Progress despite Regression:
a study of the National Rural Health Mission in India (2005-2018)

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Introduction[1]

In April 2005, India unveiled the National Rural Health Mission (NRHM). Its principal aim was to enable more vulnerable citizens to access equitable, accountable and effective primary healthcare. In particular, the Mission sought to "carry out [the] necessary architectural correction in the basic health care delivery system", paying special attention to eighteen 'high-focus' states that had poor outcomes.[2] Its specific goals were threefold. First, the NRHM sought to lower rates of infant, child and maternal mortality as well as total fertility. Second, it aimed to improve the quality of facilities and lower regional disparities by bolstering finances, pooling resources and raising standards. Third, the Mission sought to enhance local ownership and political decentralization by empowering state, district and village-level institutions and committees to develop comprehensive health plans, bolster critical human resources and administer the delivery of services.

The NRHM was part of a larger ambition: to create a new welfare regime in India. Its main architect was the United Progressive Alliance (UPA), a broad multiparty coalition under the leadership of the Indian National Congress, which ruled New Delhi from 2004 until 2014. During a decade in office, especially its first parliamentary term (2004-2009), the UPA introduced national legislation to expand the economic security and social opportunities of its citizens. Strikingly, many of these acts enshrined the language of rights, and devised new governance mechanisms to realize them. The Right to Information Act, 2005, mandated all public agencies to release information regarding their activities to individual citizens upon request in a timely manner. The National Rural Employment Guarantee Act, 2005, sought to protect the livelihoods of poor agricultural laborers during periods of distress, granting adult members of every rural household the right to demand 100 days of unskilled work at stipulated minimum wages from the state, making it the largest work guarantee programme in the world. The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act, 2006, empowered such communities the right to own traditionally cultivated land and to protect forests. Finally, the Right of Children to Free and Compulsory Education Act, 2009, made the enrollment, attendance and completion of schooling of every child between the age of six and

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[2] The following paragraph draws on the official blueprint, *National Rural Health Mission (2005-2012): Mission Document* (Ministry of Health & Family Welfare, Government of India): http://www.nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/mission_document.pdf.

fourteen the obligation of the state. The passage of these acts signified the emergence of a new "welfare architecture" with a distinct "social contract" in modern Indian democracy.[3]

For various reasons, the NRHM was neither an act of parliament, nor did it explicitly articulate a right to health. Yet it shared a number of features that distinguished the rights-based acts of India's new welfare regime as well as the innovative social policies that many countries in the global South since the end of the twentieth century. The Mission sought to address the unmet basic needs of marginalized citizens and informal workers in the rural sector, which traditional social policies had neglected in relative terms. Moreover, to serve these needs it aimed to strengthen the provision and quality of comprehensive public services in underserved areas, states and regions of the country, while simultaneously targeting conditional cash transfers to specific groups for particular ends. Finally, the NRHM stressed the importance of community participation, social equity and government accountability, itself a reflection of the inclusion of new civic actors and novel institutional processes of policy-making.

Indeed, improving the health of its most vulnerable citizens was arguably the most urgent developmental challenge facing India at the start of the twenty-first century. Three unenviable facts distinguished the comparative record of the world's largest democracy. First, despite improvements over time, rates of infant, child and maternal mortality in India remained very high, almost a century behind the comparable achievements of the advanced industrialized democracies.[4] Yet its record was poor even compared to neighbors in the subcontinent, let alone other low-income countries. By 2001, only Pakistan had made less progress in reducing child mortality. The rate of improvement in Bangladesh and Nepal, despite being poorer, was faster than in India.[5] The prevalence of morbidity, measured in levels of malnutrition and anemia, and stunting and wasting, of women and children represented a similar challenge. In 2001, the percentage of children under five in India that suffered low body weight was greater than 50 percent, the highest in South Asia. The only countries in Sub-Saharan Africa to have a similar ratio were Burundi, Eritrea and Mali, far poorer economies.[6] Similarly, more than one-third of women in India suffered from low body weight in 2005-06, nearly three times greater than in

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[3] Pratap Bhanu Mehta, "Public advisory," *The Indian Express*, 6 April 2010.
[4] The infant mortality rate of India in 2008 approximated the level recorded in England and Wales in 1925, while its maternal mortality rate was still higher in the former than recorded in the latter in 1900. See Jishnu Das and Jeffrey Hammer, "Health and health care policy in India: the case for quality of care," in Chetan Ghate (eds), *The Oxford Handbook of the Indian Economy* (New York: Oxford University Press, 2012), p. 420.
[5] *Human Development Report 2003: Millennium Development Goals—a compact among nations to end human poverty* (New York: Oxford University Press, 2003), p. 57.
[6] *HDR 2003*, pp. 199-200. Data for Angola and Equatorial Guinea were unavailable.

Sub-Saharan Africa, leading some to suggest that genetic differences may be the cause.[7] Yet children of Indian descent growing up elsewhere match local norms. Indeed, even children from relatively privileged households suffer abnormally high degrees of stunting, suggesting factors other than income poverty.[8]

Second, India had the largest disease burden of any country in the world, according to the World Health Organization (WHO). This burden had declined over time. In comparative terms, however, it remained astonishingly high. Containable infectious diseases comprised approximately 30 percent of the overall figure. By 2005, India accounted for approximately one-sixth of the world population. Yet its share of vector-borne diseases and maternal conditions comprised roughly one-third and one-quarter of the total, respectively.[9] And the country was simultaneously undergoing an epidemiological transition. Non-communicable diseases, principally cancer, cardiovascular diseases, chronic lung ailments, diabetes and stroke, comprised more than half of all deaths by 2005.[10]

Finally, public health expenditure in India as a proportion of GDP hovered around one percent of GDP at the turn of the millennium. Hence its citizens had among the highest rate of out-of-pocket expenses for health care in the world. Curative medical services comprised almost 90 percent of the total.[11] In 2004-05, visiting a rural public hospital cost an estimated Rs. 3000. Comparative rates for private facilities in rural and urban India were roughly Rs. 7000 and Rs. 11,000, respectively. Yet average consumer expenditure in rural areas on a monthly per capita basis was only Rs. 559, while the corresponding figure in urban areas was Rs.1052.[12] Moreover, roughly 90 percent of the population lacked any health insurance to cover these costs.[13] And the latter rarely covered outpatient care or purchase of medicines, which comprised approximately 69 and 77 percent of urban and rural household expenditure on health, respectively.[14] Such healthcare expenses posed a terrible burden for millions of poorer Indian citizens, which often

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[7] Jagdish Bhagwati and Arvind Panagariya, *India's Tryst with Destiny: debunking myths that undermine progress and new challenges* (New Delhi: HarperCollins, 2012), pp. 77-85.

[8] Das and Hammer, "Health and health care policy in India: the case for quality of care," p. 421; and Jean Drèze and Amartya Sen, *An Uncertain Glory: India and its contradictions* (New York: Allen Lane, 2013), pp. 158-161.

[9] *Report of the National Commission on Macroeconomics and Health* (Ministry of Health & Family Welfare, Government of India, 2005), p. 3.

[10] *Eleventh Five-Year Plan (2007-2012): Volume II—Social Sector* (Planning Commission, Government of India, 2008), p. 63.

[11] *Eleventh Five-Year Plan*, p. 105.

[12] See National Sample Survey Organization, *Level and Pattern of Consumer Expenditure, 2004-05 NSS 61st Round (July 2004 - June 2005)* (Ministry of Statistics and Programme Implementation, Government of India, December 2006). Available at: http://mospi.nic.in/sites/default/files/publication_reports/508_final.pdf.

[13] *Eleventh Five-Year Plan*, p. 82.

[14] See Table 3.1.7, *Eleventh Five-Year Plan*, p. 77, for details.

could be catastrophic. In short, the NRHM was an extremely important endeavor, a genuine mission.

Accordingly, this paper examines its genesis, implementation, successes, failures and evolution to date. Several questions frame the study. First, what were the major political, economic and social drivers of the NRHM? How did they relate to patterns and dynamics of economic growth, social distribution and global integration? What role did domestic actors, institutions and processes play vis-à-vis major donors, multilateral institutions and global development campaigns in designing, advocating and funding the Mission? Second, how well has the NRHM been implemented thus far? Has it conformed to stipulated aims, procedures and expectations? And has the Mission mobilized sufficient fiscal, administrative and political resources, and strengthened policy complementarities and institutional convergence through systematic reform? Third, what have been the principal outcomes of the NRHM to date? Has it improved community participation, public services and substantive outcomes for the most vulnerable citizens and neglected regions of India? Or do the latter continue to rely on their personal financial resources and private health care to meet their needs?

Given the scale and complexity of the NRHM, and the political, economic and social diversities of India, a comprehensive answer to these questions is beyond the scope of this study. Nonetheless, several key findings emerge. First, the genesis of the NRHM reflects the paradoxical effects of economic liberalization, global integration and multilateral campaign initiatives, and the importance of a novel policy alliance that largely involved domestic actors. The gradual liberalization of the Indian economy since the late 1980s promoted higher economic growth, lowered absolute income poverty and boosted government revenues. But the pattern of growth worsened socioeconomic disparities between classes, sectors and regions in the 1990s, exacerbated by cuts in social sector spending. These general trends characterized many Southern polities, galvanizing the UN to declare the Millennium Development Goals (MDGs) and the WHO to establish the Commission on Macroeconomics and Health circa 2000, which promoted higher public spending on basic primary care for marginalized communities. Yet the main architect of the NRHM was a progressive coalition of committed politicians, innovative bureaucrats and social activists. The election of the UPA in 2004 provided a critical political opening for these actors to advocate comprehensive public services, more preventive care and greater community participation.

Second, the impact of the NRHM upon basic health outcomes exhibited complex trends. Rates of infant, child and maternal mortality, as well as total fertility, declined steadily during its original phase (2005-2012). Immunization against basic communicable diseases improved. And

the proportion of children born in public health facilities grew rapidly, thanks to the efforts of community health workers and targeted cash incentives, closely the gap between high-focus and better performing states. These were significant positive outcomes. Nevertheless, India failed to meet its MDG targets on each measure by 2015. Rates of mortality and the quality of care continued to diverge significantly between north and south, urban versus rural and richer and poorer states. And the prevalence of morbidity among women and children, manifested in low body weight, stunting and wasting, remained distressingly high in many parts of the country.

Finally, the ramifications of the NRHM for fiscal resources, institutional capacities and local accountability of public health services were similarly complicated. In absolute terms, aggregate and per capita public health expenditure rose tremendously between 2005 and 2015. In relative terms, however, it barely increased, remaining just above one percent of GDP, far short of the three percent target set by the NRHM. Moreover, many states, districts and villages experienced difficulty spending their allocations and receiving them in a timely manner, reflecting time-consuming budgetary processes, political reluctance at the Centre and limited administrative capacities in the states to varying degrees. Similarly, the provision of public health facilities at various levels rose in absolute terms following the introduction of the Mission. The number of community health workers rose dramatically. However, the shortfall of facilities at the lowest tiers of the system vis-à-vis the newly established norms created by the NRHM actually increased. Many community health workers failed to complete their training or receive their compensation on time. Inadequate hospital amenities encouraged premature discharges and postnatal care remained generally insufficient. Moreover, relatively unskilled staff have often been responsible for the latter, leading to suboptimal medical practices and inadequate referrals for emergency care. The deficit of more specialized healthcare workers, especially doctors, technicians and specialists, grew even worse due to the inadequate number of medical colleges in high focus states, and their unwillingness to accept rural postings due to poorer working conditions and general social opportunities. And apart from community health workers, other local initiatives, namely the establishment of hospital management committees and village sanitation committees, had failed to become participatory in most states. Indeed, less than 20 percent of public health facilities met the newly established norms of the NRHM a decade after it began. As a result, the majority of households in rural India continued to rely on private medical care to meet their basic health needs, reigniting longstanding debates over the viability of public health services.

The change in government in New Delhi in 2014, which saw the Bharatiya Janata Party (BJP) capture national power, has consolidated this general trend. On the one hand, the new

ruling dispensation expressed a commitment to comprehensive health care through a broad inter-sectoral strategy. The introduction of Swachh Bharat, an ambitious mass programme to end open defecation in India by 2019, is a critical public initiative. And the BJP has pledged to ensure the availability of free primary care and essential medicines in the public health system, introducing a special cess to raise necessary fiscal resources. On the other, however, the new government has thus far squeezed funding for the NRHM. Indeed, it has vastly expanded publicly financed insurance for curative medical care, arguably entrenching the role of the private health sector. Whether such an approach can lower rates of morbidity and mortality, and reduce the serious financial burdens, afflicting vulnerable individuals, households and communities in rural India is an open question. Raising public spending, improving bureaucratic capacities and overcoming the powerful vetoes of the rent-seeking medical establishment and its nexus with the political class, which prevents the creation of a specialized rural cadre of public health professionals, remain major challenges.

The evolution of health policy in India from 1947 to 2000

By definition, good health is a multidimensional concept. Hence it has many interrelated determinants that produce conjunctural effects. In general, individual lifestyles and social habits; the provision, accessibility and quality of health care facilities, personnel and services; power relations between men and women as well as different groups, sectors and regions; and larger environmental conditions regarding the quality of air, water and sanitation available: all play a significant role in shaping these outcomes in varying degrees. A set of political and economic factors, deeper in the complex causal chain, shaped the preceding factors in turn.

In 1946, on the eve of independence, the Bhore Committee Report recommended the establishment of a national health system to deliver comprehensive preventive and curative allopathic services through a multilevel system. Such a system should be financed by government and focused on the rural sector, the Report advocated, open to all citizens irrespective of their ability to pay.[15] The focus on rural deprivation and community involvement was in keeping with neo-Gandhian principles. In 1948, the Sokhey Sub-Committee of National Planning Committee of the Congress party proposed the need to ensure a community health worker for every 1000 villagers.[16] The new Constitution of India, ratified in 1950, created a structure. It enjoined the executive and legislature to address the health of its citizens through a

[15] Vikram Patel, A.K. Shiva Kumar, Vinod K. Paul, Krishna D. Rao and K. Srinath Reddy, "Universal health care in India: the time is right," *The Lancet*, Volume 377, Issue 9764 (5 February 2011), p. 448.
[16] Debabar Banerji, "Politics of rural health in India," *Economic & Political Weekly*, 40, 30 (23 July 2005), p. 3254.

number of non-justiciable provisions in the Directive Principles of State Policy. Article 39e directed the state to ensure that men, women and children would be shielded from taking on work that could damage their health. Article 41 enjoined the state to deliver public assistance, within its capacity, to citizens suffering from unemployment, old age, and sickness and disability. And Article 47 directed the state to raise of the level of nutrition and the standard of living of its citizens and to improve public health. A three-tiered rural health care system emerged. The first level comprised Sub-Centres (SCs), operated by two community health workers, for every 5000 residents in the plains (3000 in more difficult regions). Primary Health Centres (PHCs), to be staffed by a doctor and equipped with a pharmacy and lab services for every 30,000 residents (20,000 in more difficult regions) were the second. Finally, the third level consisted of Community Health Centres (CHCs), to handle specialized medical services for every 100,000 residents (80,000 in more difficult regions).

Yet the health system that developed in India in these early decades failed to realize this integrated public-oriented vision. Three general reasons stand out. First, the 1950 Constitution divided the responsibility for health between the national government in New Delhi and the states of the Union, which fragmented interventions at each level.[17] The Centre was responsible for establishing the general policy framework, regulating the provision of services across the country, and controlling and eliminating various diseases and outbreaks. The Ministry of Health encompassed several departments: health services, family welfare, health research, and traditional medical systems. In turn, the states were responsible for providing health care and personnel training, directed by their own departments of medical education, health services and family welfare.[18] Even the Centre, moreover, dispersed the administration of various related matters under its remit among different ministries. The Ministry of Chemicals governed the pharmaceutical industry, Commerce regulated the import and export of drugs and technology, Finance administered health insurance policies, Rural Development managed water and sanitation, and so on.[19] In addition, constitutionally the states were responsible for approximately two-thirds of total public health expenditures. Yet their share of total government revenue was approximately one-third, constraining their capacity to meet their fiscal responsibilities. Lastly, these various ministries and departments had inadequate coordinating

[17] Monica Das Gupta, "Public health," in Kaushik Basu and Annemie Maertens (eds), *The Concise Oxford Companion to Economics in India* (Delhi: Oxford University Press, 2012), pp. 568-569.
[18] T. Jacob John, Lalit Dandona, Vinod P. Sharma, Manish Kakkar, "Continuing challenge of infectious diseases in India," *The Lancet*, Volume 377, Issue 9761 (15 January 2011), p. 253.
[19] *National Commission on Macroeconomics and Health*, p. 44.

mechanisms between them or vis-à-vis those in charge of water, sanitation and the environment.[20]

Second, public health spending in India was extremely low in comparative perspective. Starting from an astonishing low base of 0.22 percent of GDP in 1950-51, it grew to 0.63 percent in 1960-61, 0.74 percent in 1970-71 and 0.91 percent in 1980-81. Indeed, it was only in the mid-1980s that it finally crossed the one percent threshold.[21] As a result, private health providers entered the field over time, ranging from voluntary and not-for-profit entities and trusts to corporate and for-profit medical establishments.

