



सत्यमेव जयते

Situation Analyses

Backdrop to the National Health Policy - 2017

**Ministry of Health and Family Welfare
Government of India**

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1. Introduction

India is now the world's third largest economy in terms of its Gross National Income (in PPP terms) with the potential to develop more equitably. It possesses as never before, a sophisticated arsenal of interventions, technologies and knowledge required for providing health care to its people. However, the inequities in health outcomes continue to remain.

2. Situation Analyses

2.1 Achievements in Millennium Development Goals (MDGs)

2.1.1 India is close to reaching the Millennium Development Goals (MDGs) with respect to maternal and under 5 mortality. MDG-5 target is to reduce Maternal Mortality Ratio (MMR) by three quarters between 1990 and 2015. From a baseline of 556 in 1990¹, the nation has achieved Maternal Mortality Ratio (MMR) of 167 by 2011-13². Assuming that the Annual Compound Rate of decline observed during 2007-09 and 2011-13 continues, the MMR is likely to reach the MDG-5 target of 139. In case of under-5 mortality rate (U5MR) the MDG target is 42. From a baseline of 126 in 1990, the nation has reached an U5MR of 49 in 2013, and if the rate of reduction over the past decade is sustained, the achievement in 2015 will be very close to the target.³ However, the rate of decline of still-births and neonatal mortality has been slow. In addition there are inter and intra State variations. For instance, U5MR ranges from 73 (Assam) to 12 (Kerala)⁴. Madhya Pradesh has wide disparity in Infant Mortality Rate, with Indore at 37 and Panna at 85⁵. Progress and challenges related to MDG 6 (combating AIDS, malaria and other diseases) are described under sub heading 'performance in disease control programmes'.

2.1.2 Nutrition status is an important underlying cause of mortality and morbidity especially for young children. To achieve MDG goal for eradicating hunger, proportion of under-weight children should have decreased to 26 % by 2015. India has been able to reduce proportion of under-weight children below five years of age to 29.4% in 2013-14⁶ from the estimated 52% in 1990. However, percentage of under-weight children <3 years (weight for age) is higher in rural areas (44%) compared to urban areas (30%). Prevalence of underweight children <3 years also varies widely between States –from 58% in Madhya Pradesh to 14% in Mizoram. At the current

¹ Trends in Maternal Mortality: 1990 to 2015-Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division.

² Sample Registration System ,MMR Bulletin(2011-13),O/o Registrar General & Census Commissioner, GOI

³ Social Statistics Division, Ministry of Statistics and Programme Implementation, GoI, Millennium Development Goals India Country Report 2015, New Delhi, Pg.68

⁴ Social Statistics Division, Ministry of Statistics and Programme Implementation, GoI, Millennium Development Goals India Country Report 2015, New Delhi, Pg.70

⁵ Office of the Registrar General & Census Commissioner, Annual Health Survey 2012-13, Fact Sheet, New Delhi, Pg. 107

⁶ Ministry of Women and Child Development, GoI, Rapid Survey of Children 2013-14

rate of decline, the prevalence of underweight children is expected to be 29% by 2015, and 27% by 2017⁷.

2.2 Achievements in Population Stabilization

2.2.1 India has also shown consistent improvement in population stabilization, with a decrease in decadal growth rates, both as a percentage and in absolute numbers. Eleven of the 20 large States for which recent Total Fertility Rates (TFR) are available, have achieved a TFR of at or below the replacement rate of 2.1 and three are likely to reach this soon.⁸ The challenge is now in the remaining six States of Bihar, Uttar Pradesh, Rajasthan, Madhya Pradesh, Jharkhand and Chhattisgarh. These States account for 42% of India's population and 56% of annual population increase. The National Population Policy (2000) lays out the strategic directions for population stabilization⁹.

