* Strengthening public health capacities in disasters -

- India's DM Act, 2005
  - laid a framework for managing disasters
  - earlier adhoc measures were applied in event of disaster, which was largely reactive
  - With the Act, systemic scheme for prevention, mitigation and response was adopted
  - DM considerations taken into account in every aspect of development & other activities, incl. health
- Some headway was achieved
  - ↳ but approach is still largely reactive in case of a disaster
- DM Act was invoked during pandemic for
  - ↳ imposing lockdowns
  - ↳ price control of mask & medical services

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- Two important lessons for India -

(1) Health services and their development has to notice the disaster

(2) A legal mandate is thus necessary for strengthening public health infra.

- Public Vs Private Sector

- Pvt sector services in healthcare in India
  - ↳ inappropriate in its approach
    Eg: Overcharging by hospitals during pandemic even after capping of treatment prices
- Pvt sector characterized by
  - ↳ weak regulation & poor organisation
  - ↳ during disasters, regulatory capacity is even more compromised
- Small pvt hospitals
  - ↳ dont meet inclusion criteria for insurance schemes
  - ↳ unsuitable for disaster scenarios

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- In such a landscape, the future is envisaged chiefly
  ↳ under a publicly financed health insurance
  ↳ & to be led by private sector.
- Strong public sector capacities are much needed for disasters
  ↓
  through a legal mandate.

- DM Act fails to identify events like TB & dengue outbreaks as disasters
  ↳ These cause substantial damage
  ↳ Thus, here again a legal mandate is required to strengthen public health at grassroots level.

- Integration of DM with primary care
  ↳ National Health mission can be concurrently run with DM Act
  ↳ Making primary healthcare central to DM can be a significant step to building health system & community resilience.

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Building a robust healthcare system

The COVID-19 pandemic has brought to light the importance of a strong public health system.

High variation in health parameters among the states:

- The efficacy of the public health system in India varies widely across the country since it is a State subject.
- An analysis of certain health parameters such as Infant Mortality Rate, Maternal Mortality Ratio and Total Fertility Rate can indicate the variation of public health quality in the different states of India.

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Some key health parameters in select States

State	Infant Mortality Rate	Under Five Mortality	Maternal Mortality Ratio	Total Fertility Rate	% deliveries by untrained personnel
Bihar	32	37	149	3.2	19.0
M.P.	48	56	173	2.7	7.2
Rajasthan	37	40	164	2.5	1.6
U.P.	43	47	197	2.9	14.0
T.N.	15	17	63	1.6	0.2
Kerala	7	10	42	1.7	0.1
India	32	36	113	2.2	7.8

SOURCE: SRS DATA FOR 2018

- The northern States are performing very poorly in the above vital health parameters.

- In Madhya Pradesh, the number of infant deaths for every 1,000 live births is as high as 48 compared to seven in Kerala.
- In U.P. the Maternal Mortality Ratio is 197 compared to Kerala's 42 and Tamil Nadu's 63.
- The percentage of deliveries by untrained personnel is very high in Bihar, 190 times that of Kerala.
- Total Fertility Rate is very high in Bihar (3.2) against the stabilisation rate of 2.1. Tamil Nadu and Kerala have done so well that their population will decline over the years.

Concerns:

1. Poor health indicators:
   - Some of these States are performing so poorly that they are comparable to the poorest countries in the world, pulling down the average for India.
2. India may fail to achieve SDG-3:
   - India failed to achieve the earlier Millennium Development Goals because of the poor performance of the northern States.

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- It is doubtful whether India will be able to achieve Goal 3 (good health and well-being) of the Sustainable Development Goals (SDGs).

3. Lack of accountability on the poorly performing states:

- There is no existing mechanism to hold the poorly performing states responsible and accountable for their performance.
- The State governments too themselves are indifferent to their poor performance.
- The poor performance has been despite the fact that Finance Commissions have been pouring non-Plan funds into these States in addition to substantial Plan allocation from the Ministry of Health and Family Welfare for the Empowered Action Group States. More money has not produced better results.