Third, despite very tight resource constraints, these expenditure patterns revealed misplaced priorities and unfortunate choices. Successive governments largely emphasized a biomedical approach rather than preventive services. The Ministry of Health in New Delhi failed to establish an independent department for public health, a crucial deficiency. The vast majority of states, with the exception of Tamil Nadu, failed to do so too. Scholars offer two explanations for this early critical failure. On the one hand, an overriding belief in science and technology championed by the Nehruvian ruling elite in the pursuit of rapid planned development favored a biomedical model.[22] On the other, the mass production of antibiotics in these early decades enabled social elites to protect themselves from many communicable diseases, reducing the need to ensure public goods. Indeed, many Public Health Acts that originated in the colonial era were never rationalized or updated.[23]

Hence the establishment of a basic health system in these early decades initiated several important advances by the late 1970s. In aggregate terms, infant, child and maternal mortality fell, and life expectancy grew. The incidence of malaria fell massively. And smallpox had been eradicated in 1977.[24] But these decades also witnessed underinvestment in public hygiene, support for advances in technology that encouraged clinical remedies and rewarded curative skills in the tertiary sector, and a focus on curbing population growth through family planning.

Developments in India as well as various multilateral developmental institutions in the late 1970s suggested a change of direction, presenting an opportunity to rectify these biases. In 1975, the Centre unveiled the Integrated Child Development Services (ICDS), a national scheme to provide children under six with health, nutrition and pre-school education services in local *anganwadis*, 'courtyard shelters' in rural India. Established with the assistance of the World

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[20] Ibid.
[21] Comprising both Central and state government expenditure as a proportion of GDP, measured at market prices, with 1993-94 as the base year. See Table 2.16, ibid, p. 71.
[22] John et al, "Continuing challenge of infectious diseases in India," p. 264.
[23] Das Gupta, "Public health," pp. 568-569.
[24] *National Commission on Macroeconomics and Health*, p. 43.

Bank and UNICEF, the pillar of the ICDS was a local health worker, tasked with conducting house visits, counseling expectant and nursing mothers on how to monitor important developmental milestones, providing supplementary feeding, vitamins and non-formal schooling to all children, and carrying out immunization. By design, the programme had a cohesive vision, recognizing the multidimensionality of health. Furthermore, the Janata Party government (1977-1980) that briefly displaced the Congress party in New Delhi embraced the vision of the earlier Sokhey Sub-Committee: to ensure a community health volunteer for every 1000 villagers, putting "people's health on people's hands".[25] In 1978, the parties to the major WHO/UNICEF international conference on primary health care at Alma-Ata committed themselves to ensuring "Health for All", heralding a second generation of reforms. To secure affordable universal coverage, its architects reiterated the centrality of preventive health measures and basic public services in allied fields of education, water and sanitation.[26] In 1983, New Delhi announced a National Health Policy, committing the government to achieving "Health for All by the year 2000 AD". The Policy articulated a phased, time-bound programme to establish a network of PHCs across the country. Health Volunteers would carry out basic tasks, bolstered by various extension services, "designed in the … ground reality that elementary health problems can be resolved by the people themselves". A coherent referral system, and an integrated network of evenly spread specialty services, would provide higher-level support.[27]

Yet in practice multilateral donors, principally the WHO, UNICEF and World Bank, emphasized vertical programmes to control specific diseases on grounds that most developing countries too poor to undertake comprehensive primary health care.[28] Such programmes also reflected the interests of donors, given their clearly measured objectives and link to vaccines, and medical colleges in India, which had specializations in disease control.[29] Hence in 1978, India adopted the Expanded Programme on Immunization of the WHO, which sought to reduce child mortality. Successive revised programmes—such as Mother and Child Health, Growth Monitoring, Oral Rehydration, Breast Feeding and Immunization and Safe Motherhood—required staff retraining and general reorganization. The decision of the World Bank to

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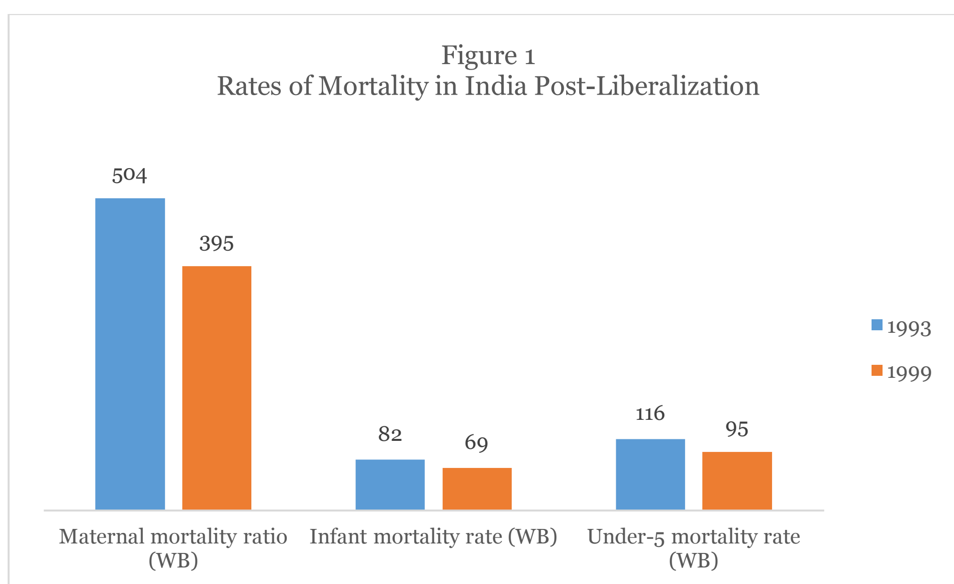
[25] Banerji, "Politics of rural health in India," pp. 3254-3256. Banerji states at one stage the number of community health workers approximated 450,000, but "…could not be sustained because of the nature of the power structure in the villages"—presumably the rising political dominance of intermediate proprietary castes in northern India.
[26] K. Anand, C.S. Pandav and S.K. Kapoor, "Consensus and conflicts in health sector reforms in India: a Delphi study," in *International Medical Journal of India*, 15, 4 (2002), p. 222.
[27] See *National Health Policy 2002* (Ministry of Health and Family Welfare, Government of India, 2002), pp. 1-2. Available at: 18048892912105179110National Health policy-2002.pdf. Downloaded on 15 May 2016.
[28] Banerji, "Politics of rural health in India," p. 3255.
[29] Interview, senior government official, Chennai, 12 August 2016.

prioritize the control of TB, malaria and leprosy led to neglect of typhoid, cholera and other infectious diseases. Collectively, these myriad vertical programmes became "a surrogate for primary health care",[30] exacerbating the neglect of basic public services by successive national governments in New Delhi. And the community health worker programme launched in 1978 had failed to realize its potential due to opposition by doctors, inadequate community ownership, and the absence of pay, confused roles and low morale of the health workers themselves.[31]

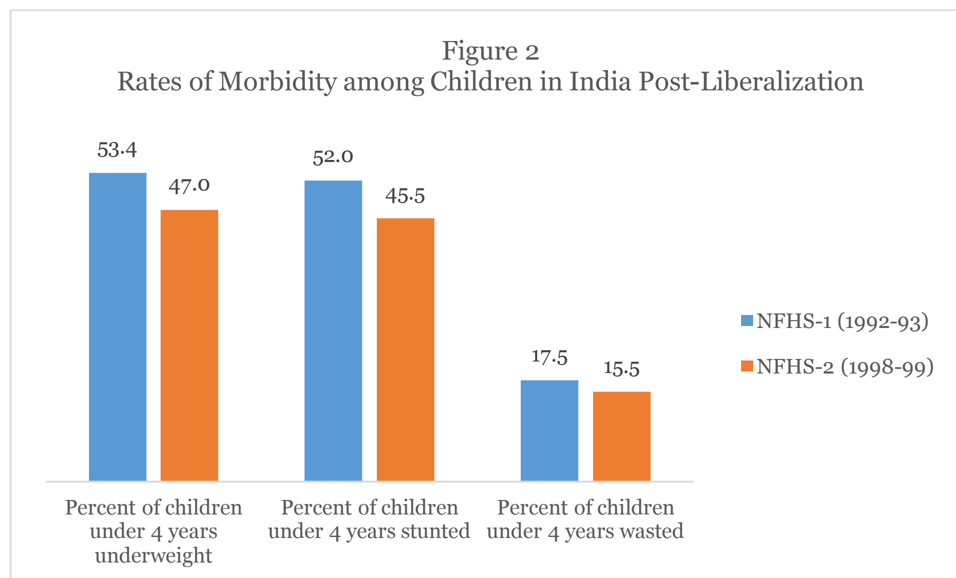
In addition, to meet the growing demand for hospital care, successive governments at the Centre and in the states offered subsidies to private health providers. Tax exemptions, concessional land rates and reimbursements for treating central and state governments' employees fueled their rapid growth. Private health providers constituted roughly 40 percent of all hospital treatments in 1986, but roughly 60 percent in 2004.[32] Yet New Delhi failed to establish a proper regulatory framework to govern their services. The absence of a proper surveillance network led to poorly designed interventions. And many state governments neglected to invest adequately in developing skilled human resources.[33]

As a result, basic health indicators continued to improve through the 1980s and 1990s, but also to lag behind other countries. Rates of infant, child and maternal mortality continued to decline (see Figure 1).[34] Yet they remained very high by international standards.



[30] John et al, "Continuing challenge of infectious diseases in India," pp. 264-65.
[31] Mohan Rao, Krishna D. Rao, A.K. Shiva Kumar, Mirai Chatterjee and Thiagarajan Sundararaman, "Human resources for health in India," *The Lancet*, Volume 377, Issue 9765 (2011), p. 589.
[32] *Eleventh Five-Year Plan*, pp. 67-68.
[33] *National Commission on Macroeconomics and Health*, p. 43.
[34] Source: World Bank, *World Development Indicators*. Note: figures rounded.

Similarly, indicators of morbidity among children improved through the 1990s (see Figure 2).[35] But the ratio of under 4s that suffered from low weight, stunting and wasting was alarming in comparative perspective. Public officials recognized that levels of morbidity among vulnerable groups remained "unacceptably high".[36]



More than half the children under five years of age that died each year succumbed to infections, prematurity and asphyxia in the neonatal stage. Approximately one-third of infants suffered from low birthweight, which comprised more than a quarter of the global burden, especially those born to women under 20 years of age. The major causes of death of under-5s who survive birth were pneumonia, diarrhea and undernutrition.[37] Open-field defecation, especially by poor families in rural settings who lacked proper sanitation facilities and faced exposure to open sewage due to poorly engineered pipes, enabled fecal contamination of water sources.[38] Relatively low rates of immunization against basic infectious diseases--for BCG (tuberculosis), measles, diphtheria, pertussis, tetanus and poliomyelitis—was another major factor contributing to the morbidity and mortality of children. India lagged behind the global average, despite being the so-called pharmacy of the global South. Many experts blamed vacant staff positions and absenteeism, defunct cold-chain equipment and weak surveillance

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35 Source: *National Family Health Survey (NFHS-I), India, 1992-93* (Bombay: International Institute of Population Studies: August 1995), and *National Family Health Survey (NFHS-II), India, 1997-98* (Mumbai: International Institute of Population Studies: October 2000).

36 Unless otherwise noted, the following draws on the *National Health Policy 2002*, p. 4.

37 Vinod Kumar Paul, Harshpal Singh Sachdev, Dileep Mavalankar, Prema Ramachandran, Mari Jeeva Sankar, Nita Bhandari, Vishnubhatla Sreenivas, Thiagarajan Sundararaman, Dipti Govil, David Osrin and Betty Kirkwood, "Reproductive health, and child health and nutrition in India: meeting the challenge," *The Lancet*, Volume 377, Issue 9762 (22 January 2011), pp. 333-334.

38 John et al, "Continuing challenge of infectious diseases in India," p. 253.

mechanisms. However, they also noted inadequate community participation and insufficient efforts to change damaging social practices.[39] Mistaken popular beliefs, particularly that individuals or imbalanced bodily forces led to the contraction of specific diseases, often led families to avoid seeking proper care. The use of traditional medicine was beneficial for many ailments. Yet such practices were unable to detect the microbial pathogens that activated specific diseases.[40] The accumulation of these critical early deficits in basic health capabilities predisposed children who survive past five years to lower educational attainment and personal income in their adult lives.[41]

Although harder to estimate correctly,[42] maternal mortality had several medical causes: hemorrhage and sepsis, complications from abortions, and hypertension.[43] These factors clearly exposed the lack of adequate facilities and trained health professionals in many parts of the country, especially in the rural sector. Yet the deeper social cause of such high rates remained the lower status of girls and women. The persistence of unequal educational opportunities between boys and girls led to early marriage and childrearing for many women, less or unremunerated work, and inadequate access to and control over family planning, including abortion services. Rates of fetal, infant and child mortality, and poor fetal growth and low birthweight of many children born, reflected these gender-based disparities.[44] And while the use of contraception by married women increased over time, contributing to a steady decline in the total fertility ratio, female sterilization accounted for two-thirds of total prevalence rates in the 1990s, due to lack of awareness and gender power imbalances.[45]

Several campaigns against communicable diseases achieved important successes, notably leprosy[46] and HIV. The advances made against the last were in no small part due to the massive global attention it received, securing adequate funding and political support in turn. A resurgence of malaria in late 1990s, especially the P-Falciparum variant, expanded its incidence to 50 percent in the country as a whole. The incidence of TB, whose rate of infection among

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[39] Paul et al, "Reproductive health, and child health and nutrition in India," p. 337.
[40] John et al, "Continuing challenge of infectious diseases in India," p. 253.
[41] Paul et al, "Reproductive health, and child health and nutrition in India," pp. 333-334.
[42] Indrani Gupta, "Health indicators," in Kaushik Basu and Annemie Maertens (eds), *The Concise Oxford Companion to Economics in India* (New Delhi: Oxford University Press, 2012), p. 499.
[43] Paul et al, "Reproductive health, and child health and nutrition in India," p. 333.
[44] Anita Raj, "Gender equity and universal health coverage in India," *The Lancet*, Volume 377, Issue 9766 (19 February 2011), p. 618.
[45] Paul et al, "Reproductive health, and child health and nutrition in India," p. 333.
[46] In December 2005, leprosy had been eradicated at the national level, using the standard measure (<1 case/1000 population). However, it remained prevalent in approximately one-fifth of districts across the country. See *Eleventh Five-Year Plan*, p. 63.

children had not declined since the 1970s,[47] showed little improvement. If anything, there were signs of increasing drug resistance in the population at large. By 2000, the pathogen afflicted more than eight million individuals.[48] Common water-borne infections, such as gastroenteritis, cholera and some forms of hepatitis, continued to afflict too many. Health officials estimated that vector-borne diseases affected more than two million persons by 2005.[49]

The negative ramifications of such trends were significant. Apart from the intrinsic cost of poor health for individuals, families and communities, a survey conducted in 1992 by the National Council of Applied Economic Research revealed that health-related costs were the second most important determinant of indebtedness among poor rural families. The reliance upon private medical care, in turn, reflected the lack of adequate public services. In 1997, the Voluntary Health Association of India submitted a report that characterized these services "in an advanced state of decay". A subsequent analysis of CHCs by the Planning Commission in 1999 reached a similar conclusion: none of them were found to be working at an optimal level.[50] And the wider ecological determinants of health were also severely wanting. Access to safe drinking water and proper sanitation in the countryside was extremely limited. The former grew in the decade after the big bang of economic liberalization began from approximately 55 percent of the rural population to 73 percent in 2001, a salutary change. Yet the latter, while nearly doubling over this period following the launch of the Central Rural Sanitation Programme in 1986, remained a paltry 17 percent of the rural population – the lowest provision in South Asia (see Figure 3).[51]

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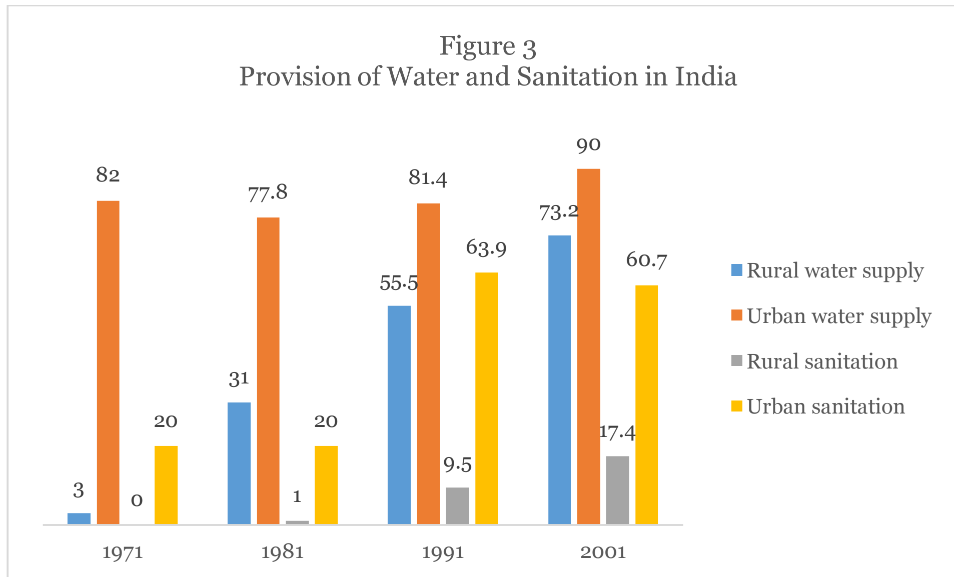
[47] John et al, "Continuing challenge of infectious diseases in India," pp. 255-256.
[48] *National Commission on Macroeconomics and Health*, p. 28.
[49] *National Commission on Macroeconomics and Health*, p. 28.
[50] Banerji, "Politics of rural health in India," p. 3256.
[51] Data from the Planning Commission, Government of India: see http://planningcommission.nic.in/data/datatable/0306/table%20234.pdf. For comparative data on South Asia, see *HDR 2003*, p. 59.