2.2.2 The persistent challenge on the population stabilisation front is the declining sex ratio. India has Child Sex Ratio (0-6 years) of 919 females per 1000 males and it is worse in urban areas (905) compared to rural areas (923). States having Child Sex Ratio less than the National average are Haryana (834), Punjab (846), Jammu & Kashmir (862), Delhi (871), Maharashtra (894), Rajasthan (888), Gujarat (890), Uttarakhand (890), Uttar Pradesh (902), Himachal Pradesh (909) and Madhya Pradesh (918). Similar to most State averages, the sex ratio shows wide intra State variations. Haryana with a State average of 834 masks the wide disparity between the districts of Jhajjar (774) and Mewat (903).¹⁰

2.3 Burden of Disease

2.3.1 India is currently experiencing a rapid health transition. There is an unfinished agenda of addressing infectious diseases, nutritional deficiencies, escalating epidemic of non-communicable diseases (NCDs), accidents/injuries and on safe motherhood. Overall, communicable diseases contribute 28% of the entire disease burden, while non-communicable diseases (60%) and injuries at (12%) now constitute the bulk of the country's disease burden.¹¹

2.3.2 The communicable diseases addressed by national health programmes, which include three chronic diseases- HIV, TB and Leprosy in addition to all vector borne diseases, are declining. Also, through the immunization programme, common childhood infections have significantly reduced. However, climate variability in India can exacerbate vector borne diseases as well as water borne diseases. Increased heat stress and air pollution would also impact

⁷ Planning Commission, Report of the Steering Committee on Health for the 12th Five-Year Plan, 2012, New Delhi, Pg. 8

⁸ Statistical Report 2013, Registrar General of India

⁹ Department of Family Welfare, Ministry of Health & Family Welfare, National Population Policy 2000, (Reprint) New Delhi

¹⁰ Office of the Registrar General & Census Commissioner, GoI, Census of India 2011.

¹¹ World Health Organization, Non communicable Diseases(NCD) Country Profiles 2014. Pg.91

health¹². Persistent levels of TB transmission and incidence of drug resistance are new challenges. The fact that 29.4% of under-five children still suffer from malnutrition despite proportion of underweight children aged less than three years showing a declining trend, points to the need for addressing this on an accelerated footing with emphasis on caring practices. Anaemia in women is another area of concern as it has a multiplier effect through birth of low birth weight babies, which affects the mental and physical growth in children. Therefore, micronutrient malnutrition requires renewed focus on food fortification.

2.3.3 The rising occurrence of Non-Communicable diseases in India is a public health challenge. WHO estimates that these diseases (with mostly preventable risk factors) account for 60% of all deaths and significant morbidity in India¹³. Despite intervention in the form of National programme on Non-Communicable Diseases, the efforts are nascent and need to be upscaled and integrated for diseases like diabetes, cardio-vascular ailments and stroke. Non-communicable diseases require renewed focus on prevention and management, while integrating AYUSH.

2.3.4 The occupational health needs are largely unaddressed for both formal and informal sector. This needs focus bearing in mind, that there are 263 million agricultural workers in India.¹⁴ This policy supports efforts to improve occupational health through inter-sectoral collaboration.

2.3.5 Like nutrition, adolescent health also has an inter-generational effect. 70% of preventable adult deaths from non-communicable diseases are linked to risk factors that start in adolescence.¹⁵ Injuries and communicable diseases in 10-14 years age group were the prominent causes of disability and death. Outcomes of sexual behaviors and mental health for 15-19 years of age group are now assuming greater prominence. Intersectoral action is required to address priority issues like nutrition, reproductive health, substance abuse, mental health and gender based violence in this age group. Towards this direction, the School Health Programme currently undertakes screening for disease, deficiency and disability amongst students aged 6- 18 years through dedicated teams and aims at convergence with Department of Education.

2.3.6 There has been a steady rise in mental illnesses in the country. According to a recent publication, one in every four women and 10% men suffer from depression in India. Against this backdrop, there is a shortfall of 8,500 psychiatrists, 6,750 psychologists, 22,600 psychiatric

¹² Kathleen F. Bush et.al, Impacts of Climate Change on Public Health in India: Future Research Directions, Environmental Health Perspectives, volume 119, number 6, June 2011, Pg. 765-770

¹³ World Health Organization, Non communicable Diseases (NCD) Country Profiles 2014. Pg.91

¹⁴ Ministry of Agriculture, Department of Agriculture & Cooperation, Directorate of Economics & Statistics, Government of India, Agricultural Statistics at a Glance 2014, New Delhi

¹⁵ The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), Every Woman Every Child, United Nations 2015

social workers and 2,100 psychiatric nurses and these needs can be addressed by family physicians only to some extent.¹⁶

2.3.7 Increase in life expectancy has increased the requirement of geriatric care. The elderly (population above 60 years) comprise 103.8 million or 8.6% of total population and 8% of them are confined to bed or home.¹⁷ Another related issue is the growing need of palliative care, requiring culturally appropriate and cost effective family centered approach. A National Programme of Health Care for the Elderly was initiated in 2011 to address the needs of the ageing population. Disaster preparedness is another area of concern given the reality that there is a major natural or manmade disaster almost every year in India. Accordingly, disaster preparedness and response system needs further capacity development.

