Indian Railways have also been brought under the hospital network of AB-PMJAY. The wealthier segment of the population mainly uses commercial health insurance.

### b. Coverage

As per the latest data, 55 crore or 38.5% of India's population was covered by commercial health insurance schemes in 2022-23. It is important to note that over half (54%) of the population with commercial health insurance is covered through government-sponsored schemes such as AB-PMJAY. These schemes only cover specific hospitalisation risks, and studies have reported barriers to accessing the benefits of government-sponsored schemes, rendering them somewhat ineffective.

*Coverage*

| | |
|---|---|
| Percentage of population covered by government schemes | 100% * |
| Percentage of population covered by social insurance schemes | 10.4% ** |
| Percentage of population covered by private schemes | 17.7%*** |
| Percentage of population uncovered | None * |

* Coverage rates are "de jure coverage" or merely theoretical – in practice, access to healthcare was severely restricted by the inability to enforce legal claims and the (un-)availability of healthcare infrastructure and services ;** 90% of the social insurance coverage is made up of ESIS, which is largely ineffective; *** unsubsidised private coverage

### c. Provision

In 2022, the ratio of allopathic physicians was 0.67 per 1,000 inhabitants. This means that there was one physician for every 1,484 people, which falls short of the requirement of at least one physician per 1,000 people, as estimated by the WHO, for adequate primary health care services. However, if we consider physicians with qualifications in the Indian System of Medicine (AYUSH), the ratio improves to 1.28 per 1,000, which equals one physician for every 784 inhabitants.

There is significant variation among states within India. For example, Bihar and Uttar Pradesh have only 0.24 allopathic doctors per 1,000 people, while Kerala has approximately 1.29 allopathic physicians per 1,000 individuals. Notably, many Indian states, like Bihar and Uttar Pradesh, have a lower physician density ratio than the rest of the world, including low-income countries. In terms of nurses, the nurse-population ratio was just under two per 1,000 in 2021, indicating the availability of one nurse per 500 persons. These statistics have been estimated using certain assumptions, as the current number of practising physicians or nurses in India is unknown. For example, there were 1,308,009 registered medical doctors (Allopathic) as of June 2022 (GOI 2022b). However, for the calculation of the doctor-population ratio, only 1,046,407 allopathic physicians were considered, assuming that 27 % (based on an estimate from a national survey) of them had either died, retired, stopped practising, or emigrated.

There are varying estimates regarding the bed-density ratio for India. Niti Aayog estimates it at one bed per 1,000 people (Sarwal et al. 2021), while my own estimate is 1.44 beds per 1,000 people for the year 2020. On the other hand, WHO puts the figure at 1.6 beds per 1,000 people for the year 2021 (WHO 2024). Nevertheless, this aggregate figure hides the substantial differences among the states. For instance, the bed density ratio of Bihar (0.25 per 1,000 inhabitants) and Madhya Pradesh (0.76) are way below the average bed-density ratio of low-income countries (calculations based on estimates by Kapoor et al 2020).

The distribution of beds between public and private sectors is as follows: 41.7% of beds are with public hospitals, while the rest are with private facilities. Private hospitals are broadly divided into two categories: for-profit and not-for-profit institutions. The private health care providers, including the ambulatory service givers, are predominantly for-profit and allopathic. According to one estimate, in 2010-11, of the total private providers, homoeopathy and ayurveda accounted for 11.2 per cent and 7.4 per cent, respectively (Hooda 2015).

Another critical feature of India's health service system is commercialisation. In 2018, public health facilities accounted for 32.5% of ambulatory care utilisation in rural areas and 26.2% in urban areas, with the private sector capturing the remaining share, 99% of which comprises for-profit providers. For inpatient care, the for-profit

private sector has become the dominant provider, accounting for 51.9% in rural and 61.4% in urban areas. Not-for-profit hospitals currently hold a marginal share of 2.4% and 3.3% in rural and urban areas, respectively (GOI 2019). In short, the private for-profit sector is dominant in both outpatient and inpatient sectors.

As mentioned earlier, the availability of service packages varies based on individuals' affiliations with different health schemes or insurance plans. However, everyone is entitled to health services provided by public health facilities. CGHS offers the most comprehensive coverage among the health schemes, while PM-JAY offers the least. Detailed benefits of all schemes have been discussed earlier.

### d. Financing

According to the latest NHA estimates, India's total health expenditure (THE) for the year 2019-20 was 3.27% of the GDP. In terms of per capita expenditure, it was Rs. 4,863. Importantly, government health spending from all sources accounted for 41.1% of THE, which has certainly improved over time, but the scale of improvement is far from satisfactory (GOI 2023).