The relatively mediocre performance of public health services in India had several plausible causes. Yet the low fiscal commitment of the state was a major contributing factor. According to the Planning Commission, health spending as a proportion of total government expenditures (Central and state) declined from 3.12 percent in 1992-93 to 2.99 percent in 2003-04. The corresponding figures, as a percentage of GDP, decreased from 1.01 percent to 0.99 percent over this period. Thus per capita public spending on health, in nominal terms, rose from Rs. 89 in 1992-93 to Rs. 215 in 2003-04. But its real value at the end of this period was merely Rs. 122.[52] The implementation of liberal economic reforms in India in 1991 had squeezed central government expenditure, particularly in the social sector.

Health policy reforms from 2000 to 2005

The start of the twenty-first century inaugurated a shift in national health policy in India, reflecting a confluence of efforts and multiplicity of actors and institutions, domestic and international. In September 2000, India signed the Millennium Declaration at the UN General Assembly, committing every country to achieve eight Millennium Development Goals (MDGs) by 2015. Six of the eighteen targets and fifteen of the 53 indicators that operationalized these goals directly concerned basic health outcomes. A number of other goals, to achieve universal primary education and promote gender equality, had a clear indirect bearing on specific health outcomes.[53]

[52] *Eleventh Five-Year Plan*, pp. 106-07.
[53] See *Millennium Development Goals: Final Country Report of India* (Ministry of Statistics and Programme Implementation, Government of India, 2017), pp. 16-18. Available at: http://www.indiaenvironmentportal.org.in/files/file/MDG_Final_Country_report_of_India.pdf.

Goal 1: Eradicate extreme poverty and hunger	Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger.
Goal 4: Reduce child mortality	Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate.
Goal 5: Improve maternal health	Target 6: Reduce by three quarters, between 1990 and 2015, the maternal mortality rate.
Goal 6: Combat HIV/AIDs, malaria and other diseases	Target 7: By 2015, have halted and begun to reverse the spread of HIV/AIDS. Target 8: Have halted and begun to reverse the incidence of malaria and other diseases, principally TB.
Goal 7: Ensure environmental sustainability	Target 10: Have, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

How the signatories to the Declaration would achieve the MDGs in terms of policy change and institutional reform remained critical questions.

Yet the turn of the millennium also spurred progressive social movements in India. The most important in the field of health was the Jan Swasthya Abhiyan/People's Health Movement. In November 2000, it convened a National Health Assembly in Kolkata, bringing together more than 2000 delegates from 19 states representing medical professionals, health activists, women's groups, science movements and trade unions.[54] Its National People's Health Charter proclaimed:

> We declare health as a justiciable right and demand the provision of comprehensive health care as a fundamental constitutional right of every one of us.

Constitutionally, the right of citizens in India to adequate health care was a non-justiciable entitlement under the Directive Principles of State Policy. However, since the mid 1980s the Supreme Court had issued several judgments that interpreted certain entitlements as integral to the right to life under Article 21, a fundamental justiciable right. In *Parmanand Katara v. Union of India* (1989), the Court observed that no medical establishment could refuse to treat a critically ill patient. In *Consumer Education and Research Centre v. Union of India* (1995), it issued safety guidelines for asbestos workers. The following year the Supreme Court declared, in *Paschim Banga Khet Mazdoor Samity v. State of West Bengal* (1996), the state had an obligation to provide emergency medical care regardless of its perceived financial constraints. And in *State of Punjab v. Mohinder Singh Chawla* (1997), the Court observed that the state had a constitutional obligation to provide health facilities to government workers, or reimburse them

[54] Ravi Narayan, N.H. Antia, B. Ekbal and T. Sundararaman, "A People's Charter for Health and beyond," *The National Medical Journal of India*, 14, 2 (2001): 67-70.

for private medical treatment. Yet none of these judgments defined what a right to health comprehensively entailed.[55] Hence the latter remained an aspiration for public health activists.

Apart from its holistic vision regarding the wider determinants of social well-being, the Charter challenged the top-down, mission-oriented bio-medical approach to healthcare in India. Specifically, it criticized the increasing corporatization, subsidization and commercialization of medical care. It was also unimpressed with the “charity-based approach” of the MDGs.[56] Instead, it advocated the establishment of comprehensive primary health care, as envisioned in the 1978 Alma Ata Declaration. To realize such a vision entailed many reforms. Chief among them were an increase in public health expenditure to 5 percent of GDP; a commitment to decentralized planning, participatory decision-making and community-based interventions, and a rationalized drug policy; and greater medical training in government colleges, focusing on primary care and public health, and compulsory rural postings for graduates.[57] Yet the so-called Calcutta Declaration was part of a broader dissatisfaction with the format and process of conventional health policy in the WHO and the implications of the creation of the World Trade Organization for access to medicine and the privatization of healthcare.[58] Hence delegates from India joined forces with 1350 counterparts representing more than 100 countries in Dhaka in December 2000, demanded a right to health through comprehensive public care. India would become the largest chapter in the global movement and the site of one of its three coordinating offices.

Shortly thereafter, the WHO Commission on Macroeconomics and Health submitted its Report, in December 2001. Chaired by the American economist Jeffrey Sachs, its eighteen commissioners included Manmohan Singh, the former Union finance minister in the Congress minority government of Narasimha Rao (1991-1996), which began to liberalize the Indian economy in 1991.[59] The Commission reiterated the intrinsic value of good health for reducing human suffering and extending life expectancy, as well as its instrumental value for lowering income poverty, enhancing labor productivity and spurring economic growth.[60] It recommended

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[55] See Sharanjeet Parmar and Namita Wahi, “Citizens, courts and the right to health: between promise and progress?” in Alicia Eli Yamin and Siri Gloppen (eds), *Litigating Health Rights: can courts bring more justice to health?* (Cambridge: Harvard University Press, 2011), pp. 155-189.
[56] Interview, public health activist, New Delhi, 18 August 2015.
[57] See Jan Swasthya Abhiyan, *People’s Health Charter*: http://phmindia.org/wp-content/uploads/2015/08/Indian_Peoples_Health_Charter.pdf.
[58] Interview, public health activist, New Delhi, 18 August 2015.
[59] The other commissioner from India was Isher Judge Ahluwalia, then director of the Indian Centre for Research in International Economic Relations, in New Delhi.
[60] The following highlights key points of the Executive Summary of the *WHO Commission on Macroeconomics and Health: investing in health for economic development* (Geneva: World Health

low and middle-income countries to focus their efforts on controlling infectious diseases and improving child and maternal health through a dramatic scaling up of essential health services. Specifically, the Commission advised governments to double public health spending through domestic resource mobilization and improved budgetary reallocation. It also recommended various institutional reforms, empowering local health centers, fostering community participation and enhancing political accountability, to create a "close-to-client" system. Finally, the Commission called for a five-fold increase in external financial assistance from bilateral donors and multilateral agencies, particularly for Sub-Saharan Africa. Nonetheless, citing limited domestic capacities and continuing donor interest, it advised governments to maintain vertical disease-control programmes.[61] To initiate action, the Commission urged countries to set up national commissions by 2002, to analyze their respective deficits and formulate a plan of action.

The ruling National Democratic Alliance, led by Prime Minister Atal Bihari Vajpayee of the Bharatiya Janata Party (BJP), did not follow through. Yet it unveiled a new framework, the National Health Policy 2002 (NHP 2002), which addressed many issues raised by the Commission on Macroeconomics and Health and the People's Health Movement. Seeking "to achieve an acceptable standard of good health among the general population of the country", the NHP 2002 candidly identified many challenges. First, the Policy recognized that existing health resources in the public sector were very inadequate. Essential drugs were often unavailable or insufficient, the number of staff often fell below required norms, and the buildings and equipment were often dilapidated or overcrowded. Hence estimates that less than half of those seeking medical attention went to a public hospital.[62] Save for polio and HIV/AIDS, the national disease surveillance network was "extremely rudimentary", and extended only up to the district level.[63] And mental health disorders remained largely neglected.[64] Second, the NHP 2002 recognized that private sector facilities significantly contributed towards secondary and tertiary-level care. Yet it acknowledged that many perceived these services to be "uneven", "exploitative" and under-regulated, especially the growing number of paramedical personnel.[65] Third, the Policy noted the imbalanced distribution and uneven quality of medical colleges across the country. Many quarters perceived standard medical training either too theoretical, outdated or

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Organization, 2001):
http://apps.who.int/iris/bitstream/handle/10665/42463/a74868.pdf?sequence=1&isAllowed=y.

[61] Banerji, "Politics of rural health in India," p. 3255.

[62] *NHP 2002*, p. 9.

[63] Ibid, p. 17.

[64] Ibid, p. 13.

[65] Ibid, p. 15.

incomplete, given recent developments in molecular biology and gene manipulation, or even scarce in fields of anesthesiology, radiology and forensic medicine. Indeed, public health and family medicine were generally underserved areas of training.[66] Fourth, the NHP 2002 criticized the prevailing strategy of Information, Education and Communication (IEC) as “too fragmented” and “too heavily [reliant] on the mass media”. As a result, it “[did not] address the needs of [many poor citizens]”.[67] Lastly, the Policy recognized that discrimination towards girls and women in education, healthcare and work,[68] and unsafe drinking water, inadequate sanitation and polluted air, contributed heavily to morbidity and disease. The inherent multidimensionality of health thus enjoined strong inter-sectoral coordination.[69]

To overcome these myriad challenges, the NHP 2002 proposed “establishing new infrastructure in deficient areas, and … upgrading the infrastructure in … existing institutions” through greater “public health investment” by the Centre, and increasing access to traditional medicine. Indeed, it aspired to increase the utilization of public health facilities to more than 75 percent.[70] Yet the Policy also sought to bolster the contribution of the private sector, particularly for those with the ability to pay.[71] Indeed, given the failure to achieve the goals set out in the 1983, it advised “pitch[ing] [current aspirations] at a level consistent with our realistic expectations of financial resources, and about the likely increase in Public Health administrative capacity”.[72] Various time-bound goals were announced: to eradicate polio, yaws and leprosy, and kala azar, and to establish an integrated system of disease surveillance and National Health Accounts and Health Statistics, by 2005; to stabilize the growth of HIV/AIDS by 2007; and to reduce the incidence of malaria, TB and other vector diseases by 50 percent, and the IMR to 30/1000 and MMR to 100/100,000, by 2010.

To achieve these myriad goals, the NHP 2002 presented a five-pronged strategy. First, it pledged to raise total public health expenditure to two percent of GDP. This required state-level contributions and central grants to increase from 5.5 to 8 percent and from 15 to 25 percent of total health spending by 2010, respectively. Given the fiscal constraints facing most states, the Union government would be responsible for raising public expenditure. To promote equity, the Policy recommended that primary care should receive 55 percent of the latter, with 35 and 10

[66] Ibid, pp. 11-12.
[67] Ibid, p. 14.
[68] Ibid, p. 20.
[69] Ibid, p. 19.
[70] Box IV, Ibid, p. 23.
[71] Ibid, pp. 22-23.
[72] Ibid, p. 5.

percent for secondary and tertiary care, respectively.[73] It also promoted raising spending on research, especially for new therapeutic drugs and tropical disease vaccines, to one percent of total health spending by 2005 and two percent by 2010.[74] Yet the NHP 2002 failed to recommend an earmarked health cess on grounds that it would constrain the ability of the Centre to adjust government spending when necessary.[75]

Second, the Policy highlighted the need to reorganize public health facilities. Vertical programmes for TB, malaria and HIV/AIDS as well as universal immunization had a positive impact, it noted, yet proved costly and difficult to sustain. Moreover, a widespread perception existed that rural health staff predominantly focused on family planning. Indeed, "there [was] no identifiable service delivery system at all" for programmes lacking a vertical structure. Consequently, the NHP 2002 envisaged the gradual convergence of all health programmes under a single field administration, where rural health staff could perform myriad tasks.[76] It also encouraged the establishment of autonomous implementation bodies at the district and state level to provide greater operational flexibility and well-informed decision-making.[77] Given the unavailability of many essential medicines in public health facilities in many states beyond those in the south, it proposed to provide a basket of basic generic drugs through central government funding, which in turn might revive public facilities.[78] A fully operationalized integrated disease control network from the lowest rung to the central government, with baseline estimates of the incidence of various common diseases, would have to be established.[79]

Third, to bolster human resources, the NHP 2002 encouraged the states to consider a mandatory two-year posting for medical student graduates, enabling the development of 'licensed medical practitioners', and simplifying the procedures for hiring contract employees in order to expand the pool of providers in rural areas. It urged states to decentralize programme implementation to the panchayats.[80] And the Policy emphasized the need to revise medical curricula towards a more needs-based syllabus with greater practical training, to progressively allocate 25 percent of seats in postgraduate courses to public health and family medicine, and to improve the ratio of nurses to doctors by subsidizing more training facilities.[81]

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[73] Ibid, pp. 24-25.
[74] Ibid, p. 33.
[75] Ibid, p. 40.
[76] Ibid, p. 9.
[77] Ibid, pp. 25-26.
[78] Ibid, p. 27.
[79] Ibid, p. 35.
[80] Ibid, pp. 28-29.
[81] Ibid, pp. 30-31.

Fourth, the NHP 2002 presented several proposals regarding the private health sector. It emphasized the need to legislate minimal standards for personal conduct and physical infrastructure. Yet it also called for exploring the utility of private insurance schemes through pilots.[82] Indeed, rather than seeking to constrain the private sector, the Policy encouraged the latter to provide tertiary health services for overseas customers in order to increase their profitability and earn foreign exchange.[83]

Finally, the NHP 2002 emphasized the importance of expanding public awareness. To do so, it advocated greater reliance on traditional media to promote behavioral change and on NGOs to monitor the impact of these activities.[84]

The Policy generated a range of reactions among professionals, activists and scholars. Overall, a survey of many relevant stakeholders in the *International Medical Journal of India* revealed a consensus on bolstering public facilities in rural sector, regulating private actors and enhancing community participation. Yet disagreement arose over whether it was prudent to maintain vertical disease control programmes, roll out health insurance schemes and empower *sarpanches* to monitor local doctors.[85] Two specific reviews, whose assessments diverged, probed more deeply. On the one hand, V. Mohanan Nair commended its concern over persistent absolute deprivations among many vulnerable groups and found the new Policy to be realistic. Yet he raised several concerns. First, integrating vertical programmes was hard to do and may worsen accountability. Granting financial autonomy to state health societies may too, as well as the scope for professional decision-making. Second, the reluctance of individuals to utilize public health facilities was a national problem (albeit lesser in the south) due to factors other than lack of drugs, such as rural connectivity, low public awareness and poor community involvement. Indeed, simply raising spending without improving these intermediary factors would likely frustrate stated objectives. Third, compulsory rural service for college medical graduates was a good idea. But revising curricula in existing medical colleges would prove inadequate. And producing a cadre of licensed medical practitioners would lead to "rampant quackery". Ultimately, Nair argued, improving the performance of public health services in the rural sector enjoined the states to establish public health cadres with attractive remuneration, good job prospects and career development. Tamil Nadu provided a model.[86]

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[82] Ibid, pp. 34-35.
[83] Ibid, p. 38.
[84] Ibid p. 33.
[85] Anand et al, "Consensus and conflicts in health sector reforms in India," pp. 224-226.
[86] V. Mohanan Nair, "Draft National Health Policy 2001: a leap forward in assessment but limping in strategies," *International Medical Journal of India*, 15, 4 (2002): 216-221.