2.4 Social Determinants of Health

This policy recognizes the causal links between health outcomes and social determinants of health¹⁸. Health of the population is determined largely by lifestyle (50%) followed by biological and environmental factor (20% each), whereas health systems related factors contribute only 10%.¹⁹ Achievement of national health goals would require addressing all the social determinants (distal and proximal) in the context of rapid economic growth and changing life styles with a focus on the most vulnerable and marginalized. This preventive aspect needs to be adequately addressed through assessing the impact of existing and future non-health sector programmes and policies through the health lens.

2.5 Inequities in Health Outcomes

- i. We also need to keep in mind that high degree of inequity in health outcomes and access to health care services exists in India. This is evidenced by indicators disaggregated for vulnerable groups and between and within States. Identifying the deprived areas/ vulnerable population groups (including special groups) through disaggregated data is a first step to address the existing inequities in health outcomes between and within States in India.

¹⁶ The Silent Epidemic -2 Crore Indians need help for mental disorders, India Today, 2011 Accessed on 15 October 2014 (<http://indiatoday.intoday.in/story/2-crore-indians-need-help-for-mental-disorders/1/143355.html>)

¹⁷ National Sample Survey Office, Ministry of Statistics and Programme Implementation, Report No. 507, Morbidity, Health Care and the Condition of the Aged, Jan-Jun 2004, Published 2006, New Delhi.

¹⁸ WHO, Closing the gap in a generation: health equity through action on the social determinants of health, Final Report of the Commission on Social Determinants of Health, 2008, Geneva

¹⁹ U.S. Department of Health and Human Services. Physical Activity and Health: A Report of the Surgeon General. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, 1996.

Indicator	India			% difference
	Total	Rural	Urban	
TFR (2013) <i>Source: Statistical Report 2013, Registrar General of India</i>	2.3	2.5	1.8	39%
IMR (2013) <i>Source: SRS Bulletin, 2014</i>	40	44	27	63%

Even in States where overall averages are improving, marginalized communities and poorer economic quintiles of the population, especially in remote and tribal areas, continue to fare poorly. For instance, fully immunized children aged 12-23 months in Odisha were only 45% in scheduled tribes as compared to 62% for the State. Corresponding figures for skilled attendants at birth are 26% and 51%.²⁰

Indicator	States with good performance	States with greater challenges
TFR (2013) <i>Source: Statistical Report 2013, Registrar General of India</i>	West Bengal (1.6), Tamil Nadu (1.7), Punjab (1.7), Himachal Pradesh (1.7), Delhi (1.7)	Bihar (3.4), Uttar Pradesh (3.1), Madhya Pradesh (2.9), Rajasthan (2.8)
IMR (2013) <i>Source: SRS Bulletin, 2014</i>	Goa (9), Manipur (10), Kerala (12), Puducherry (17), Nagaland (18)	Madhya Pradesh (54), Assam (54), Odisha (51), Uttar Pradesh (50), Rajasthan (47)
MMR (2011-13) <i>Source: MMR Bulletin, 2015 (Registrar General of India)</i>	Kerala (61), Maharashtra (68), Punjab (141), Tamil Nadu (79)	Uttar Pradesh /Uttarakhand (285), Bihar /Jharkhand (208), Madhya Pradesh / Chhattisgarh (221), Rajasthan (244), Odisha(222)

- ii. Demarcating areas/ populations with low coverage, is a precursor to identification and removal of barriers in the underserved areas/ population. The Tanahashi framework for systemic bottlenecks analysis identified six key bottlenecks under the NRHM: (1) limited availability of skilled human resources; (2) low coverage in marginalized communities with low skilled staff posting; (3) inadequate supportive supervision of front line workers; (4) low

²⁰ UNICEF, The Situation of Children in India - A Profile, New Delhi, 2011, Pg.83

quality of training and skill building; (5) lack of focus on quality of services and (6) insufficient IEC on key family practices.²¹ Some of these requiring policy consideration e. g. human resource, skill building and quality of services are addressed in this policy.