The break-up of public sources of health financing is as follows: the union (national) government contributed 35.8%, and the combined share of state governments was 64.2%. It is worth mentioning that the central government's involvement in health has significantly increased over time, with its share of public health spending reaching 35.8% in 2019-20 from just around 10% in 1950-51. The total spending on government-sponsored health insurance schemes amounted to Rs. 13,809 crores or 0.07% in terms of percentage of GDP. However, when considering social security spending on all health schemes, it turns out that SHI contributed 9.3% of THE. Private health insurance accounted for 7% of THE, and the contribution of external donors was 0.5% of THE. Disconcertingly, household out-of-pocket expenditure remained the dominant method of health care financing with a 47.1% share of THE in 2019-20 (GOI 2023). Further, according to the World Bank's estimate for the year 2021, the share of OOP was 49.8%, one of the highest in the world. Notably, the average OOP share of THE in low-income and lower-middle-income countries was 40.9% and 49.4%, respectively, in 2021.

### e. Regulation of the dominant system

Both the central and state governments share the responsibilities of health system functioning, viz., governance, financing, and delivery, though the centre is not directly involved in provisioning except for the services delivered through a number of apex central government medical colleges. At the central level, the Ministry of Health and Family Welfare (MoHFW) is mandated to devise and implement health policies and programmes across the country. MoHFW has two departments: the Department of Health and Family Welfare and the Department of Health Research. While the former is responsible for organising and implementing various health schemes, including national health mission and national health programmes through their respective departments, the latter has the mandate to promote and regulate clinical and health research, including the development of ethical standards for conducting such research, investigation of outbreaks, development of tools for control, technical support for dealing with epidemics, as well as provision of advanced training in research related to health and medicine and administration of awards/fellowships for such training. It has two departments: the Department of Health and Family Welfare and the Department of Health Research. The former organizes and implements various health schemes, such as the national health mission and national health programmes. The latter promotes and regulates clinical and health research, including setting ethical standards, investigating outbreaks, providing technical support for epidemics, and offering advanced health and medical research training.

Additionally, MOHFW has two attached offices, namely the Directorate General of Health Services (DGHS) and the National Health Authority (NHA). DGHS's job is to provide technical inputs on medical and public health matters to MOHFW and ensure the implementation of national health schemes by coordinating with its state counterparts through its regional offices. There are also two administrative bodies, namely CDSCO (central drugs regulator; details of its role were discussed before) and Central Bureau of Health Intelligence (CBHI), which fall under DGHS. The latter collects, analyses and presents health and health-related statistics for policy and programme formulation. Besides, it identifies and promotes new models for health sector reforms and organises training to build human resource capacity to store medical records in public and private facilities. Established in 2019, NHA is the apex body for implementing AB-PMJAY and the National Digital Health Mission. Ministry

of AYUSH set up in 2014, is responsible for the promotion and development of Indian systems of medicine, i.e., Ayurveda, Yoga, Unani, Siddha and Homeopathy. Apart from the above central administrative bodies, there are drugs and health insurance regulators, namely CDSCO and IRDA. Their roles have been discussed earlier.

At the state level, the State Ministry of Health and Family Welfare is legally obligated to ensure that people receive health services when needed. The administrative structure of the health ministry varies from state to state. Generally, under the ministry, many directorates and corporations function, each having the responsibility of looking after certain aspects of health. For example, the Health and Family Welfare Department, Government of Tamil Nadu has several departments, including NHM, Public Health and Preventive Medicine, Indian Medicine and Homeopathy, Family Welfare, Drugs Control, Medical Education, Medical and Rural Health Service, Tamil Nadu Medical Services Corporation, Food Safety and Drug Administration. The mandate of the Directorate of Medical and Rural Health Services (DMRHS) is to render health services through its network of district hospitals, block and non-block hospitals, dispensaries, and mobile medical units. In addition, TB and Leprosy clinics and hospitals are under the control of DMRHS. In some states, this responsibility is shouldered by the Directorate of Health Services (DHS) and it gets technical and financial support from the central DGHS. The chief medical officer of Health or Civil Surgeon is the administrative head of the medical facilities in a district and reports to DHS. At the district level, PRI (in rural areas) and municipal bodies (in urban areas) also play a key role in the planning and administration of health services.

For sponsored schemes like PMJAY or *Swasthya Sathi*, semi-parastatal agencies like the State Health Agency (SHA) are responsible in respective states. SHA, established under the Societies Act, 2001 engages with public and private commercial insurance companies to provide insurance cover to the eligible population. Besides, SHA also purchases service packages directly from public and private healthcare providers in states where the scheme is implemented using the Trust or Hybrid model.