4. Wrong approach:

- The Central government seems to be satisfied with the all India averages for the health parameters which are somewhat reasonable thanks to the excellent performance of well-governed States.

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- This is a skewed approach given that meaningful development would require equitable health opportunities for all.

5. Accentuate the existing inequalities:

- The existing inequalities will only increase without equitable access to quality health and life opportunities for the people in the poorer states. Unless they give health the highest priority, rapid improvement is not possible.
- This would have a detrimental impact on poverty, example–the high TFR in states would lead to over population and can contribute to further poverty.
- Unequal access to healthcare will only increase the wealth of the already wealthy and accentuate income disparity.

Way forward:

1. Focusing on the low performing states:

- The governments – both at the Centre and the Empowered Action Group States – should take steps to bring these States on a par with the southern States.

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- There is the need to hold the Empowered Action Group States accountable to the SDGs. They must be asked to reach the levels of the southern States within three to five years.

2. States to lead the efforts:

- Since health is a State subject, the primary onus lies with the State governments. Each State government must focus on public health and aim to improve the vital health indicators discussed above first.

3. Political will:

- Only clear focus and better governance can help improve the public health system in India.

4. Focus on preventive health care:

- Preventive public healthcare systems offer the most efficient and low cost, high impact intervention when it comes to the domain of healthcare in India.

5. Primacy to public healthcare system.

- The governments must give health its due importance through sufficient resource allocation.

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* POSHAN Abhiyaan needs a boost

- or National Nutrition Mission
  - ↳ world's largest nutrition programme for children & mothers launched in 2018
  - ↳ improve nutritional outcomes for children, pregnant women and lactating mothers
  - ↳ AIMS
    - ↳ Reduce stunting by 2% a year (total 6% by 2022)
    - ↳ " wasting " 2% " (" 6% " ")
    - ↳ Reduce anaemia by 3% " (total 9% by 2022)
      - ↳ among children, adolescent girls, pregnant women & lactating mother

- NFHS data for children under 5

Indicator	NFHS-4 (2015-16)	NFHS-3 (2005-06)
Stunted (low height for Age)	38.4%	48%
Wasted (low weight for height)	21%	19.8%
Severely Wasted	7.5%	6.4%
Underweight (low weight for Age)	35.8%	42.5%

- NFHS → National Family Health Survey

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- Findings of NFHS-4:
  - ↳ more than 1/3rd of children under 5 face stunting & wasting
  - ↳ 40% aged 1-4 years are anaemic
  - ↳ Over 50% of pregnant and other women found to be anaemic
- NITI Aayog Review Report on POSHAN
  - Need accelerated actions to meet targets
  - A POSHAN-plus strategy
  - Renewed focus on other social determinants like governance challenges of NHM/ICDS delivery mechanism
  - Emphasis on complementary feeding & breastfeeding, both.
    - ↳ This can avert 60% stunting cases
  - India's goal for stunting reduction levels of 13.3% by 2022 is conservative
    - ↳ as global target set up by World Health Assembly is 5%.
  - Also India's target for anaemia reduction is conservative

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First steps in the journey to universal health care

For India, the lesson from COVID-19 demands setting forth on a steady and incremental path to universal health coverage.

Budgetary allocations

- The Union Ministry of Health and Family Welfare budget for 2021-22 saw a 10.2% increase over the (BE) of 2020-21.
- A corpus of ₹64,180 crore over six years has been set aside under the PM Atma Nirbhar Swasth Bharat Yojana (PMANSBY) for strengthening health institutions
- ₹13,192 crore have been allocated as a Finance Commission grant.

Universal Health Coverage through Insurance:

- Large expenditure projections and time constraints involved in the input-based strengthening of public health care have inspired the shift to the insurance route for achieving universal health coverage.

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- However, insurance does not provide a magic formula for expanding health care with measly levels of public spending.