2.6 Concerns on Quality of Care

- i. The quality of care determines its effectiveness. For example, though over 90% of pregnant women received one antenatal checkup, only about 69% received the mandatory three antenatal check-ups.²² Similarly for institutional delivery, standard protocols are often not followed during labour and the postpartum period. Sterilization related deaths are often a direct consequence of poor quality of care. There are gaps in access to safe abortion services too, as well as in the care for sick neonates.
- ii. Accreditation and certification through a voluntary process are nascent methods, introduced to determine standards of a particular health care unit. Also, the Indian Public Health Standards (IPHS) revised in 2010, lays down the essential and desirable requirements for services, building, equipment, manpower, and drugs for public health facilities across various levels. For ethical practice and patient safety, it is important that rules, standards and notifications are applied to all sectors uniformly.

2.7 Performance in Disease Control Programmes

- i. India's progress on communicable disease control is mixed. Polio has been eliminated along with maternal and neonatal tetanus and Leprosy though significantly reduced is stagnant at current levels of new infective cases and disabilities. Kala-azar and Lymphatic Filariasis are expected to decline below the threshold, except in a few blocks where the prevalence is relatively higher. In AIDS control, progress has been good with a decline from a 0.41 % prevalence rate in 2001 to 0.27% in 2011- but this still leaves about 21 lakh persons living with HIV, about 1.16 lakh new cases and 1.48 lakh deaths in 2011. In Tuberculosis, the prevalence is still close to 211 cases, while mortality is 19 deaths per 100,000 population. The increasing Multi-Drug Resistant Tuberculosis cases pose serious challenges. In Malaria, there has been a significant decline, but the challenges of resistant strains and of sustaining the gains still remain. Viral Encephalitis, Dengue and Chikungunya are on the rise, particularly in urban areas.
- ii. Performance in disease control programmes is largely a reflection of the strengths of the public health systems e.g. human resource deployment, logistics and infrastructure. Where these are inadequate, national health programmes do badly. This was one of the important reasons for the launch of the National Rural Health Mission, which was geared to strengthen health systems.

²¹ Ministry of Health and Family Welfare, GoI, A Strategic Approach to Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCH+A) in India, 2013, New Delhi Pg. 8

²² UNICEF, Coverage Evaluation Survey, National Factsheet, 2009, New Delhi

2.8 Developments under the National Rural Health Mission: The National Rural Health Mission (NRHM) led to a significant strengthening of public health systems. It brought in a workforce of close to 900,000 community health volunteers, the ASHAs, who aided in bringing the community closer to public services, improving utilization of services and health-seeking behaviors. The NRHM deployed over 18,000 ambulances for free emergency transport of a million patients monthly and added over 178,000 health workers to the public health system. It also provided cash transfers to over ten million pregnant women annually - to seek free care in the institutions. NRHM also made serious attempt to address infrastructure gaps. Across States, there were major increase in outpatient attendance, bed occupancy and institutional delivery. However, much of the increase in service delivery was related to select reproductive and child health services and the national disease control programme. Further, States with better capacity at baseline were able to take advantage of NRHM financing promptly. Larger gaps in baselines and more time taken to develop capacity to absorb the funds, meant that the gaps in achievement were larger in high focus States. These gaps were further compounded by inefficiencies in fund utilization, poor governance and leakages. Therefore, a differentiated strategy is called for.

2.9 NRHM as an instrument for strengthening State health systems: The National Rural Health Mission was intended to strengthen State health systems to cover all health needs. The progress however remained confined to a few indicators only, like mortality and disease prevalence. Such selective focus and facility development is clearly not efficient. Strengthening health systems for providing comprehensive care requires higher levels of investment and human resources, than were made available. The budgetary support and the expenditure was only about 40% of what was envisaged for a fully revitalised NRHM Framework.

2.10 Urban Health: Rapid and unplanned urbanization has led to massive growth in the number of the urban poor, including migrant populations. This section of the population has poorer health outcomes due to adverse social determinants and poor access to health care facilities, despite living in close proximity to many hospitals - public and private. As a matter of fact, primary healthcare in many urban areas require considerable strengthening. The National Urban Health Mission (NUHM), sanctioned in 2013, has a strong focus on primary care especially for urban poor and vulnerable population. NUHM aims at strengthening primary health care- through additional ANMs, urban ASHAs, women's health committees, a network of primary health centers and inter-sectoral convergence. However, substantial expansion on a sustained basis is required to improve urban health.