On the other, Sen Gupta found the NHP 2002 unsatisfactory along several dimensions. He contended that an excessively top-down drafting process excluded state governments as well as the Central Council of Health and Family Welfare, established in 1988 to provide advice to the Ministry. As a result, the Policy had many substantive omissions as well as commissions. Most importantly, it omitted the concept of universal and comprehensive health care, contra the NHP 1983, as well as importance of village health workers. Hence the Policy failed to engage women's health and completely ignored child health. Second, it maintained vertical control initiatives and a leading role for the central government in designing health programmes, despite acknowledging the negative ramifications of the former and need to enhance state participation in the latter. The pledge to increase public spending to two percent of GDP remained far less than the five percent target recommended by the WHO and endorsed by the public health movement. Third, although the NHP 2002 registered the importance of decentralization, greater spending and integrating public services, it failed to prescribe the policies necessary to achieve these ends. Similarly, expanding family medicine in postgraduate training was a salutary idea. But it failed to address the expansion of private medical colleges. Indeed, the recommendation to allow private health providers to cater to overseas patients to earn foreign exchange, and to develop private insurance on an experimental basis, would merely enhance their predominant role. Thus, even if the Centre raised its contribution to two percent of GDP by 2010, the country would remain one of the most privatized health systems in the world.[87]

The formulation of the NRHM

The 2004 general election proved to be a critical turning point. The NDA, having called an early poll to exploit the popularity of Prime Minister Vajpayee, recent victories by the BJP in several key states and rising economic growth, campaigned on the slogan "India Shining". It suffered a stunning political defeat. Many observers claimed it was a rejection of greater economic liberalization, rising social inequalities between classes, sectors and regions, and militant Hindu nationalism. The causes of the verdict were more complex. Yet the NDA had failed to address mounting social distress in the rural hinterlands of many states. In contrast, the Congress party had campaigned in the name of the *aam aadmi* (common man), acquiring a new electoral base that disproportionately represented socially marginalized groups. Short-term

[87] Amit Sen Gupta, "National Health Policy 2002: a brief critique," *International Medical Journal of India*, 15, 4 (2002): 215-216.

political tactics rather than a transformational social agenda facilitated its success.[88] Nevertheless, the party deftly cobbled together a multiparty coalition, named the United Progressive Alliance (UPA).

Significantly, the new ruling dispensation committed itself to implementing a National Common Minimum Programme, committed to pursuing "economic reform with a human face".[89] On the one hand, the UPA vowed to cut the fiscal deficit to redirect scarce resources towards social investment, encourage private investment in industry and manufacturing, and enhance the commercial autonomy of competitive public undertakings. On the other, it pledged to promote employment, agricultural development and social welfare of marginalized social groups. To coordinate policy, the UPA established a National Advisory Council, chaired by Sonia Gandhi, which brought together many leading public intellectuals, social activists and government officials to formulate progressive initiatives. They proceeded to devise a series of groundbreaking national measures to expand the economic security and social opportunities of its citizens. Strikingly, many of these new entitlements became acts of parliament, and thus legally enforceable rights. During its first tenure in office (2004-2009), the UPA passed the Right to Information Act, 2005, mandating all government agencies to release information regarding their activities to individual citizens upon request in a timely manner. The National Rural Employment Guarantee Act, 2005, which sought to protect the livelihoods of poor agricultural laborers during periods of distress, granted adult members of every rural household the right to demand 100 days of unskilled work at stipulated minimum wages from the state, making it the largest work guarantee programme in the world. The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act (FRA), 2006, empowered such communities the right to own traditionally cultivated land and to protect forests. Finally, the Right of Children to Free and Compulsory Education Act, 2009, made the enrollment, attendance and completion of schooling of every child between the age of six and fourteen the obligation of the state.

Historically, the severe health deficits facing the country had garnered little attention in electoral campaigns, parliamentary debates or media coverage.[90] Nonetheless, the National Common Minimum Programme made specific pledges in the domain of health. The UPA vowed

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[88] See Yogendra Yadav, "The elusive mandate of 2004," *Economic & Political Weekly*, 39, 51 (18 December 2004): 5383-5395.
[89] Unless otherwise noted, the following summary and quotations are from the Common Minimum Programme: https://www.thehindu.com/2004/05/28/stories/2004052807371200.htm.
[90] According to Drèze and Sen, approximately one percent of editorials in mainstream English press in the early twenty-first century addressed health issues, and less than five percent of all parliamentary questions concerned child care. See *An Uncertain Glory*, pp. 143-144.

to raise public spending on health minimally to between "two and three percent of GDP by 2009, with focus on primary healthcare"; "to introduce a national scheme for health insurance for poor families"; and to "step up public investment in programmes to control all communicable disease and also provide leadership to national AIDS control effort". The governing coalition also pledged to "take all steps to ensure availability of life-saving drugs at reasonable prices … [especially for] poorer sections …". And it promised to universalize the ICDS, as well as a mid-day meal scheme for all schoolchildren, across the country.

Upon taking office, the UPA committed itself to addressing the severe health deficits facing the country. The new Government finally established a National Commission on Macroeconomics and Health, which had been notified on the eve of the 2004 general election. Its Report delivered an extremely frank assessment of the critical shortcomings of and many challenges facing the health sector in India.[91] The National Commission attributed the severe inadequacy and massive underutilization of public health facilities to three broad factors: "poor governance and the dysfunctional role of the state; lack of a strategic vision; and weak management". These deficiencies manifested themselves in inadequate expenditure, facilities, personnel, supplies and training; overcentralized decision-making processes and narrow vertically driven strategies; and poor resource management, regulatory controls and treatment protocols. Moreover, while acknowledging that private health providers served many needs, the Report noted the failure of the sector to offer quality care at reasonable cost on an equitable basis. The Government vowed to strengthen the public health delivery system by rectifying these myriad problems.

The centerpiece of its efforts, launched in April 2005, was the National Rural Health Mission (NRHM). Its principal aim was to improve the availability and access of rural inhabitants—especially children, women and the poor—to equitable, affordable, accountable and effective primary healthcare. To do so, the NRHM would "carry out necessary architectural correction in the basic health care delivery system", paying special attention to eighteen 'high-focus' states that had poor outcomes and/or weak infrastructure.[92] These comprised Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Himachal Pradesh, Jharkhand, Jammu & Kashmir, Manipur, Mizoram, Meghalaya, Madhya Pradesh, Nagaland, Orissa, Rajasthan, Sikkim, Tripura, Uttaranchal and Uttar Pradesh. The key objectives of the NRHM were threefold: to lower the rates of infant and maternal mortality as well as total fertility; to improve the quality of facilities

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[91] The following highlights several key points of the *National Commission on Macroeconomics and Health*, pp. 3-11. The quote below is on p. 4.
[92] Unless otherwise stated, the following draws on the official blueprint, *National Rural Health Mission (2005-2012): Mission Document* (Ministry of Health & Family Welfare, Government of India): http://www.nhm.gov.in/images/pdf/guidelines/nrhm-guidelines/mission_document.pdf.

and lower regional disparities by bolstering finances, pooling resources and raising standards; and to enhance local ownership and community participation through greater decentralization. To realize these ambitious objectives, the Mission advocated a "synergistic approach", mainstreaming traditional medical practices involving Ayurveda, yoga, naturopathy, unani, siddha and homeopathy (AYUSH), and integrating specific programmes into comprehensive health plans, and incorporating the MDG targets for India.[93]

The NRHM was a product of an intensive consultative process over six to eight months, involving several thematic groups, initiated by the Ministry of Health with some input from the National Advisory Council.[94] A progressive reformist coalition of politicians and bureaucrats, as well as intellectuals and activists, was instrumental in shaping its design. According to some health officials, then Secretary for Family Welfare P.K. Hota was keen from the start to "develop [a national] agenda" in his meetings with various donors. The newly appointed Health Minister, Anbumani Ramadoss, a medical doctor trained in Tamil Nadu, the leading state in public health, proved very receptive. Prime Minister Manmohan Singh displayed "strong political commitment" to increase public expenditure to "energize the system".[95] Key central bureaucrats also reportedly played crucial roles. Amarjeet Sinha, joint secretary in health and family welfare, provided "heart and muscle" within the administration.[96] R. Gopalakrishnan, joint secretary in the prime minister's office, enabled the "unprecedented influence" of civil society representatives, who pushed to expand its World Bank-led focus beyond reproductive and child health.[97] A key figure among the latter was Dr. Noshir Antia, the highly regarded founder of the Foundation in Research for Community Health, an important volunteer organization in rural healthcare in Maharashtra. He had collaborated with Gopalakrishnan in designing a community worker programme in Madhya Pradesh, called Jana Swasthya Rakshak.[98] In addition, several representatives from the People's Health Movement played a critical role, especially T. Sundararaman, Ravi Narain and Abhay Bang. The question of whether to actively participate and critically oppose the policies of the Government triggered a debate within the movement.

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[93] Shyam Ashtekar, "The National Rural Health Mission: a stocktaking," *Economic & Political Weekly*, 43, 37 (13 September 2008), p. 23.
[94] Interview, senior government official, New Delhi, 16 August 2016.
[95] Interviews, senior government official, New Delhi, 2 August 2016; public health activist, Mumbai, 21 August 2016.
[96] Interview, senior government official, Chennai, 13 August 2016.
[97] Interviews, senior government official, New Delhi, August 2016; and public health activist, Mumbai, 21 August 2016.
[98] K. Sujatha Rao, *Do We Care? India's health system* (New Delhi: Oxford University Press, 2017), p. 306.

Ultimately the decision to get involved was made on grounds that "otherwise it [NRHM] was bound to fail".[99]

Yet the NRHM never became a vehicle to introduce a right to health along the lines of the other rights-based acts. On the one hand, government officials claimed there was "no point in making it a right or an act [because of] the lack of essential [public] services"[100] … "unlike the Right to Education, which had built up the basic infrastructure, the gap was huge".[101] They also felt it was problematic given the many determinants of good health. On the other, public activists believed a genuine rights-based approach presumed a state "ideologically committed to redeeming those rights" and willing to devote the necessary fiscal resources.[102] Yet some acknowledged the difficulty in legislating a right to health via the NRHM given the multidimensionality of the concept, in contrast to the Right to Food, which focused on a single tangible good.[103]

A number of features and initiatives of the NRHM deserved special attention. The first key component was the introduction of a resident female Accredited Social Health Activist (ASHA) in every village. Given that other salaried health workers often failed to discharge their functions, and to infuse a sense of trust and ownership in each village, the Mission envisioned ASHAs as honorary volunteers appointed by the local panchayat.[104] However, they would receive performance-based compensation to administer vaccination, medicines and contraceptives, and to offer counselling, referral and escort services for reproductive and child health. To enable them to discharge these duties, ASHAs would initially undergo public health pedagogy for 23 days over twelve months, followed by on the job training through the year, and provided with a drug kit containing traditional as well as allopathic medicines. In addition, they would help to prepare a Village Health Plan under the direction of the panchayat, in conjunction with the Auxiliary Nurse Midwife, *anganwadi* worker and others who normally participated in these plans. Proponents of the ASHA programme strongly believed that such actors were essential to creating an effective rural health system. Hence they stressed the need to recruit, train and integrate its volunteers well, and ensure they had sufficiently good opportunities to have a sense of vocation.[105]

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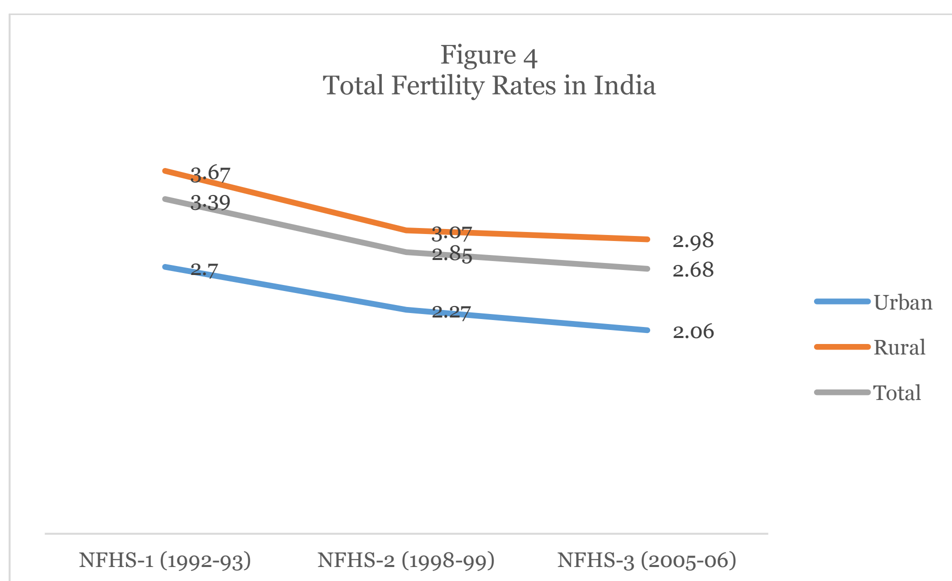
[99] Interview, public health activist, New Delhi, 14 August 2015.
[100] Interview, senior government official, New Delhi, 17 August 2015.
[101] Interview, senior government official, New Delhi, 16 August 2016.
[102] Interview, public health activist, New Delhi, 18 August 2015.
[103] Interview, public health activist, New Delhi, 14 August 2015.
[104] Interview, senior government official, Chennai, 13 August 2016.
[105] A.K. Shiva Kumar, "Budgeting for health: some considerations," *Economic & Political Weekly*, 40, 14 (2 April 2005), p. 1394.

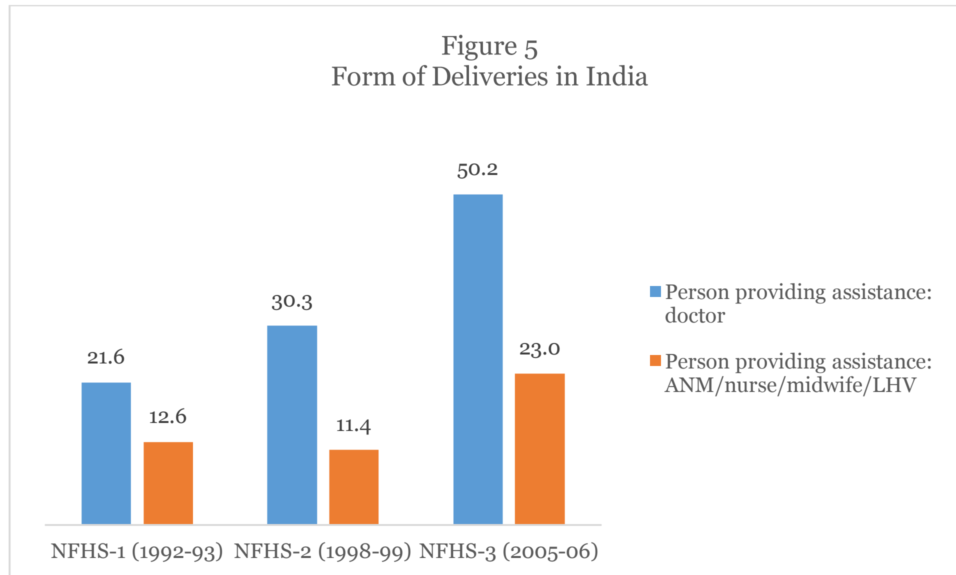
To promote reproductive and child health, the Government announced the Janani Suraksha Yojana (JSY), a centrally sponsored scheme funded entirely by New Delhi. Its aim was to encourage women to give birth in proper facilities with skilled health workers, especially in ten states with low rates of institutional delivery (Assam, Bihar, Chhattisgarh, Jammu & Kashmir, Jharkhand, Madhya Pradesh, Orissa, Rajasthan, Uttarakhand and Uttar Pradesh). Specifically, the JSY provided a conditional cash transfer of Rs. 600 and Rs. 1400 to all ASHAs and expectant mothers, respectively, who gave birth in proper health facilities in rural areas of these states. The compensation for deliveries in urban areas of the latter was Rs. 1000 and Rs. 400, respectively.[106]

Total fertility rates in India, urban as well as rural, had declined since the early 1990s (see Figure 4).

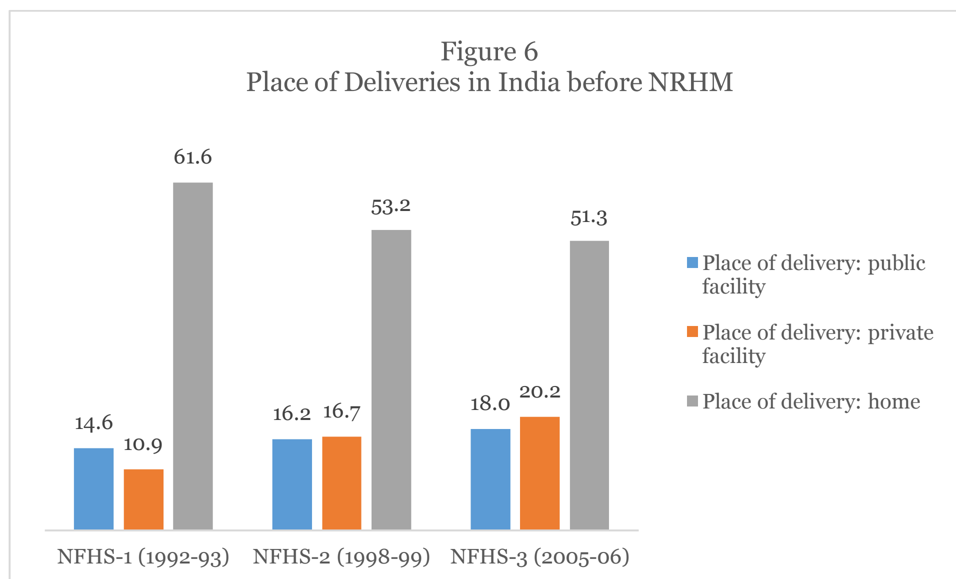


Moreover, the number of women that reported that a doctor or female health worker had assisted their deliveries rose dramatically, from roughly 20 percent in 1992-93 to 50 percent in 2005-06 (see Figure 5).

[106] In high-performing states, only mothers who had BPL (below poverty line) cards or were members of Scheduled Caste or Scheduled Tribe communities were eligible under the scheme. Expectant mothers and ASHAs in rural and urban areas of these states received Rs.700 and Rs.600 and Rs.600 and Rs.400, respectively.