Pradhan Mantri Jan Arogya Yojana (PM-JAY):

- The BE for the Pradhan Mantri Jan Arogya Yojana (PM-JAY) has stagnated at ₹6,400 crore for the current and the preceding couple of years. This should be a cause of concern.
- PM-JAY covers over 50 crore poor Indians for hospital expenses up to ₹5 lakh per annum.
- Available estimates have pegged the costs to be between ₹62,000 crore and ₹1,08,000 crore for 2021, if PM-JAY is to meet its stated commitments.

Comprehensive primary care:

- About 1.5 lakh Health and Wellness Centres offering a comprehensive range of primary health-care services are to be operationalised until December 2022.
- Of these, about 1.2 lakh would be upgraded as sub-health centres and the remaining would be

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primary health centres and urban primary health centres.

- Initially, most States prioritised primary health centres/urban primary health centres for upgradation over sub-health centres, since the former required fewer additional investments.
- However, now, this offers huge cost projections – as per early (conservative) estimates, turning a sub-health centre into a health and wellness centre would require around ₹17.5 lakh, and around ₹8 lakh annually to run it thereafter.

Concerns:

- Allocations have not kept pace with the rising targets each year.
- Making do with meagre spending year after year means that the scheme benefits are being spread out too narrowly or too thin.
- Continuing the expansion of health and wellness centres without enough funding would mean that the full range of promised services will not be available..
- Under-funding would waste an opportunity for the health and wellness centre initiative

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- Another related issue is the persistent and large discrepancies between official coverage figures and survey figures across Indian States
- Also, high actual coverage cannot be equated with effective financial protection.
    - For example, Andhra Pradesh has among the highest public health insurance coverage scores but still has an out-of-pocket spending share much above the national average.
    - In contrast, Himachal Pradesh (H.P.) with a much lower public health insurance coverage has a lower out-of-pocket expenditure.

Way forward:

- Additional funding under the PMANSBY and Finance Commission grants are reassuring, but a greater focus on rural health and wellness centres is a must.
- Robust research into the implementational issues.
- Alongside the availability of funds, there is a need for robust institutional capacity to assimilate those funds.
- India must not attempt a sudden and giant leap.

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* New cross sector initiative for UHC

- A Roadmap to achieve Universal Health Coverage (UHC) in India
  - ↳ by Lancet Citizens' Commission on Reimagining India's Health System
- Why is there need for UHC in India?
  - Considerable progress across health indicators like MMR & IMR
  - but disease burden is high
  - structural inequities of caste, class, gender, geography & community in India
    - ↳ leads to health inequalities
      - ↳ amplified by state of health systems
- Four principles that will guide the roadmap -
  (1) UHC to cover all health concerns
  (2) Prevention & long term care is key
  (3) Financial protection for all health costs
  (4) Access of same quality of health system for all.

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* Stopping the slide of health care in India.

- Healthcare in India -
  - 70% is private & 30% public
  - 80% people do not have any protection for health.
    - ↳ out of pocket expense is very high ~62%.
  - Public spending is at 1.13% of GDP
    - ↳ very low.
  - Huge shortage of health care workers
    - ↳ particularly nurses and midwives.
- Issues with the insurance model
  - Private sector healthcare driven by return on capital
    - ↳ insurance backup incentivises hospitals to expand the bill while patients don't get much attention.
  - Govt health insurance
    - ↳ drives down the price of procedures
    - ↳ so hospitals selectively offer services and procedure, while denying some.

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- Consumption is high for those health services
  ↳ which are often inefficient
  ↳ due to supplier-induced demand
  ↓
  Created & provided by doctors & hospitals

- Impact of such inefficient consumption
  - ↑ in insurance premium.
  - Exclusion of poor.

- Thus, insurance based healthcare causes
  - state to neglect primary health care
  - No long term investment by state.
  - Such social insurance schemes prospers at the cost of neglecting public hospitals

- India's health problems
  - 80:20 rule
    ↳ 20% can afford modern health care
    ↳ 40% cannot afford it
    ↳ 40% (so called non-poor) pay with difficulty
  - ~70 mn of non-poor slide into poverty on year-to-year basis.