2.11 Cost of Care and Efforts at Financial Protection

- i. All services available under national programmes are free and universally accessible with fairly good rates of coverage. For instance, India has one of the largest programmes of publicly financed antiretroviral therapy (ART) drugs for HIV affected persons. In addition,

all drugs and diagnostics in vector borne disease control programmes, Tuberculosis, Leprosy, immunization programmes and much of the maternity, newborn and infant care are free. There is limited contribution of the private sector in these areas.

- ii. The fact however remains that inability to cover the entire spectrum of health care needs, through increased public investment has led to a rise in the out of pocket expenditure and consequent impoverishment. Over 63 million persons are pushed to poverty every year due to health care costs²³. In 2011-12, the share of out of pocket expenditure on health care as a proportion of total household monthly per capita expenditure was 6.9% in rural areas and 5.5% in urban areas.²⁴ This led to an increasing number of households facing catastrophic expenditures due to health costs (18% of all households in 2011-12 as compared to 15% in 2004-05).²⁵ It has been observed that, in 2014 the average amount spent per child birth as inpatient in private hospitals was nine times that spent in public hospitals for both rural and urban areas across all quintiles²⁶. Under NRHM, free care in public hospitals was extended to a select set of conditions. User fees on all other services especially for diagnostics, as also the purchase of drugs added to the cost of care. Several essential services, especially for chronic illnesses, were only available at overcrowded district and medical college hospitals - resulting in physical and financial hardship and poor quality of care.

2.12 Publicly Financed Health Insurance: A number of publicly financed health insurance schemes were introduced to improve access to hospitalization services and to protect households from high medical expenses. Eight States introduced health insurance programmes for covering tertiary care needs. However, over time as the expenditures increased, many of these States (Andhra Pradesh, Karnataka, Tamilnadu, Maharashtra, etc.) moved to direct purchasing of care through Trusts while reserving some services to be delivered only through public hospitals. The Central Government launched the Rashtriya Swasthya Bima Yojana (RSBY) in 2008. The population coverage under these various schemes expanded from almost 55 million in 2003-04 to about 370 million in 2014 (almost one-fourth of the population). Nearly two thirds (180 million) of this population were those in the Below Poverty Line (BPL) category.²⁷ Evaluations show that schemes such as the RSBY, have improved utilization of hospital services, especially in private sector and

²³ Berman.P et.al, The Impoverishing Effect of Health Care Payments in India, *Economic & Political Weekly (EPW)*, Vol XLV, No. 16, 2010. Pg. 65

²⁴ National Sample Survey Office, Ministry of Statistics and Programme Implementation, Press Release - Key Indicators of Household Consumer Expenditure in India, 2011-12, New Delhi 2013. Pg.5

²⁵ Karan A, et.al., Moving to Universal Coverage? Trends in the Burden of Out-Of-Pocket Payments for Health Care across Social Groups in India, 1999–2000 to 2011–12. *PLoS ONE* 9(8), 2014.

²⁶ National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India, Key Indicators of Social Consumption in India Health, NSS 71st round (Jan-Jun 2014)

²⁷ Planning Commission of India, High Level Expert Group Report on Universal Health Coverage for India, New Delhi, 2011

among the poorest 20% of households and SC/ST households.²⁸ However, there are concerns on low awareness among the beneficiaries about the entitlements and on how and when to use the RSBY card. Another concern is related to denial of services by private hospitals for many categories of illnesses, and over supply of some services. Some hospitals, insurance companies and administrators have also resorted to various fraudulent measures²⁹, including charging informal payments. There have been reports of major increase in certain operations like hysterectomies due to coverage under the health insurance schemes, following which modifications were made in schemes like Arogyasri in Andhra Pradesh to avoid such excessive procedures^{30,31}. Schemes that are governed and managed by independent bodies have performed better than other schemes that are located in informal cells within existing departments or when managed by insurance companies. Insurance schemes vary widely in terms of benefit packages and have resulted in fragmentation of funds available for health care; especially selective allocation to secondary and tertiary care over primary care services.³² There is need to explore the possibility of National and State health insurance schemes being aligned into a single scheme and a single fund pool to reduce fragmentation. The RSBY scheme has now been shifted to the Ministry of Health & Family Welfare. This would help the State and Central Government to move to a tax financed single payer system approach, thereby enabling comparative assessment of the relative cost per patient for alternative routes of financing, viz., purchase through insurance, direct purchase from private sector and from public sector, free care by public sector etc. to take the best decision for a given context.