Yet the percentage of births that reportedly occurred in a health facility, whether public or private, increased far less (see Figure 6).



Home-based deliveries and newborn care were not inherently less safe. The active presence of well-trained and supervised community health workers could lower infant mortality rates and empower the most disadvantaged communities to take care of their health, realizing *arogya swaraj*, exemplified by the Gadchiroli model of the pioneering voluntary organization SEARCH

in Maharashtra.[107] In the absence of such progressive associations, however, access to proper institutional facilities was valuable.

Buttressing human resources and physical facilities of SCs, PHCs and CHCs was the second key component of the NRHM. Simply put, the rural health system was "in shambles" in many parts of the country.[108] Hence the Centre pledged to cover the entire cost of the NRHM until 2007, 85 percent during the Eleventh Plan (2007-2012) and then 75 percent during the Twelfth (2012-2017). All three levels of the health system had meet new Indian Public Health Standards, which replaced the earlier population-based norms. The NRHM sanctioned creating new, or upgrading old, premises at each tier to meet these norms. To address the shortage of doctors in PHCs and integrate other knowledge, it allowed the mainstreaming of AYUSH practitioners. In addition, the NRHM empowered PHCs and CHCs to pool their block-level resources and availability of drugs, equipment and services to help improve the quality of care and to reduce absenteeism. And it proclaimed that each block should have a CHC to act as the first referral unit, with 24-hour services, including ambulances and mobile clinics in tribal and underserved areas.[109]

The commitment to strengthen the three-tiered health system was significant given the shortfall of resources at each level, which comprised staff as well as equipment and infrastructure. In aggregate terms, the number of auxiliary nurse midwives (ANM), male health workers (MHW), female and male assistants, doctors and block extension educators posted in SCs and PHCs in 2005 fell considerably short of the quantity actually required (see Figure 7).[110] Particularly acute was the lack of MHWs, which remained the responsibility of the states.

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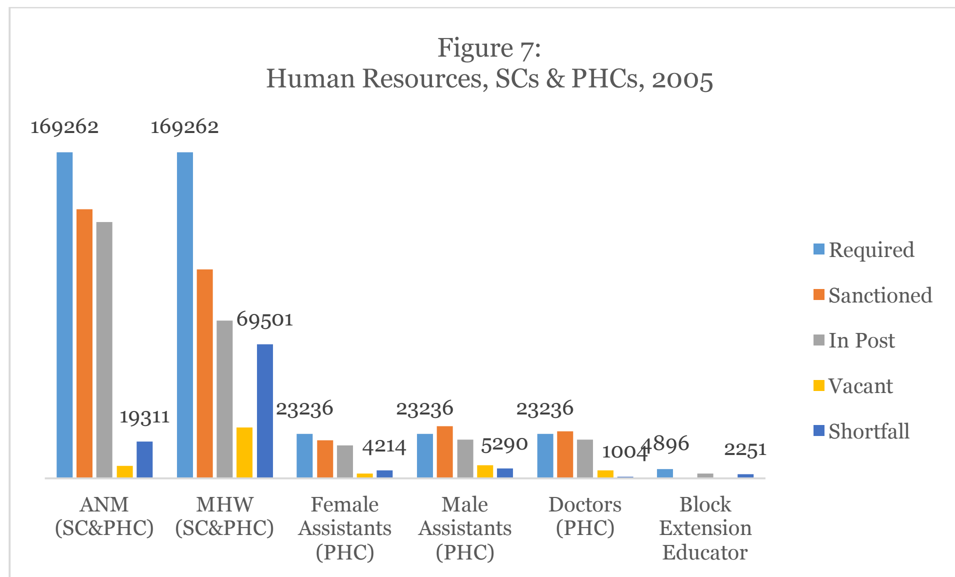
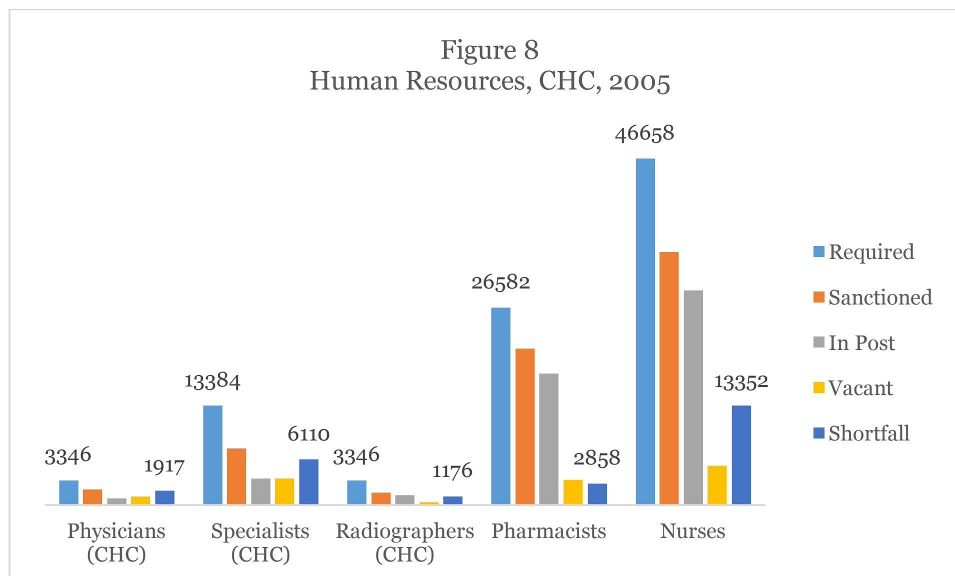
[107] See Society for Education, Action and Research in Community Health (SEARCH): http://searchforhealth.ngo/.
[108] *Eleventh Five-Year Plan*, p. 61.
[109] Kumar, "Budgeting for health," p. 1393.
[110] Source: *Rural Health Statistics in India, 2006*, Tables 17-18, 21-22 and 33, pp. 35-40 and 51 (Ministry of Health and Family Welfare, Government of India). Note: The 'Sanctioned' column for Block Educators means the number 'In Post', while 'Shortfall' means the number of posts 'Vacant', since these actors were not 'Required'. In general, several interviewees advised that data from these bulletins should be treated with caution, due to the lack of verification by independent observers. However, given that shortfalls have increased over time, there appears to be no systematic upward bias.



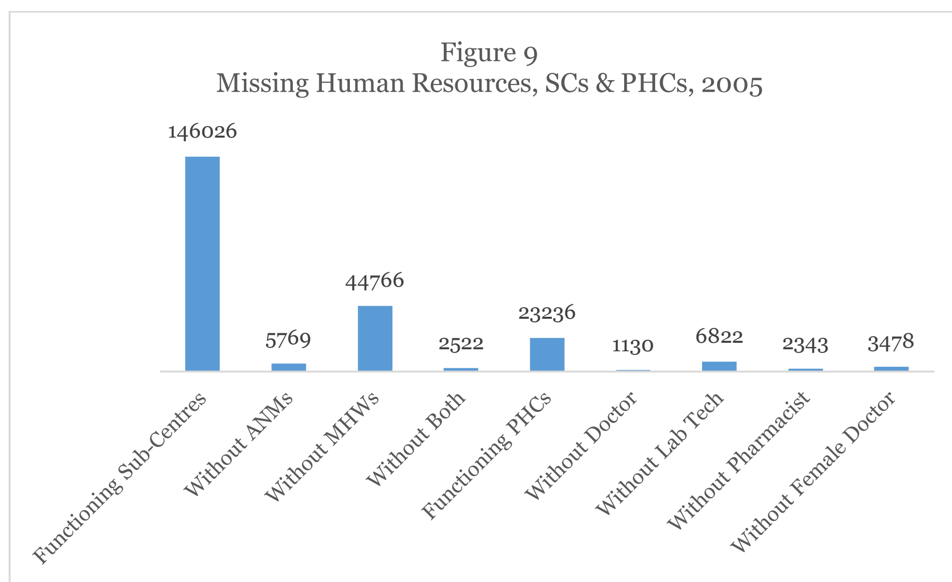
The human resource deficit among CHCs was also severe. The number of the nurses and pharmacists in post was approximately 60 percent of the requisite figure. The analogous figures for radiographers, approximately 40 percent, and physicians and specialists, roughly 25 percent, were more sobering (see Figure 8).[111]



Indeed, even ostensibly functioning SCs and PHCs lacked basic human resources to carry out routine activities (see Figure 9).[112] In 2005, while most SCs had an auxiliary nurse midwife,

[111] Source: *RHS 2006*, Tables 26, 28-29, pp. 44-47. Note: the data for Pharmacists, Lab Techs and Nurses is compiled from *Rural Health Statistics in India, 2012* (Ministry of Health and Family Welfare, Government of India), Statement 9-11, pp. 37-39, and includes the number in post in PHCs too.
[112] Source: *RHS 2006*, Tables 19 and 23, pp. 37 and 41.

more than a third lacked a male health worker. Similarly, most PHCs nominally had a male doctor, approximately ten percent lacked a pharmacist, fifteen percent lacked a female doctor and almost thirty percent lacked a lab technician.



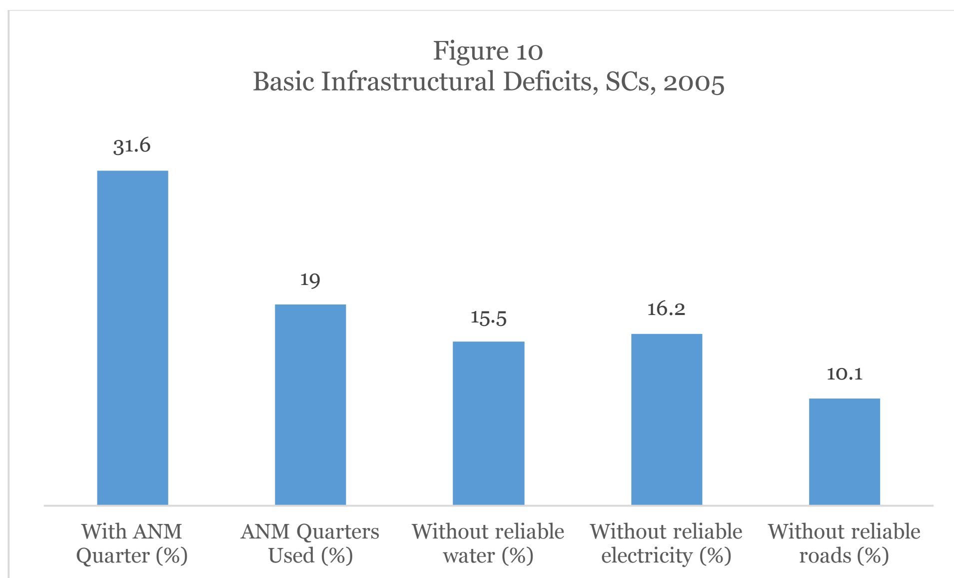
If anything, the preceding shortfalls underestimated the situation, since they neither accounted for absenteeism of rural health staff nor their unpredictability in being at work, let alone significant regional disparities. An oft-cited survey of the World Bank, conducted between 2002 and 2003, found that on average more than a third of rural healthcare staff in India were absent on any given day. Absenteeism in SCs and PHCs, especially in poorer states and remote areas, was even worse. The lack of transportation and various service amenities, and opportunities for public doctors to moonlight, were contributing factors.[113] It was especially a concern in non-southern states, which had roughly one third of the population of the country, but two-thirds of its medical colleges and nursing institutions.[114]

Hence in 2006, to improve the availability of reliable tertiary healthcare in the country and to correct regional imbalances in medical education, the Centre unveiled the Pradhan Mantri Swasthya Suraksha Yojana (PMSSY). The initiative established six new All India Institutes of Medical Sciences in Bihar (Patna), Chhattisgarh (Raipur), Madhya Pradesh

[113] Nazmul Chaudhury, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan and F. Halsey Rogers, "Missing in action: teacher and health worker absence in developing countries," *Journal of Economic Perspectives*, 20, 1 (Winter 2006): 91-116.
[114] Rao et al, "Human resources for health in India," p. 593.

(Bhopal), Orissa (Bhubaneswar), Rajasthan (Jodhpur) and Uttaranchal (Rishikesh). It also provided funds to upgrade thirteen existing medical institutions in various states.[115]

Indeed, basic infrastructural deficits at an all-India level further hampered the functioning of SCs and PHCs that had the requisite health staff, as well as their accessibility. The majority of SCs lacked a separate quarter for auxiliary nurse midwives to perform their duties, and utilization of these facilities was approximately 60 percent. In addition, ten to fifteen percent of SCs lacked reliable electricity, roads and water (see Figure 10).[116]



Corresponding measures for PHCs were generally better. Yet only half of them had the requisite number of beds for patients and even few possessed a delivery room or operation theatre (see Figure 11).[117]

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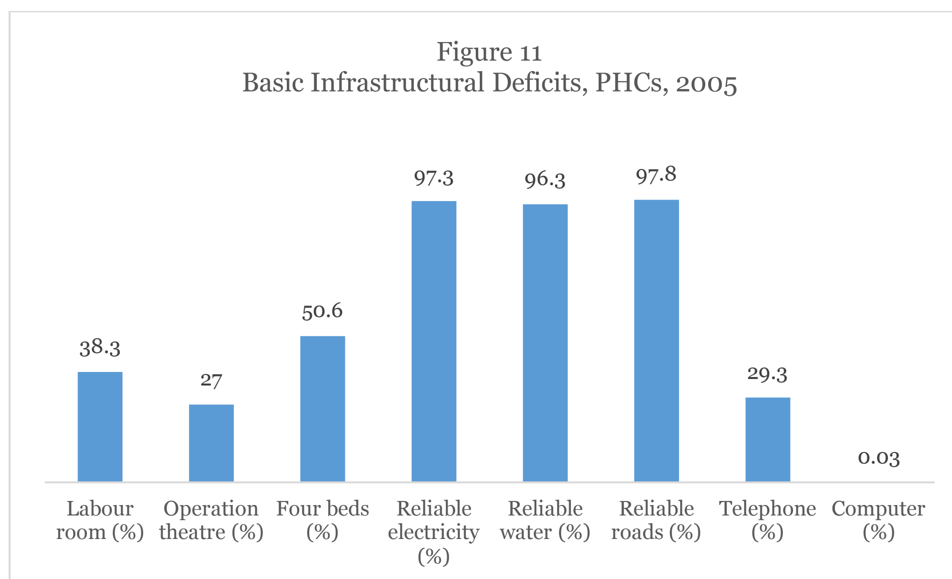
[115] For basic details, see the website of the Pradhan Mantri Swasthya Suraksha Yojana: http://pmssy-mohfw.nic.in/history.aspx.
[116] Source: *RHS 2006*, Tables 35a-b, pp. 53-54. Note: 2006 figures calculated using state figures, since no all-India was provided.
[117] Source: *RHS 2006*, Tables 36 and 37, pp. 55-56. Note: 2006 figures calculated using state figures, since no all-India was provided.