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- Many reach Registered Medical Practitioners, who are not properly trained
  ↳ routinely prescribe antibiotics & steroids for quick relief.

– Measures needed.

- ↑ no. of doctors and obligation to serve in rural areas.
- Need to revive the Licentiate Medical Practitioner
  ↳ was there pre-independence.
- Empower grads of BSc (Nursing) to be nursing practitioners, as is prevalent in many countries.
- Primary health care
  ↳ should receive 3x more allocation.
  ↳ doubling of doctors & paramedic strength.
- States → should be incentivised to carry out appointments of health workers & doctors
  ↳ Indian ⇒ Nurses: Doctor is 0.6, while WHO specification is 3 nurses per doctor.
- PHCs should also charge a reasonable fee

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* Pandemic resilience

- Public Health sector crisis in India
  - National Health Profile 2019 data
    ↳ 0.55 govt hospital beds for 1000 people
  - Health infra in tatters
    ↳ Underinvestment by Govts
  - Millions dependent on highly commercialized private sector.
    ↳ little regulatory oversight
  - Situation → more worse in rural areas
    ↳ weaker care facilities
    ↳ urban workers fled to their villages, afraid of the cost of falling sick in cities
- India
  ↳ committed itself to SDGs, etc
  ↳ but does not wants to make the Right to health a full legal and justiciable right under National Health Policy

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- Report of the Parliamentary Standing Committee on Home Affairs

- called for an omnibus law to curb profiteering during times of crisis
- provide cashless health insurance.
- Ensure that patients are not turned away in a crisis, like COVID 19.
- Panel called for a limit to rise in health premium
  - ↳ staggering rise after pandemic (upto 25%)
- Removal of max age of entry for a standard policy
  - ↳ IRDAI, itself, has set 65 years as the limit ⇒ affecting older citizens
- Universal state-provided health services
  - ↳ under rights based, non-exclusionary framework, with states implementing it.
- Raising public spending to 2.5% of GDP
  - ↳ COVID has already exposed dangers of excessive reliance on private tertiary sector.
- central procurement of essential drugs and free distribution

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✳ A national health service in India

— Structural issues in the healthcare system of India:

- The health crisis brought out by the pandemic has exposed the problems of the healthcare system in India.

(1) Low public spending:

- India has very low public spending on health (barely 1% of GDP).
- Though India's public spending on health is set to double in the 2021-22 financial year, it continues to remain grossly inadequate when compared to the levels in other similar developing nations.

(2) High out of pocket expenditure:

- The share of 'out of pocket' (OOP) health expenditure (of total health spending) in India was over 60% in 2018.
- Medical expenses constitute the major reason for personal debt in India and have pushed many into poverty.

(3) Regional inequality:

- India's fragmented, urban-centred, variably functional and grossly underfunded primary health centres and elite-focused healthcare system cater to only a small section of the population.
- In certain rural areas, the doctor-population ratio is over 1:40,000.

(4) Lack of regulation of private health sector:

- The private health sector in India is poorly regulated in practice.
- Some private healthcare providers have objected to public authorities' orders on widened patient access during the ongoing health crisis.

The article argues for a national health service in India modelled on the British National Health Service.

British National Health Service:

- The service is funded entirely from general taxation and the general public receive treatment solely according to their clinical needs without any exception.
- The system includes payment to general practitioners, most of whom remain private providers but are paid by the state for treating NHS patients.
- All hospital treatment and medicines are free, as are outpatient and follow-up appointments. Only a proportion of patients in England have to pay for prescription items.
- The NHS is the largest employer in the U.K. Its current budget is about 7.6% of GDP, and it provides highly localised access to care.
- It has resulted in the provision of top-class universal healthcare, including training and research.
- It integrates preventive and curative medicine at all levels.

Additional information:

According to the Lancet Planetary Health journal, air pollution accounted for 1.7 million deaths in India in 2019. The annual business cost of air pollution is currently estimated at $95 billion, which is about 3% of India's GDP.