2.13 Healthcare Industry

- i. The private health care industry is complex. It includes insurance and equipment which accounts for about 15%, pharmaceuticals over 25%, diagnostics about 10% and hospitals and clinical care about 50%. The private health care industry is valued at \$40 billion and is projected to grow to \$ 280 billion by 2020 as per market sources.³³ The current growth rate of the healthcare industry, at 14% is projected to be 21% in the next decade.

²⁸ Karan A, et.al., Moving to Universal Coverage? Trends in the Burden of Out-Of-Pocket Payments for Health Care across Social Groups in India, 1999–2000 to 2011–12. PLoS ONE 9(8), 2014.

²⁹ Shaktivel et al, Why Publicly Financed Health Insurance Schemes are Ineffective in Providing Financing Risk Protection. Economic and Political Weekly (EPW),Vol.XLVII, no.11. 2012

³⁰ R Shukla et.al, Arogyasri Healthcare Model: advantage Private Sector, Economic and Political Weekly (EPW), Vol XLVI No 49, 2011.

³¹ Bharath Bhushan Mamidi et al, Hysterectomies and Violation of Human Rights: Case Study from India, International Journal of Social Work and Human Services Practice, Vol.1. No. 1, Horizon Research Publishing, 2013, Pg. 64-75

³² Shaktivel et al, Why Publicly Financed Health Insurance Schemes are Ineffective in Providing Financing Risk Protection. Economic and Political Weekly (EPW),Vol.XLVII, no.11. 2012

³³ Business Standard, Healthcare sector to touch \$280 bn by 2020: FICCI, Press Trust India, New Delhi (Accessed on 20 October 2014, http://www.business-standard.com/article/economy-policy/healthcare-sector-to-touch-280-bn-by-2020-ficci-110090600170_1.html)

- ii. The Government has invested heavily in the last 25 years in building a positive economic climate for the health care industry. Amongst these measures are lower direct taxes; higher depreciation in medical equipment; Income Tax exemptions for 5 years for rural hospitals; and custom duty exemptions for lifesaving equipment. Other forms of assistance are - preferential and subsidized allocation of land, subsidized professional education in government institutions; and provision for 100% FDI. This active policy enabled the private health care industry attract over 2 billion dollars of FDI in 2012-13, which as per market sources was mostly as venture capital. For International Finance Corporation, the Indian private health care industry is the second highest destination for its global investments in health. While recognizing that the growth of such industry brings in revenue and provides employment, there is a need for the Government to actively shape the growth of this sector so as to ensure that it is aligned to national health policy goals, especially with regard to equity, access and financial protection. Accordingly, the private sector is expected to fulfill its mandatory obligations in return of myriad benefits provided by the Government. There is also a need to ensure that the basic policy structure, especially as regards costs, standards and regulation is not unduly influenced by the requirements and perceptions of industry.

2.14 Non-Government sector in Health

- i. Over 70% of ailing population in rural areas and almost 80% in urban areas utilize private facilities.³⁴ The private health care sector is highly differentiated. Majority of the private health care enterprises are Own-Account-Enterprises (OAEs), which are household run businesses without regular hiring of a worker.³⁵ Over time OAEs have been declining while the number of medical establishments and corporate hospitals are rising. There are major ongoing efforts by the Government to streamline the OAEs within the corporate sector and to regulate them. Often for OAEs and smaller medical establishments the main grounds for engagement with Government are not financial partnerships, but skill up-gradation, referral support, sharing information of public health importance and improved clinical quality for effectiveness in public health priority areas. An area of concern is the variability in the quality and rationality of care currently provided by the private medical sector. There is evidence of supplier induced demand and lack of standard treatment practices, leading to aberrations such as unnecessary injections, irrational treatment regimens and excessive medications being provided in the private medical sector³⁶.