Hence the NRHM permitted high focus states to direct up to a third, and other states a quarter, of their allocation towards infrastructure.[118]

The third key component of the NRHM was enhancing the capacity of states, districts and villages to determine their own priorities and enhance their participation in decision-making. The NRHM tasked gram panchayats, district administrations and state governments to produce Village Health Plans, District Health Plans and State Health Plans, respectively. These bodies could request NRHM funds for five specific domains: RCH Flexi Pool (for reproductive, maternal, new born and child health); NRHM Mission Flexi Pool (to strengthen health resource systems, innovations and Information, Education, Communication (IEC) initiatives); Immunization; National Disease Control Programme (NDCP); and Infrastructure Maintenance. That said, SCs, PHCs and CHCs could spend untied grants worth Rs. 10,000, Rs. 25,000 and Rs. 50,000, respectively. Central allocations would be disbursed through autonomous implementing bodies, State Health Societies and District Health Societies (involving elected representatives, health department officials and other stakeholders), crucially allowing unspent funds in any given fiscal year to be carried over. In addition, to promote institutional complementarity and policy convergence, District Health Plans would amalgamate Village Health Plans and vertical control programmes, as well as other related initiatives such as the Total Sanitation Campaign and ICDS.[119] Lastly, many earlier programmes called for development and promotion of self-help attitudes, organizing the poor to demand their basic

[118] *National Rural Health Mission: Framework for Implementation: 2005-2012* (Ministry of Health & Family Welfare, Government of India), p. 2.
[119] Kumar, "Budgeting for health," p. 1393.

rights, and active community participation. To promote accountability of public health providers to their communities and a sense of ownership, the NRHM enjoined the creation of Village Health and Sanitation Committees (VHSCs) and Rogi Kalyan Samitis (RKS), 'Patient Welfare Societies'. Convened by the resident ASHA as a sub-committee of the gram panchayat, the VHSC would comprise minimally fifteen members, half of whom should be women. It would plan, integrate and monitor various health-related services on behalf of its community, including hygiene, sanitation and drinking water. Analogously, the RKS would be a registered body of local trustees, responsible for ensuring the proper daily running of hospital services, determining spending priorities and responding to any patient grievances. Apart from the district magistrate, medical superintendent and chief health officer of a hospital, its membership could encompass the director of AYUSH services, members of parliament, legislative assemblies and local government, and representatives of local NGOs, corporate hospitals and medical colleges. Prominent health activists claimed the establishment of ASHAs and community-based monitoring reflected the concerns of the People's Health Movement, who had representatives on the various task forces that designed the Mission.[120] Some wished the role of local civic participation had been emphasized as a separate objective. Nonetheless, they felt that encouraging community mobilization was the most radical innovation of the NRHM.[121]

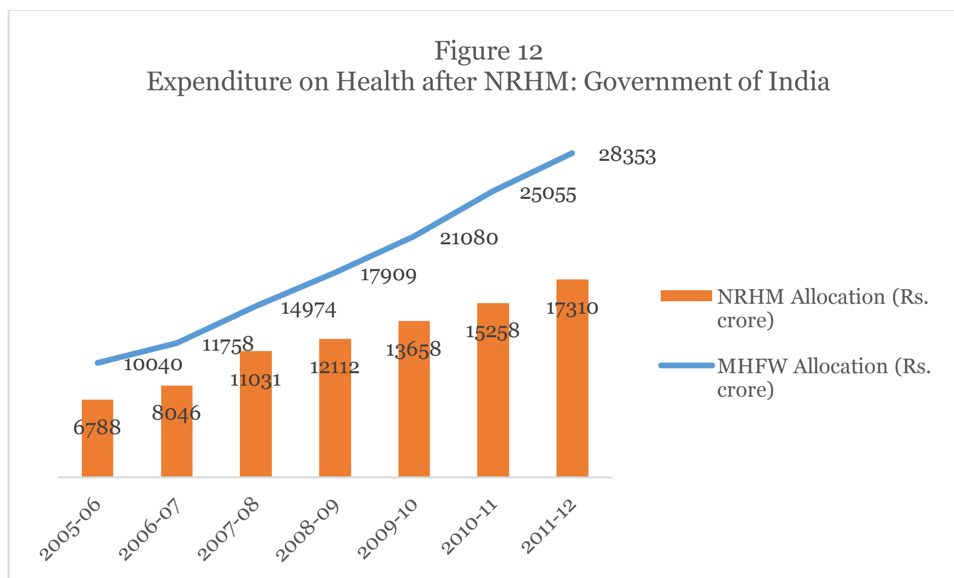
The implementation of the NRHM from 2005 to 2012

How well did the Government of India and the various states implement the NRHM between 2005 and 2012, its projected duration? Officially, the Ministry of Health and Family Welfare completed six common review missions over this period, while its Population Research Centres performed more rapid appraisals. In addition, the Comptroller and Auditor General of India conducted a performance evaluation in 2008. Finally, many independent scholars, professionals and activists have conducted their own studies. Hence a fine-grained comprehensive assessment, given the diversity of its goals and benchmarks as well as divergent performance across regions, is beyond the scope of this study. Yet it is possible to discern important trends regarding changes in the level, source and performance of expenditure; the availability, quality and adequacy of facilities, medicine and staff; and key health outcomes of morbidity and mortality. The following analyzes these parameters using official government data as well as the observations and insights of selective independent studies.

[120] Interview, public health activist, New Delhi, 18 August 2015.
[121] Ravi Narayan, "Universal health care in India: missing core determinants," *The Lancet*, 377, 9769 (12 March 2011), p. 884.

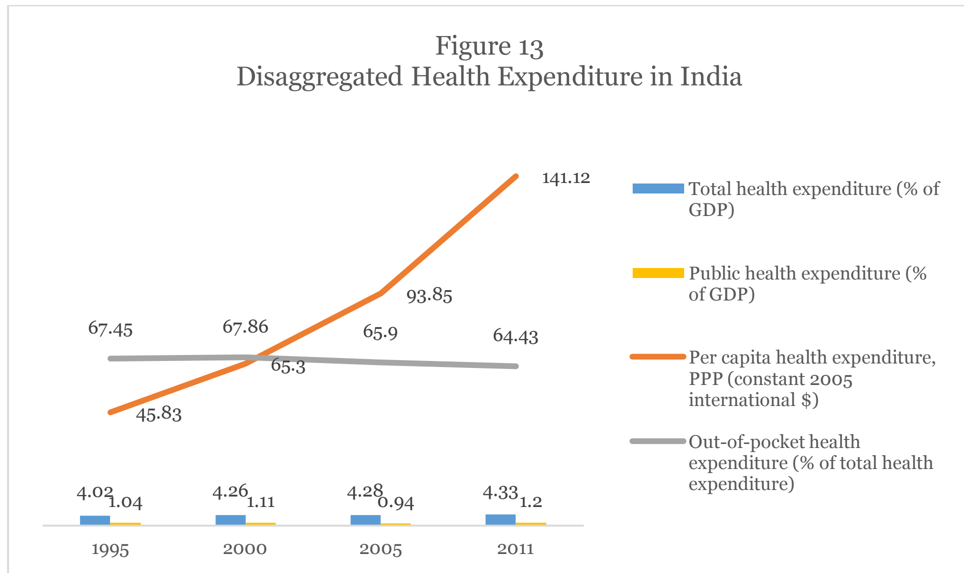
Expenditure performance

Spending on health by the Government of India rose significantly between 2005-06 and 2011-12. Budgetary allocations for the NRHM increased from Rs. 6788 crore to Rs. 17, 310 crore, while provision for the Ministry of Health & Family Welfare as a whole grew from Rs. 10,040 crore to Rs. 28, 353 crore (see Figure 12).[122]



Moreover, total health expenditure per capita roughly tripled over this period, rising from $93.85 (PPP) to $141.83 (PPP). As a proportion of GDP, however, it only increased marginally to 4.33 percent (see Figure 13). According to officials, as a proportion of total health spending, state expenditures fell as central spending increased, reflecting in turn a lack of pressure by voters and lack of interest by parties in many states.[123] And the proportion of states' budgets allocated to primary care, while higher in absolute terms, declined to some extent too.[124]

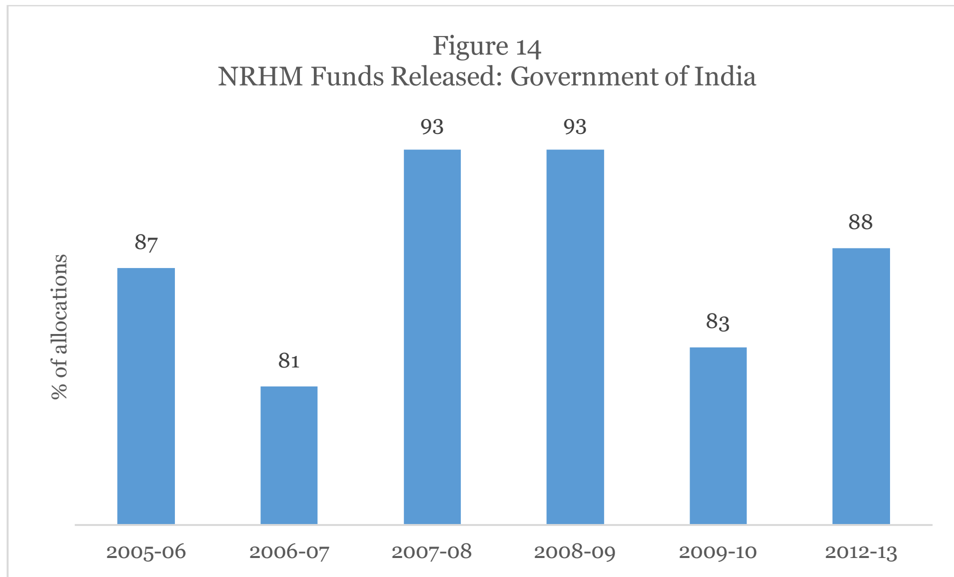
[122] Source: *Budget Briefs* for the National Rural Health Mission/National Health Mission, 2011-12, 2015-16 and 2018-19 (Accountability Initiative, Centre for Policy Research, New Delhi). Figures for all years are revised budget estimates in crores of rupees. Note: There is a slight discrepancy in the values recorded for the same year across these reports (e.g. Rs. 13,680 crore vs Rs. 13,658 crore). However, they do not affect overall trends.
[123] Interview, senior government official, New Delhi, 2 August 2016.
[124] Rao, *Do We Care?* p. 67.



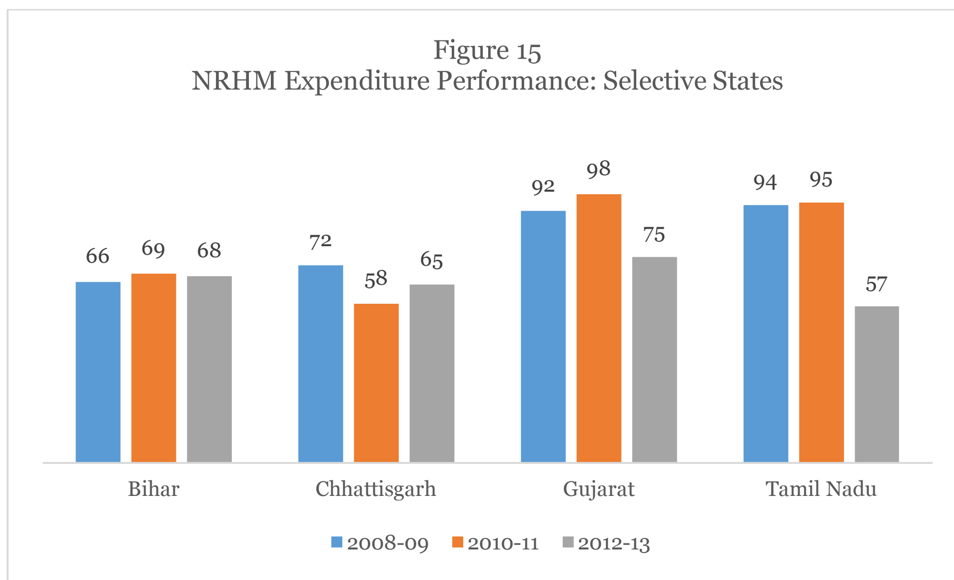
Second, the source of spending barely changed. Indeed, the analogous figure for public health expenditure (comprising all ministries, the Centre and state governments) was 1.02 percent of GDP, far short of the two to three percent goal declared in 2005. This was striking given that aggregate economic output and central government revenues in India grew at their fastest rate since independence over these years. Some government officials claimed the target was too ambitious to meet within the stipulated time-frame.[125] But the result was that private out-of-pocket expenses for healthcare remained extremely high, comprising almost 65 percent of total expenditures, and thus a terrible burden for many vulnerable groups.

Third, actual expenditure on the NRHM was less than allocated by the Government of India. On the one hand, the amount of funding released by New Delhi revealed a gap vis-à-vis proposed state allocations. The level varied over time, ranging from 81 percent in 2006-07 to 93 percent in 2008-09 (see Figure 14).[126]

[125] Interview, senior government official, New Delhi, 16 August 2016.
[126] The data are compiled from the *Budget Briefs* for the NRHM in 2011-12 (p. 2) and NHM in 2015-16 (p. 2). Note: the former shows releases to comprise 83 percent of allocations in 2009-2010, but the latter states that it was 99 percent. However, all other data are reported consistently in the series.



On the other, considerable variation existed among the states regarding their level of expenditures vis-à-vis the total resource envelope available (including approved shares and unspent balances). Indeed, many states did not spend their approved funds, "the biggest challenge" according to one of its architects.[127] This was especially true of high focus states with traditionally poorer health outcomes that actually needed to spend resources well to a greater extent, such as Bihar and Chhattisgarh, whose State Health Societies in turn were periodically slower to release funds to their districts. In contrast, large non-high focus states such as Gujarat and Tamil Nadu usually spent their funds better (see Figure 15).



[127] Interview, senior government official, Chennai, 13 August 2016.

In principle, several factors may cause poor expenditure performance at the state level. The first is bureaucratic capacity. The ability of states to formulate coherent plans, consult effectively with counterparts in the districts as well as New Delhi, and submit necessary documentation in a timely manner varies tremendously across the Union. The National Commission on Macroeconomics and Health had noted that the lack of enough bureaucratic officers adequately trained in health policy and financial management, to monitor performance and follow up administratively, often caused many delays. Complex programme design was another complicating factor.[128] Properly managing over 200 central schemes was daunting was a daunting challenge facing every state, creating an over-bureaucratized but understaffed administrative structure.[129] And frequent transfers of administrative personnel, due to changes in government and the increasing politicization of the bureaucracy in many states, exacerbated these difficulties.[130]

Thus it was hard to determine where the most important obstacles lay. On the one hand, a mid-term assessment by the Comptroller and Auditor General in 2008 found that district-level annual health plans had not been prepared in nine states, while corresponding plans at the village-level had not been formulated in 24 states.[131] Indeed, despite attempts to empower local communities, even untied funds to SCs, PHCs and CHCs went unspent, totaling Rs. 13,233 lakh at the end of the 2008 fiscal year. On the other, the accumulation of outstanding utilization certificates under various programmes and the delay in release of funds from the state health societies to their district counterparts were more significant given the sums involved.[132] Hence central health officials acknowledged slow releases from New Delhi had occurred in the early years of the NRHM. Yet they believed the primary responsibility for bureaucratic delays seemed to rest with state capitals, in developing their project implementation plans and issuing utilization certificates, limiting their capacity to absorb central funds.[133] Some claimed that "another big challenge", particularly in the northern states, was "officials frequently changed".[134]

That said, others contended that critiques of state absorptive capacity more generally failed to appreciate how relatively low funding itself made it harder for states to spend their allocations. In particular, inadequate medical supplies and infrastructural capacities at the level

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[128] *National Commission on Macroeconomics and Health*, pp. 80-81.
[129] See Devesh Kapur, "The political economy of the state," in Niraja Gopal Jayal and Pratap Bhanu Mehta (eds), *The Oxford Companion to Politics in India* (New Delhi: Oxford University Press, 2010), pp. 443-458.
[130] Interview, public health activist, New Delhi, 17 August 2015.
[131] *Report No. 8 of 2009—Performance Audit of National Rural Health Mission of Union Government, Ministry of Health & Family Welfare*, x.
[132] See Report *No. 8 of 2009*, Annexes 5.2, 5.4 and 5.6, pp. 127, 129 and 131, respectively.
[133] Interviews, senior government officials, New Delhi, 2 and 4 August 2016.
[134] Interview, senior government official, Chennai, 13 August 2016.

of SCs and PHCs deter healthcare staff from taking up posts. These poor working conditions lead to shortfalls of the latter, which in turn causes underspending. The reluctance of the Centre and the states to decentralize fiscal powers sufficiently exacerbates these difficulties.[135] Indeed, the Comptroller and Auditor General found that 26 states had failed to prepared a procurement manual for essential medicines, while thirteen others had neither adopted a formulary list of available drugs nor standard bid documents.[136] Hence well-known health experts stated it was unsurprising that "[the] under-resourced health system predictably underperforms and is unable to spend even its limited funding … policy makers use the 'poor absorptive capacity' of the public health system as an alibi for curtailing the much needed funds. [This is] akin to starving a sick child."[137] Some public health activists concurred, using the analogy of trying to fix a "rusty bicycle": "you need investment to increase infrastructure to absorb investment".[138] The cuts of the 1990s had "depleted" the capacity of many states to spend.[139]

Second, the peculiarities of central government planning, budgeting and funding cycles in India affects schemes generally.[140] Individual districts typically present sectoral plans to their respective state ministries in October of a given year, which the latter would then consolidate, submit and negotiate a state-wide plan vis-à-vis central ministries in New Delhi. Hence states might only gain approval in the summer of the following calendar year, even though the fiscal year began in April. Moreover, the timing of the planning cycle meant that plans were based on spending estimates rather than actual expenditures. Poor coordination and inadequate transparency between departments, in addition, exacerbated these difficulties. And releases by central ministries remained conditional upon the size of the budget envelope available as well as the submission of utilization certificates by the states.[141] Hence the latter often did not know their real allocations until the financial year ends. A "thicket of regulations" and system of line-item budgeting that manifests in hundreds of rows, "based on mistrust", "produced rigidity" and

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[135] See Ravi Duggal, "The political economy of absorptive capacity—case of the health sector," Centre for Budget and Governance Accountability, *Budget Track*, Volume 10, Track 1-2 (October 2014): 27-28. See http://www.cbgaindia.org/wp-content/uploads/2016/03/Budget-Track-Issues-before-the-14th-Finance-Commission.pdf.
[136] *Report No. 8 of 2009*, xii.
[137] K. Srinath Reddy, "2014: a political consensus on health?" *Livemint*, 31 December 2013.
[138] Interview, public health activist, New Delhi, 18 August 2015.
[139] Interview, public health activist, Mumbai, 21 August 2016.
[140] Unless otherwise noted, the following paragraph summarizes the views of Avani Kapur, "The vicious cycle of unspent balances—part 1," *Business Standard*, 18 September 2015: https://www.business-standard.com/article/punditry/the-vicious-cycle-of-unspent-balances-part-1-115091800272_1.html.
[141] Interview, public health activist, New Delhi, 17 August 2015.