* The fault line of poor health infra.

- Poor state of India's health infra as per WB -
  - Physicians → 85.7
  - Beds → 53
  - Nurses → 172.7

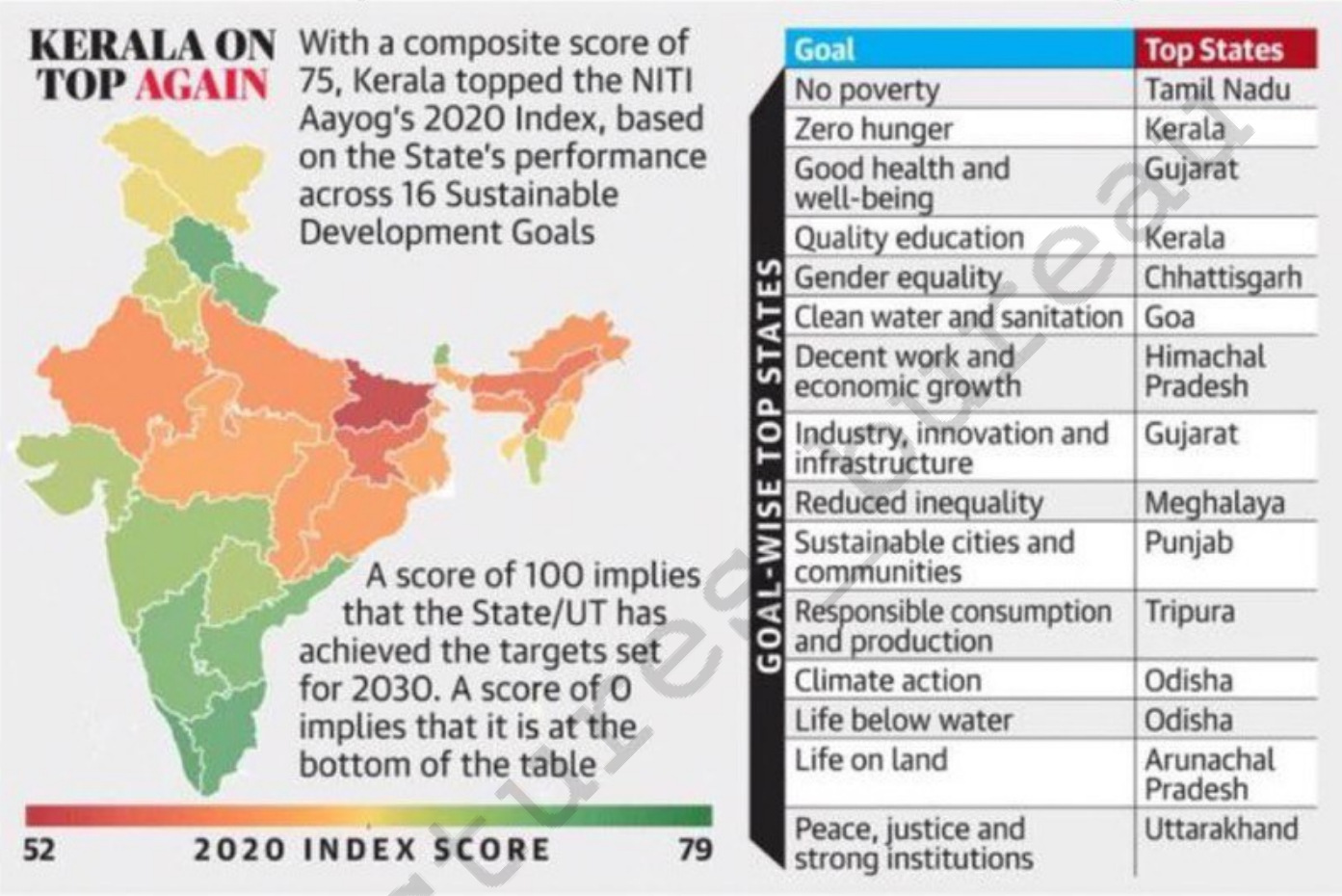
  } per 1 lac population in 2017 (lower than Pak, SL, Japan in most)
- Reason: Low public health expenditure
  - ↳ 1% of GDP in 2013-14
  - ↳ 1.28% " in 2017-18