³⁴ National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India, Key Indicators of Social Consumption in India Health, NSS 71st round (Jan-Jun 2014)

³⁵ National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India, Key Indicators of Social Consumption in India Health, NSS 63rd round

³⁶ IPEN Study Group, The INCLIN Trust International, Injection Practices in India, WHO South-East Asia Journal of Public Health; 1 (2), 2012,189-200, Pg 189, 198

- ii. In terms of comparative efficiency, public sector is value for money as it accounts for about 28.6 % of total health expenditure.³⁷ This provides for 28% outpatient care in rural areas and 21% in urban areas. As regards inpatient care, public sector accounts for 42 % in rural areas and 32 % in urban areas.³⁸ This same expenditure also pays for 60% of end-of-life care (RGI estimates on hospital mortality), and almost 100% of preventive and promotive care and a substantial part of medical and nursing education as well.

2.15 Realizing the Potential of AYUSH services

The implementation of National Policy on Indian Systems of Medicine and Homeopathy adopted in 2002, led to phased integration of ISM with health delivery systems, enabling considerable expansion of AYUSH services. A National AYUSH Mission has been launched for overall strengthening of AYUSH network in the public sector with focus on AYUSH services, development of infrastructural facilities in teaching institutions, improving quality control of drugs, capacity building, and community based preventive and promotive interventions. In addition, there is need to recognize the contributions of the large private sector and not-for-profit organizations providing AYUSH services, conducting research for growth of the knowledge base of the AYUSH systems and their services. The contribution of several organizations across the country is also visible in documenting, validating and promoting home and community based traditional practices as also special knowledge, held by various population groups e.g. tribes, thereby empowering the marginalized groups. Globally there has been an emergence of integrative medicine as a new frontier and India has the potential to become a world leader in this sphere, if adequate support for research and institution building is provided.

2.16 Human Resource Development

The last decade has seen a major expansion of medical, nursing and technical education. For instance, in nursing education there are 1050 ANM, 1541 GNM, and 1160 graduate nursing schools, while 388 post-graduate nursing schools are being set up. Similar expansion in medical colleges, AYUSH institutions, dental colleges and pharmacy education has occurred. Though further expansion is needed and planned for, there is a need to ensure that the human resources emerging from these institutions have orientation towards rural services with optimal skill sets. It may be noted that the huge human resource deficit in public and especially rural services is because of inadequate production and deployment as also conditions of work and remuneration.

2.17 Health Research

The Department of Health Research established in 2007 delivers through the research institutions under the Indian Council of Medical Research and through strengthening of

³⁷ National Health Accounts Technical Secretariat, National Health System Resource Centre, National Health Accounts Estimate for India, July 2016

³⁸ National Sample Survey Office, Ministry of Statistics and Programme Implementation, Government of India, Key Indicators of Social Consumption in India Health, NSS 71st round (Jan-Jun 2014)

research support to Medical Colleges. There have been significant contributions made by the Department, but a modest funding of less than 1 % of all public health expenditure has resulted in limited progress. Research presently is largely confined to medical field and needs expansion to encompass areas of health systems, services and policy. Increase in Government funded health research and providing fiscal incentives to private sector, for medical research on identified issues, is required. The report of the Committee that examined the functioning of the ICMR in 2012, and the report of the Working Group constituted for the 12th Plan can guide policy in this area.

India's strength in AYUSH can also be leveraged for becoming a world leader in drug discovery, as also in integrative medicine. This would need investment in creating institutional structures for documentation, validation and accreditation of AYUSH systems.

2.18 Regulatory Role of Government

The Government's regulatory role extends to the regulation of drugs through the CDSCO, the regulation of food safety through the office of the Food Safety and Standards Authority of India, support to the regulation of professional education through the six professional councils and the regulation of clinical establishments by the National Council for the same. Progress in each of these areas has been challenging. Some of the challenges relate to institutional strengthening as also the mechanisms of institutional governance, which may sometimes require amendments to the laws. Regulation of drug pricing is under the Department of Pharmaceuticals which has been playing an active and effective role in monitoring of drug prices and its implementation. Reforms in each of these areas, especially in professional councils and clinical establishments are facing resistance from certain stakeholders. Considerable political leadership and public support would be required to implement these reforms. But clearly, as private industry grows rapidly and quality health care for all is envisioned, the Government needs to find ways to move forward on these responsibilities.