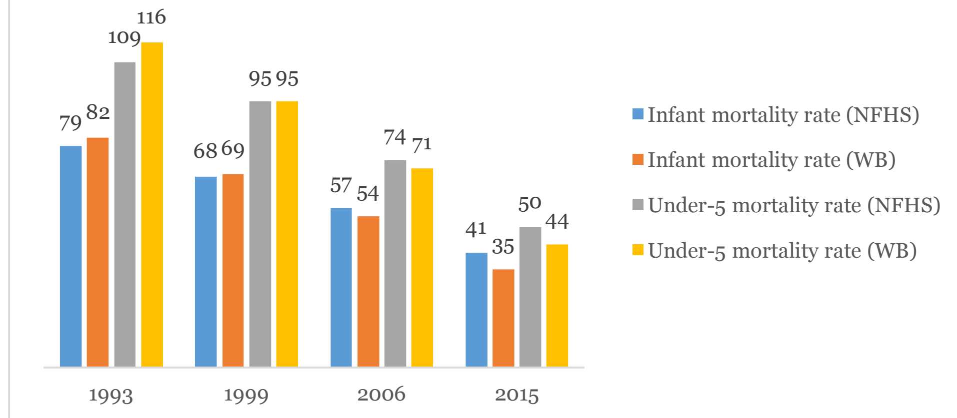
constituted a form of "expenditure control".[142] This situation affected every state in India. Yet it was a greater burden for those with less bureaucratic capacity.

Lastly, the third factor behind divergent expenditure patterns across the Union concerned the electoral politics and fiscal situation in the states and their relations vis-à-vis the Centre. Politically, some chief ministers genuinely seek to implement particular schemes well, whereas others are less interested. This frequently reflected the priorities of their respective parties, and sometimes whether they had initiated a specific programme. Economically, a poor fiscal situation in a state could lead financial officials informally to delay the release of funds officially sanctioned, if directed.[143] Finally, whether the ruling administration in a state belonged to the same party, or the same governing coalition in New Delhi, often mattered too.

Health outcomes and institutional performance

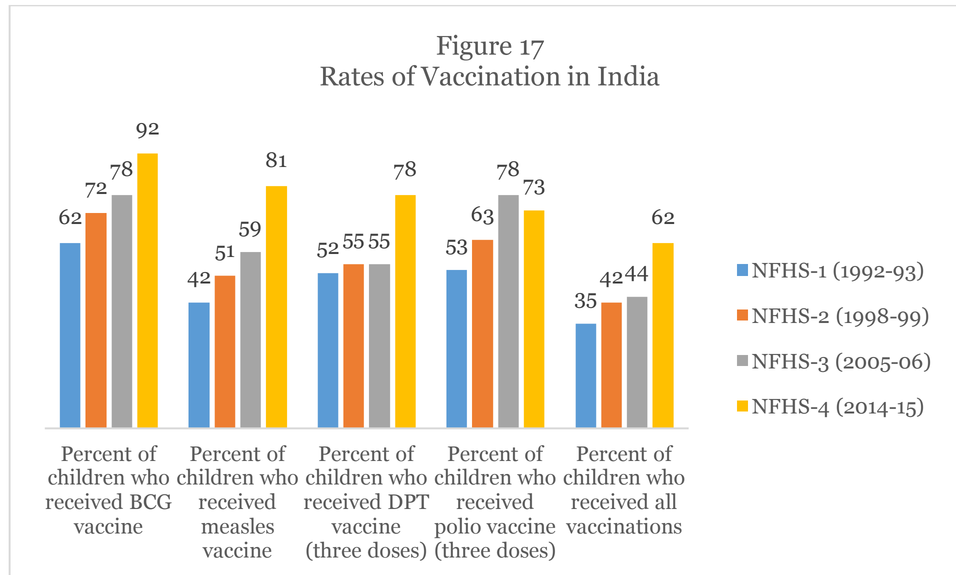
In terms of basic health outcomes, the principal aim of the NRHM was to help lower rates of infant, child and maternal mortality, as well as total fertility. India witnessed steady progress on every front. First, according to NFHS-3 and NFHS-4, rates of infant and child mortality (per 1000 live births) declined from 57 and 74 in 2005-06 to 41 and 50 in 2015-16. World Bank indicators, systematically higher than corresponding NFHS figures before 2005, implied even slightly better progress: infant mortality declined from 54 in 2005 to 35 in 2015, while child mortality decreased from 71 to 44. According to Sinha, infant mortality declined thrice as fast between 2007 and 2010 compared to its rate of decline between 2003 and 2006.[144] In short, the advent of the NRHM enabled significant advances. Nevertheless, the MDG 4 target for infant mortality for India was 28, which it failed to achieve. Its incidence was considerably higher in Assam, Madhya Pradesh, Odisha, Rajasthan and Uttar Pradesh, high focus states.[145] And despite considerable progress since 2005, it missed reaching its MDG target, which was 42 (see Figure 16).

[142] Interviews, senior government official, Chennai, 12 August 2016; public health activist, Mumbai, 21 August 2016.
[143] *National Commission on Macroeconomics and Health*, p. 79.
[144] Amarjeet Sinha, "Health evidence from the states," *Economic & Political Weekly*, 47, 6 (11 February 2012): 16-18.
[145] *Twelfth Five-Year Plan (2012-2017): Social Sectors, Volume III* (Planning Commission, Government of India, 2013), p. 3.



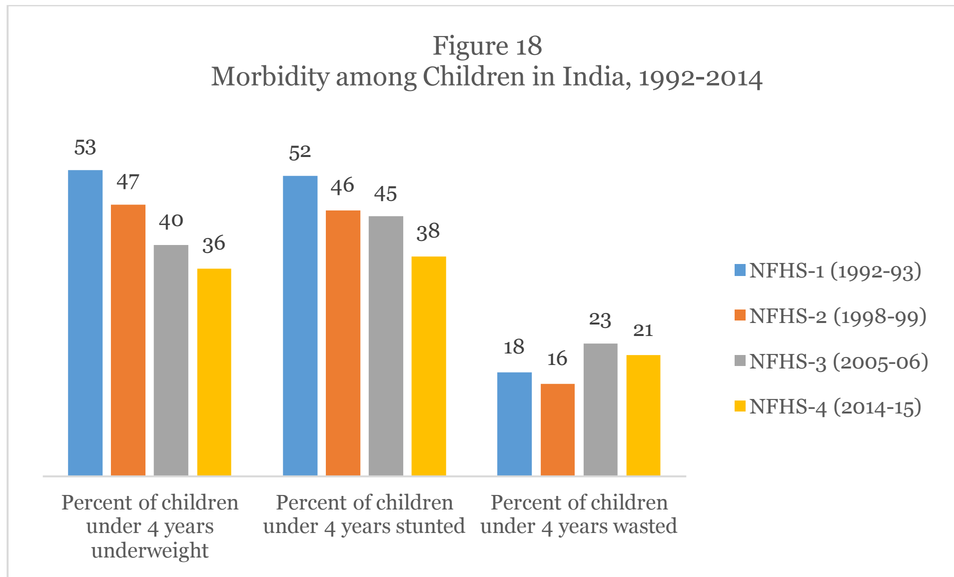
Second, child immunization rates noticeably improved after NRHM began. Many observers attributed the change to the introduction of ASHAs. The proportion of children between the ages of 12 and 23 months vaccinated for many basic infectious diseases increased (see Figure 17). Overall, the ratio that received all their vaccinations rose from 43 percent in 2005-06 to 62 percent in 2015-16, a significant jump of almost 20 percentage points. By 2015-16, more than 90 percent were inoculated against tuberculosis (BCG), and roughly 80 percent against measles and diphtheria, pertussis and tetanus (DPT). The gains against all three maladies, especially the last, were particularly noteworthy given the relative stasis of previous years. And the last case of polio registered in India was in 2011, a potential breakthrough.[146] Yet the fact that close to 40 percent of all children in India had not received full protection against these basic contagious diseases remained a serious concern. Indeed, according to the NFHS, immunization against polio actually fell, from 78 percent in 2005-06 to 73 percent to 2015-16, a distressing retrogression if true.

[146] Subhadra Menon, "India's battle to finish off polio," BBC, 25 January 2012: https://www.bbc.com/news/world-asia-india-16715392.

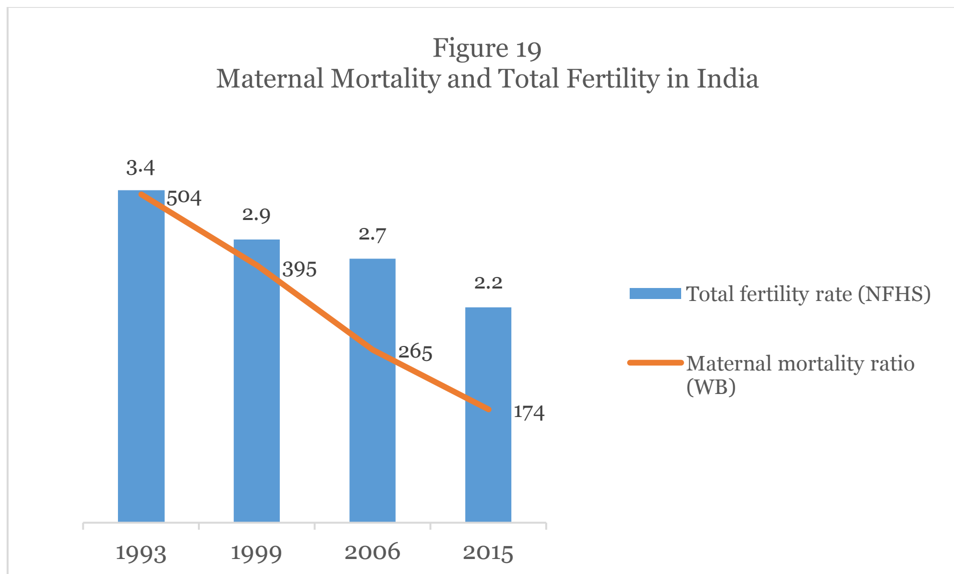


Third, the proportion of children under four years of age with poor nutritional status continued to decline, yet remained far too high (see Figure 18).[147] The percentage of underweight children decreased from roughly 40 percent in 2005 to 36 percent in 2015, exhibiting a relatively steady trend. The ratio experiencing stunted growth also fell, from approximately 45 percent to 38 percent over the same period, after a period of stasis. Lastly, the proportion of children that suffered from wasting declined from roughly 23 in 2005 to 21 percent in 2015, an important corrective given its rise between 1998 and 2005. Nevertheless, the fact that in 2015 wasting afflicted more than 20 percent of children under four in India, and that between 35 and 40 percent continued to suffer from stunting and low body weight, was extremely distressing. The greater relative progress made on indicators of mortality was inevitable, according to some health officials, since they had "identifiable objectives" and could achieve "demonstrable [short-term] progress". In contrast, tackling the sources of morbidity required a more comprehensive approach to well-being, often across generations of children and mothers.[148] Other health officials lamented that the Centre had failed to make the necessary investments—human, institutional and financial—to enable genuine inter-sectoral convergence.[149]

[147] Note: the 3rd round of the NFHS in 2005-06 measured children under three years of age, while the 4th round in 2015-16 measured children under five years.
[148] Interview, senior government official, Chennai, 12 August 2016.
[149] Rao, *Do We Care?* p. 312. Rao also notes that technical directors of vertical missions, uninvolved in the design of NRHM, were later reluctant to cede control (p. 318).



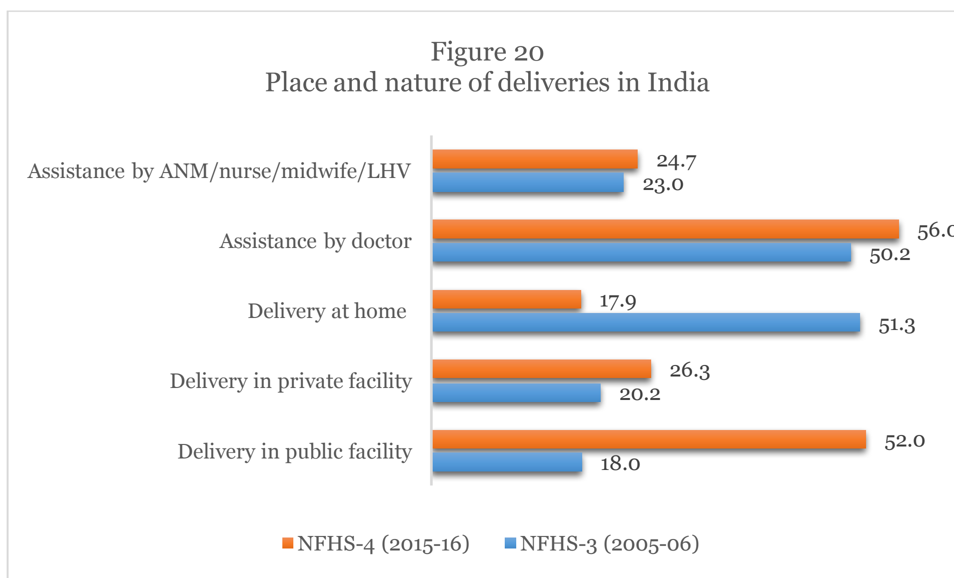
Fourth, India made considerable progress in reducing rates of maternal mortality as well as total fertility after NRHM began. The former declined from 265 (estimated per 100,000 live births) in 2006 to 174 in 2015, while the latter fell from 2.7 to 2.2, respectively. Compared to 1993, when the maternal mortality ratio was an extremely high 504, this was a significant achievement (see Figure 19). Despite such progress, however, India failed to meet its MDG target of 109. Indeed, only three states did: Kerala, Maharashtra and Tamil Nadu. The rate in Bihar, Rajasthan and Uttar Pradesh, in contrast, exceeded 300.[150]



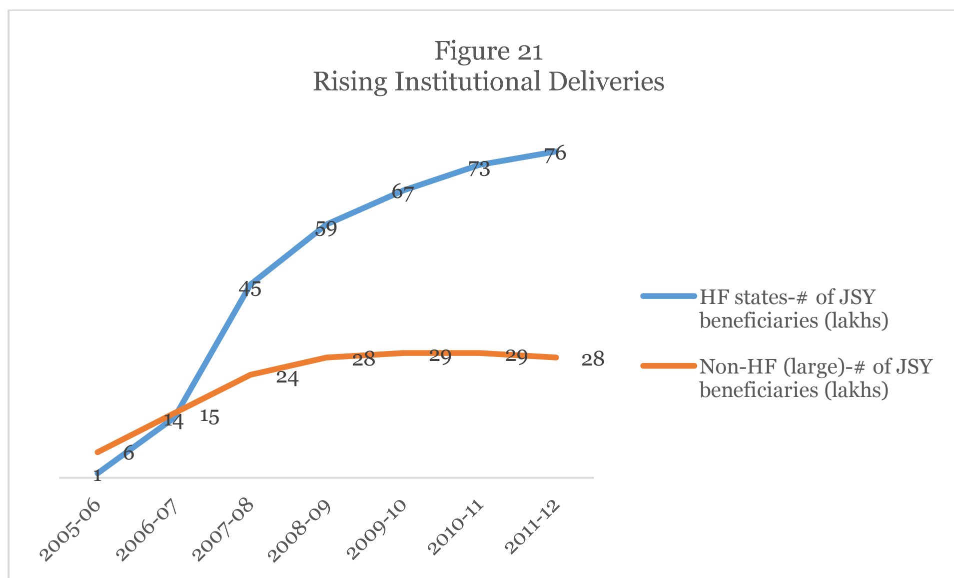
[150] *Twelfth Five-Year Plan*, p. 3.

Many interacting factors influence the risk of maternal mortality. These range from the nutritional condition and educational status of girls and women, and their age of marriage and childbirth, to gender relations and working opportunities in their households and wider social communities. According to the NFHS, the median age of marriage among women between 25 and 49 years of age rose from 16.1 years in 1992-93 and 16.8 in 2005-06 to 18.7 in 2015-16, a noticeable increase. The corresponding age of women in this cohort who gave birth to their first child reflected a similar trend, rising from 19.4 in 1992-93 and 19.8 in 2005-06 to 21.0 in 2015-2016. The ability of girls and women to marry and begin childrearing later may have reflected the higher school enrollment of girls following the introduction of the Sarva Shiksha Abhiyan in 2001, among other factors that may have expanded their autonomy.

Yet all things being equal, medical complications during pregnancy are also a major cause of mortality for women, making access to good health services a crucial element. By design, the Janani Suraksha Yojana was a key institutional reform to address this vital issue. The NFHS registered little change in the proportion of women that received assistance from either doctors or ANMs/midwives/LHVs between its 3rd round in 2005 and 4th in 2015 (see Figure 20). Indeed, more than 50 percent of respondents claimed to have been assisted by a doctor in both rounds, a surprising figure given persistent reports of too few doctors in rural India. Yet the ratio of home deliveries fell from roughly 51 percent in 2005 to 18 percent in 2015, a dramatic shift. Childbirths in private health facilities, which rose from approximately 20 to 26 percent over this period, accounted for some of this change. But the proportion of deliveries in public health facilities, which rose from 18 to 52 percent, contributed a far greater extent.