  } includes Centre, States & all UTs
- Dual Control
  - ↳ Health: A state subject with states spending ~68% of total govt health expenditure
  - ↳ But Centre is key player as it controls expert bodies like NCDC, ICMR etc
- Inter-State variation in per capita health exp.
  - ↳ Kerala & Delhi → Toppers
  - ↳ Bihar, Jharkhand & UP → lowest
  - ↳ Odisha → an exception; had same per capita health exp. as UP in 2010, but now has more than double that of UP
    - ↳ reflected in its relatively good COVID-19 management

- Out of Pocket Expenditures (OOP)
  - ↳ India ⇒ one of the highest OOP
  - ↳ OOP → money that people spend on their own at time they receive health care
  - ↳ Thus making the poorest even more vulnerable worst victims of health emergency
- COVID-19 & vaccination : Govt Role
  - Centre controls major decisions → funds, vaccines
    - ↳ was done at central level in 1st wave
  - 2nd ware
    - ↳ Centre has shifted most responsibilities to States, even on vaccine procurement.
- Advantage of central coordination on vaccine procurement
  - Bargain on cost due to economies of scale
    - ↳ as was done by EU for its member states
  - Needs based & transparent distribution
  - Due to the present decentralised policy, richer states may get better deals
    - ↳ Eg: Global tenders floated by Maha, Karnataka, Telangana
    - ↳ leaving the poorer states on their own.

* Significant progress in SDGs : NITI Index

- NITI Aayog's 2020 SDG Index
  - ↳ Kerala > (TN, HP) > . . . . > Assam > Jharkhand > Bihar
  - ↳ Best performers ⇒ Mizoram & Haryana



Goal	Top States
No poverty	Tamil Nadu
Zero hunger	Kerala
Good health and well-being	Gujarat
Quality education	Kerala
Gender equality	Chhattisgarh
Clean water and sanitation	Goa
Decent work and economic growth	Himachal Pradesh
Industry, innovation and infrastructure	Gujarat
Reduced inequality	Meghalaya
Sustainable cities and communities	Punjab
Responsible consumption and production	Tripura
Climate action	Odisha
Life below water	Odisha
Life on land	Arunachal Pradesh
Peace, justice and strong institutions	Uttarakhand

- NIT Aayog's 2020 SDG Index
  - ↳ launched in 2018
  - ↳ to monitor progress on goals of SDG through data driven assessment
  - ↳ Foster a competitive spirit among States & UTs

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- Report for 2020
  - Bad performing sectors
    - ↳ Wages & Industrial growth, Decent Work
    - ↳ Industry & Infra.
    - ↳ Clean Water & Sanitation
  - Good performance in
    - ↳ Eradication of Poverty, Hunger & Inequality
    - ↳ Clean Energy, Urban development & health.
- While UN Assessment of impact of pandemic
  - ↳ India may see rise in inequality.
- Reason for contrary assessment:
  - ↳ Indicators to measure progress changed by NITI Aayog.
  - ↳ More weightage given to social indicators while omitting key economic indicators, like

Eg: 2019 → Inequality indicators included
Growth rates for household expenditure per capita among bottom 40% population
→ used **Gini Coefficient**
(measures distribution of income - in rural & urban)
2018 → **Palma ratio** used

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* Rural healthcare needs fixing

- Pandemic → Rural people struggling the most
  → No quality health care
- WHO's principle of **Universal Health Coverage**
  ↳ ensuring all people have access to needed health services of sufficient quality (including prevention, promotion, treatment, rehab & palliation)
  ↳ such that user is not exposed to financial hardships
- Scenario in India