2.19 Investment in Health Care

Despite years of strong economic growth and increased health spending by the Government in the 11th Five Year plan period, the total spending on healthcare in 2013-14 in the country was about 4.02% of GDP³⁹. Global evidence on health spending shows that, unless a country spends at least 5–6% of its GDP on health with Government expenditure being a major part, basic health care needs are seldom met.⁴⁰ The Government spending on healthcare in India is only 1.15% of GDP. This is 3.8 % of total Government expenditure and accounts for 28.6% of total health spending. This translates in absolute terms to Rs. 1042 per capita at current market prices. The Union Government share of this is Rs. 365 per capita (0.40% GDP)

³⁹ National Health Accounts Technical Secretariat, National Health System Resource Centre, National Health Accounts Estimate for India, July 2016

⁴⁰ World Health Organisation, Western Pacific Region- South East Asia Region, Health Financing Strategy for Asia Pacific Region (2010-2015), 2009, Pg 27

while State Government share translates to about Rs. 677 per capita (0.75% of GDP) at base line scenario.⁴¹ Perhaps the single most important policy pronouncement of the National Health Policy 2002 articulated in the 10th, 11th and 12th Five Year Plans, and in the NRHM Framework, was the decision to increase public health expenditure to 2% to 3 % of the GDP.⁴² Public health expenditure rose briskly in the first few years of the NRHM, but at the peak of its performance it started stagnating at about 1.04 % of the GDP.

Though there is always space to generate some more value for the money, it is unrealistic to expect achieving key goals in a Five Year Plan on half the estimated and sanctioned budget. The failure to attain threshold minimum levels of public health expenditure, remains the single most important constraint. While it is important to recognize the growth and potential of a rapidly expanding private sector, international experience (as evidenced from the table 2) shows that health outcomes and financial protection are closely related to absolute and relative levels of public health expenditure.

Among the developing countries (Table-2), two nations, Brazil and Thailand, are considered to have achieved close to universal health coverage- Thailand at 3.2% has almost the same percent of total health expenditure to GDP as India, but its proportion of public health expenditure is 77.7% of total health expenditures, which results from a form of strategic purchasing in which about 95% is purchased from public health care facilities. This is what gives its public health system such a high efficiency.⁴³ Brazil spends 9% of its GDP on health of which public health expenditure constitutes 4.1 % of the GDP and 45.7% of total health expenditure. This public health expenditure accounts for almost 75 % of all health care provision.⁴⁴ Most expert groups have estimated 2.5 % as being realistic and achievable public health expenditure target. At such levels of expenditure, “purchasing,” would have to be mainly from public providers for efficient use of resources with purchasing from private providers only for supplementation.

⁴¹ National Health Accounts Technical Secretariat, National Health System Resource Centre, National Health Accounts Estimate for India, July 2016

⁴² Planning Commission of India, High Level Expert Group Report on Universal Health Coverage for India, 2011, Pg 20

⁴³ World Health Organisation, Western Pacific Region- South East Asia Region, Health Financing Strategy for Asia Pacific Region (2010-2015), 2009, Pg 17

⁴⁴ Rao KD et al, Progress towards Universal Health Coverage in BRICS: Translating Economic Growth into Better Health, WHO Bulletin 2014;92:429–435, 2014, Pg 430

Table-2: Health Outcomes and Health Expenditures in Selected Countries				
Country	Total Health Exp per capita (USD) – 2011	Total Health Exp as % of GDP – 2011	Govt. Health Exp as % of Total Health Exp - 2011	Life Expectancy at birth (years) 2012
India	\$62	3.9%	30.5%	66
Thailand	\$214	4.1%	77.7%	75
Sri Lanka	\$ 93	3.3%	42.1%	75
BRICS Countries				
Brazil	\$ 1119	8.9%	45.7%	74
China	\$ 274	5.1%	55.9%	75
Russia	\$803	6.1%	59.8%	69
South Africa	\$670	8.7%	47.7%	59
OECD Countries				
USA	\$ 8,467	17.7%	47.8%	79
United Kingdom	\$ 3,659	9.4%	82.8%	81
Germany	\$ 4,996	11.3%	76.5%	81
France	\$ 4,968	11.6%	76.8%	82
Norway	\$ 9,908	9.9%	85.1%	82
Sweden	\$ 5,419	9.5%	81.6%	82
Denmark	\$ 6,521	10.9%	85.3%	80
Japan	\$ 4,656	10%	82.1%	84

This situation analyses forms the backdrop to the National Health Policy, 2017 which envisages to address the urgent need to improve the performance of the health systems within the global context of sustainable development goals. It aims to leverage economic growth to achieve better outcomes leading to improved productivity and equity.