The Clinical Establishments (Registration and Regulation) Act (CEA), 2010 is an important piece of regulation brought by the Central Government to ensure that clinical establishments can operate and provide services only if they meet the minimum standards of infrastructure, equipment and human resources set by the CEA. In order to obtain registration, all clinical set-ups, whether public or private, including single physician clinics, barring those of the armed forces, are required to fulfil the minimum standards requirements of CEA, 2010. Notwithstanding, CEA 2010 has still not been adopted by many states. As of now, only 13 states and six union territories have implemented the act. Besides, West Bengal, an Indian state, has enacted its own legislation, namely West Bengal Clinical Establishments (Registration and Regulation), in 2010 and in 2017. The clinical establishments must apply for the license to the registrar of the respective districts (district registrars are under the state health department) and renew it periodically. It is worth noting that the minimum standards fixed by the CEA 2010 or WBCEA 2017 are not applicable to teaching hospitals or medical colleges designated for the research and training of physicians and nurses. The latter needs to follow the guidelines of the National Medical Commission (NMC).

In 2019, the central (federal) government established the NMC following the passage of the National Medical Commission Act 2019 in the Indian Parliament. The NMC replaced the erstwhile MCI and is responsible for developing policies to uphold quality and standards in medical education and implementing necessary regulations to ensure this. It specifies the norms regarding infrastructure, faculty, and the quality of education to be maintained by medical colleges offering undergraduate and postgraduate courses in medicine, according to the regulations made under the NMC Act. The establishment of medical colleges is governed by specific regulations set by the NMC. Both public and private medical colleges must obtain permission from the NMC to operate, start new academic programmes, and determine the student intake for their respective programmes. The practice of allopathic medicine is regulated by various sections of the NMC Act 2019. The Ethics and Medical Registration Board (EMRB) is responsible for maintaining national registers of all licensed medical professionals under section 31 of the NMC Act. Upon obtaining a medical qualification from a university or institution in India or abroad (provided it is recognised by NMC), the EMRB issues unique ID numbers to medical professionals in respective states, granting them a license to practice medicine.

Aside from the above institutional arrangements, national-level authorities have developed various frameworks to address healthcare quality concerns in public and private health facilities. The National Accreditation Board for Hospitals and Healthcare Providers (NABH) is an autonomous body and a constituent of the Quality Council of India. It was established in 2005 to implement accreditation programmes for healthcare organizations, regardless of their ownership, size, or legal status. The NABH standards are organized into ten chap-

ters, covering patient-centred and organization-centred standards. These standards are widely recognized and benchmarked. Hospitals accredited by NABH adhere to global benchmarks set by the International Society for Quality in Health Care (ISQua), ensuring international recognition for these hospitals. The private hospitals in India have adopted NABH accreditation in a big way, though the penetration among public hospitals is quite limited.

The National Health Systems Resource Centre (under MOH&FW) introduced quality certification, specifically for public health facilities, to recognize the good work done by them and to enhance people's perception of these facilities. Certification is provided based on meeting predetermined criteria outlined in the National Quality Assurance Standards (NQAS). The NQAS covers eight broad dimensions- Service Provision, Patient Rights, Inputs, Support Services, Clinical Care, Infection Control, Quality Management, and Outcomes. They have been developed specifically for public health facilities, up to district hospitals. The NQAS standards are on a par with global benchmarks in terms of comprehensiveness, objectivity, evidence and rigour of development.

Then MOH&FW also initiated initiatives like Kayakalp Award Scheme to improve Cleanliness, Hygiene and Waste Management practices in public health facilities; Swacch Swasth Sarvatra Initiative to encourage Kayakalp winner PHC to make the adjoining villages 'open defecation free'; LaQshya, whose main objective is to reduce maternal and newborn mortality and morbidity resulting from complications during and after delivery. So, under LaQsya, measures are taken to provide the required trained human resources and upgrade the labour room infrastructure, including equipment, to improve the quality of care processes. The NQAS monitors quality improvement in the labour room and maternity operation theatre. The LaQshya programme is being implemented across all medical college hospitals, district hospitals, First Referral units (FRU), and Community Health Centers (CHCs); Laboratory Initiative For excellence, and Mera Aspatal (My hospital) Patient Feedback System.

The above measures are currently being implemented to enhance the credibility of public hospitals in the community. Financial incentives are also given to nudge public health facilities to obtain quality certification. However, to date, only a small number of facilities are NQAS-certified. For example, Karnataka, an Indian state, has 2,531 PHCs, but as few as 16 PHCs (rural and urban) have received NQAS certification. The primary reason for not being certified is that most facilities are not able to meet the standards set by NQAS.

## 7. Role of global actors

According to the most recent National Health Accounts, external or donor funding accounts for only 0.5% of India's total health expenditure. No global actors are directly engaged in healthcare provision in India.

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