	Required	Actuals
• PHCs	29337	25743
• CHCs	7322	5624

- One PHC for 25 villages in India
  ↳ Needs 10 villages per PHC
- Shortfall of 81.8% specialists at CHCs
- A/q to **HDR 2020**
  ↳ No. of hospital bed 10K population
  8 in India, 40 in China
- Focus on Rural India
  ↳ 91 crore Indians in villages (>65%)

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- Risk factors
  - Non Communicable Diseases like BP, diabetes and Cardiovascular diseases (CVD)
  - NCDs + Respiratory Problems + Cancer
    - ↳ nearly 41 mn deaths (71% of all) globally
    - ↳ ~5.8 mn deaths (60% of all) in India
  - Persons with co-morbidities
    - ↳ most vulnerable in pandemic
- Way Forward
  - Treat diseases at primary level
    - ↳ save lot of money at tertiary healthcare
    - ↳ Well functioning of SHCs, PHCs & CHCs (Sub Health Centres)
  - Regular health camps
    - ↳ identify those on verge of developing TB, BP, etc
  - More specialists in CHCs
    - ↳ At least 30 beds per CHC
    - ↳ Infra support
  - Health is a state subject, but those in rural areas are a collective responsibility of Centre & States.

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* Health infra has increased 45-fold : Centre

— SC raised concern on health infra and Govt's preparedness for successive waves of the pandemic.

— Govt's response.

- Health infra has increased up to 45 fold

Infra	Earlier	Now	Increase
ICU Beds	2500	1.13 lac	45x
Total isolation beds	41000	17 lac	42x
COVID dedicated hospitals	163	4096	25x
O_2-supported beds	50583	3.81 lac	7.5x
Isolation Railway coaches	0	5601	

- Over 1.5 lac health personnel engaged.
  ↳ medical officers, specialists, nurses, MHWs, community volunteers, ASHA & ASHA facilitators, etc
- Insurance coverage given to 22 lac health workers.
- Testing capacity ↑ with 2621 labs.
  ↳ Phenomenal ↑ in testing capacity to 22 lac tests per day.

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* The next step is a constitutional right to health

↳ Background

- The Pandemic has exposed and aggravated the cracks in our health-care systems
- Presently, any investment in health case fails to translate into a sense of security and sanctuary for the people of India
- complex and often corrupt means of accessing even existing health care only adds to the suffering

↳ Need for the constitutional 'Right to Health for all'

- It will provide much needed medical financial security to the poor section of society like seasonal workers, landless farmers and migrant workers.
- It will ensure better access of medical facilities for vulnerable sections like women.
- Quality and affordable healthcare facilities to the large no. of children who belong to the poorest and most marginalised communities
- It will transform not only the health and well-being of our people but will act as a leap for the economic and development progress of the nation.

conclusions

- vision for Ayushman Bharat will be strengthened with a constitutional 'Right to Health' and govt should consider this seriously.

Per capita out-of-pocket health expenditure sees decline: report

5th edition of the National Health Accounts (NHA) estimates for India for 2017-18 has been released

- The NHA report is produced by National Health Systems Resource Centre.

Reduced Out-of-pocket expenditure:

- Out-of-pocket expenditure (OOPE) as a share of total health expenditure and the per capita OOPE has come down.
- As a share of total health expenditure, the OOPE has come down to 48.8% in 2017-18 from 64.2% in 2013-14.
- The decrease in OOPE can be attributed to
  - Increase in utilisation and reduction in cost of services in Government health facilities
  - Increase in social security expenditure on health in the form of health insurance programme and medical reimbursements made to Government employees.

Increased government expenditure on health:

- The report notes an increase in the share of Govt health expenditure in the total GDP of the country.
- It has increased from 1.15% in 2013–14 to 1.35% in 2017–18.
- This has helped increase the per capita Government health expenditure as well.
- Additionally, the share of Government Health Expenditure in total health expenditure has also increased over time.
- From being 28.6% in 2013–14, it has now increased to 40.8% in 2017–18