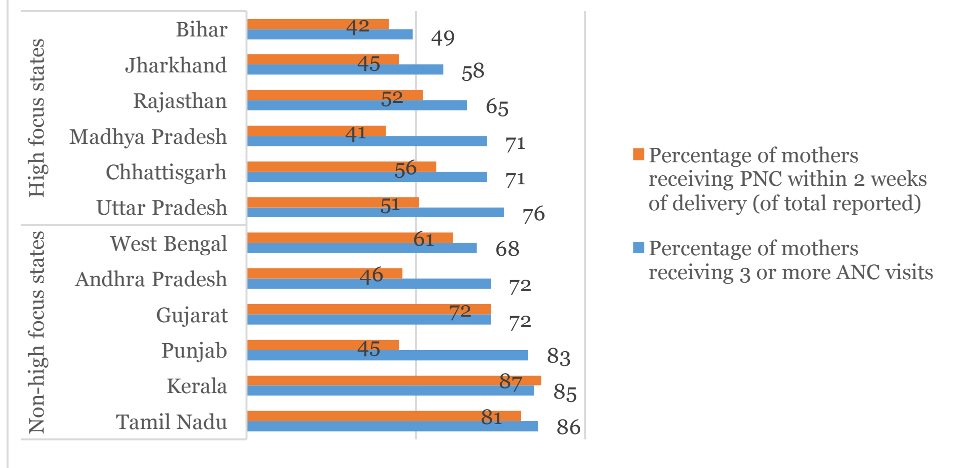
Presumably, the Janani Suraksha Yojana was the main catalyst. Following its launch, the number of beneficiaries increased dramatically, from approximately 7.38 lakhs (738,000) in 2005-06 to 109.38 lakhs (109,380,000) in 2011-2012. Moreover, high-focus states accounted for both the majority of deliveries as well as an increasing share over time (see Figure 21).



However, urban-rural disparities in delivery practices continued to exist. Women in urban localities were more likely to have a safer experience than in rural settings.[151] In addition, the percentage of women that received full antenatal care was suboptimal. Postnatal care was even less so. In contrast to the trend regarding institutional deliveries, the gap between high-focus states and other states persisted. In 2012, the percentage of women that had three or more antenatal care visits in a proper health facility ranged from 49 percent in Bihar to 81 percent in Tamil Nadu. The corresponding figures of mothers that received postnatal care within two weeks of delivering their children in these two states were 42 and 86 percent. The fact that approximately 60 percent of health centres in Tamil Nadu provided 24 hour services was a significant factor.[152] That said, the provision of antenatal care in several large high-focus states, namely Chhattisgarh, Rajasthan and Uttar Pradesh, was surprisingly better than in some richer states, such as Punjab and Andhra Pradesh (see Figure 22).[153]

[151] For more comparative state-wise data, see *Budget Brief: NRHM, GOI, 2013-14* (Accountability Initiative, Centre for Policy Research, Delhi), p. 7.
[152] *Eleventh Five-Year Plan*, p. 73.
[153] *Budget Brief: NRHM, 2013-14*, p. 6.

Figure 22
Beneficiaries of Ante & Post-natal Care, 2012



In general, whether or not women received proper ante- and postnatal care may have reflected their awareness of these services, and thus in turn the communication strategies of the relevant health ministries in different states. Yet independent studies found that a more important determinant was the availability of trained personnel and decent facilities. Quick post-delivery discharges and limited postnatal care reflected the lack of adequate hospital amenities. Relatively unskilled staff were responsible for the latter, leading to suboptimal medical practices and inadequate referrals for emergency care. And late payments and everyday corruption were reported too.[154] Indeed, the Twelfth Plan noted shortfalls in recruitment of ASHAs in many states, and that many had neither received full training nor timely payment.[155]

That said, state-level innovations in certain regions enabled important gains. Tamil Nadu operationalized its PHCs for emergency obstetric care and referral services, developed sub-district hospitals and implemented an audit of maternal deaths, increasing the rate of deliveries to 98 percent. To overcome the lack of obstetricians in rural public hospitals, Gujarat has introduced the Chiranjeevi scheme, which paid a fee to private doctors to perform deliveries. Its relative success reportedly led other states to emulate the model.[156]

<u>Infrastructural capacities, public facilities and human resources</u>

The NRHM had aimed to execute a major 'architectural correction' of the health system. Assessing its record, as official government data reveals, is a complex multidimensional matter.

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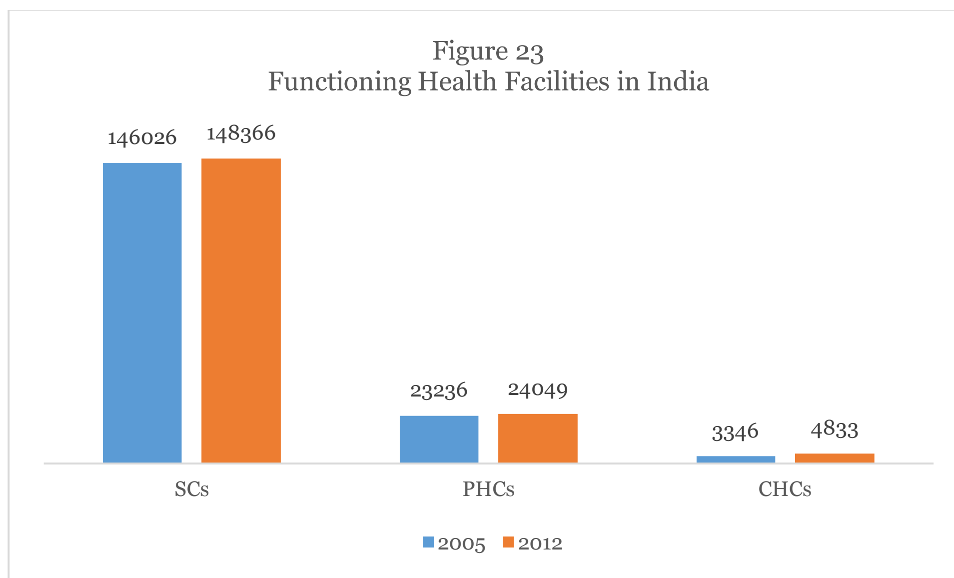
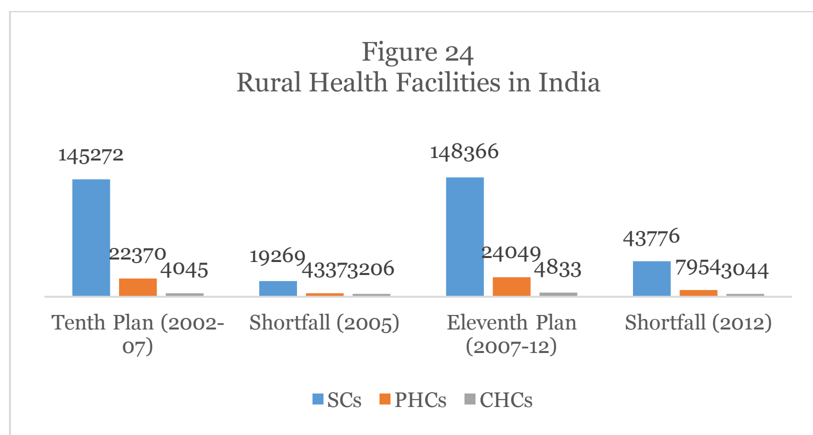
[154] The Planning Commission noted these problems too. See *Eleventh Five-Year Plan*, p. 72.
[155] *Twelfth Five-Year Plan*, p. 5.
[156] Vinod Kumar Paul et al, "Reproductive health, and child health and nutrition in India," pp. 338-9.

First, in absolute terms, the provision of facilities rose between 2005 and 2012. The number of SCs increased from 146,026 to 148,366; of PHCs from 23,236 to 24,048; and of CHCs from 3346 to 4833 (see Figure 23). In percentage terms, the provision of CHCs, PHCs and SCs increased by approximately 44, 3 and 2 percent, respectively.[157] The extremely low expansion of facilities in the two lowest tiers of the health system represented a significant lost opportunity, given their pivotal role in principle in affording preventive care regarding basic nutrition, immunization against communicable diseases, and child and maternal health.

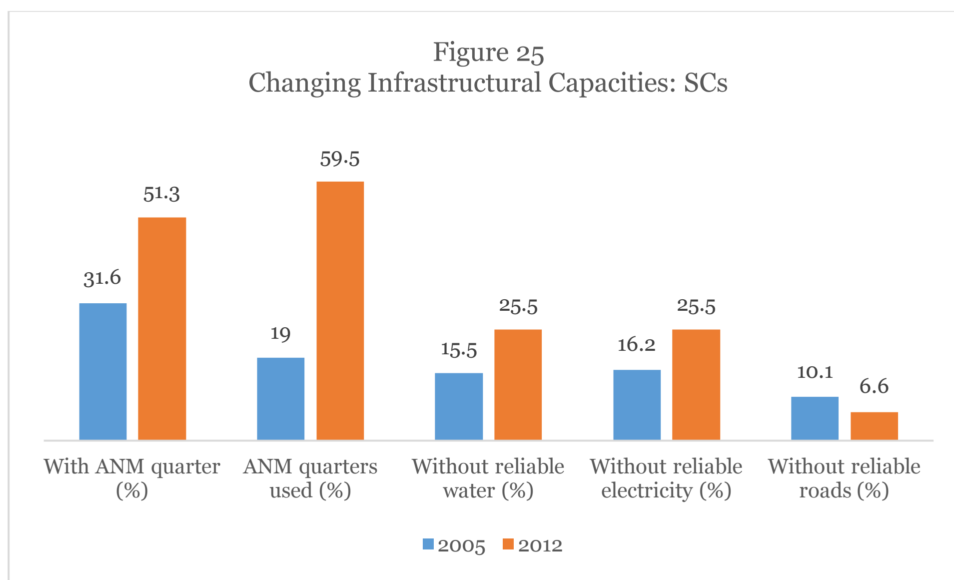


Indeed, measured against the norms of the Indian Public Health Standards, the shortfall in the number of SCs more than doubled between 2005 and 2012, from 19,269 to 43,776. Similarly, the shortage of PHCs rose from 4337 to 7954, respectively. CHCs were the only tier to witness of decrease on this score. According to officials, this partly reflected the upgrading of PHCs to CHCs in many states.[158] Nevertheless, the provision of CHCs still had a shortfall of 3044 in 2012, and thus remained below IPHS norms too (see Figure 24).[159]

[157] *RHS, 2012*, p. 13. Data available in Statement 1, p. 29.
[158] Interview, senior government official, New Delhi, 2 August 2016.
[159] *RHS 2012*, Table 11, p. 60. The shortfall in health infrastructure, calculated as of March 2012, is based on provisional 2011 population figures.



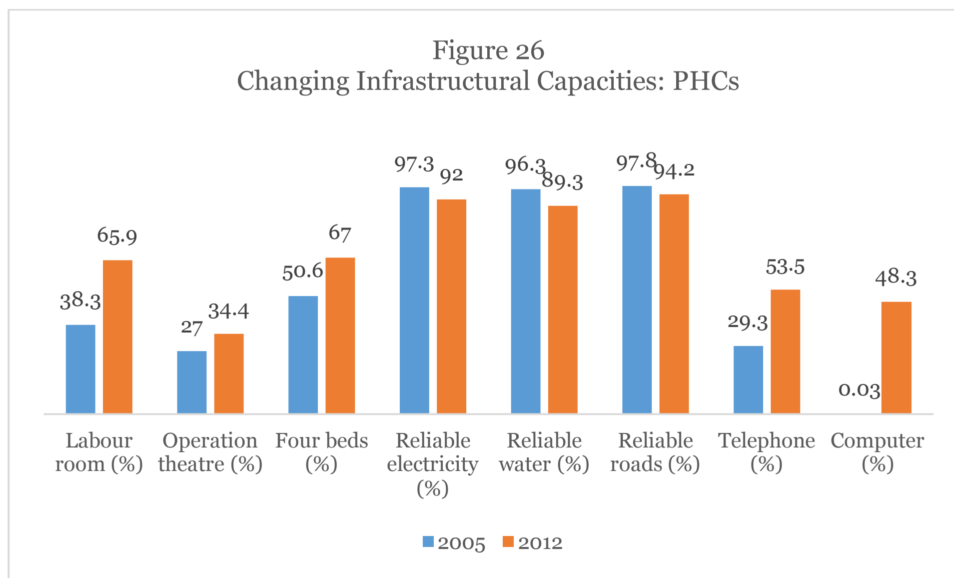
Second, the infrastructural capacities of different tiers of the rural health system exhibited divergent trends. Despite the greater relative shortage of SCs across the country in aggregate terms, more than half had a separate quarter (section) for auxiliary nurse midwives to perform their duties, and a slightly higher percentage of these healthcare workers used these facilities by 2012. Yet the proportion that reportedly lacked a reliable supply of water and electricity also rose. The only infrastructural facility ostensibly to improve for SCs was their access to roads (see Figure 25).[160]



In contrast, the infrastructural capacities of PHCs generally improved, in aggregate. Ninety percent had reliable access to electricity, water and roads. Yet approximately 35 percent still lacked a delivery room or the requisite number of hospital beds, while 65 percent did not have an operating room. And only approximately half of PHCs reported having a telephone or

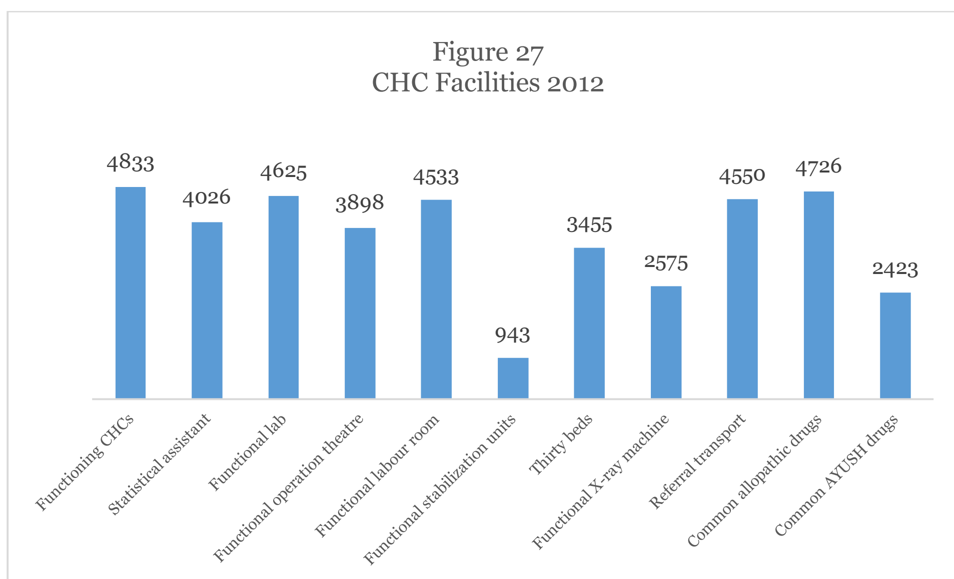
[160] *RHS 2006*, Tables 35a-b, pp. 53-54; and *RHS 2012*, Tables 35a-b, pp. 91-92. Note: 2006 figures calculated using state figures: no all-India was given.

computer (see Figure 26). Indeed, of the 23,940 active PHCs in India in 2012, only 3635 met IPHS functioning norms, a mere fifteen percent of the total.[161]



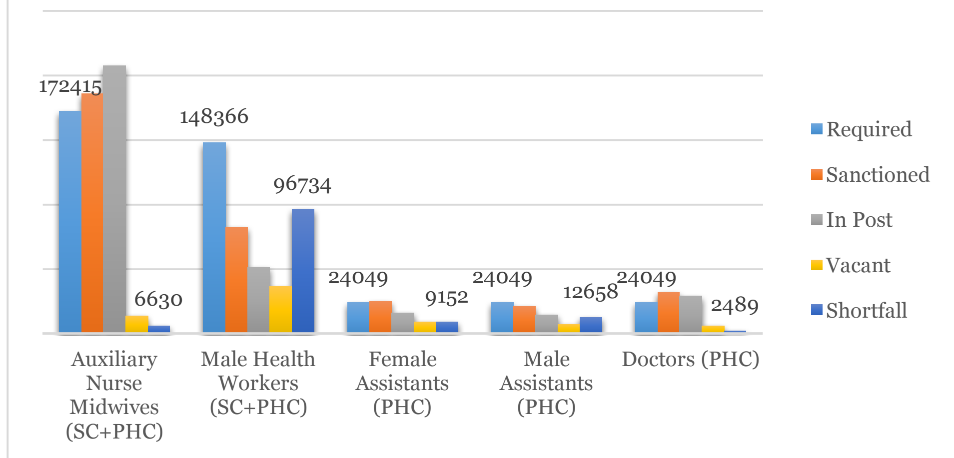
The vast majority of CHCs reportedly had many functional basic facilities in 2012. Yet there were several glaring deficits. Of the 4833 active centers, roughly 20 percent lacked a functional operation theatre, almost 30 percent did not have the requisite 30 beds, and close to 50 percent neither had a functional X-ray machine nor common AYUSH drugs. Although more than 90 percent had a functional labor room, less than 20 percent had a stabilization unit for newborns in need of intensive medical care. Indeed, only 742 of the 4833 CHCs met IPHS norms, a mere 15 percent of the total—the same low ratio of PHCs that met these standards (see Figure 27).[162] And competitive bureaucratic dynamics reportedly complicated the maintenance of facilities in various tiers.[163]

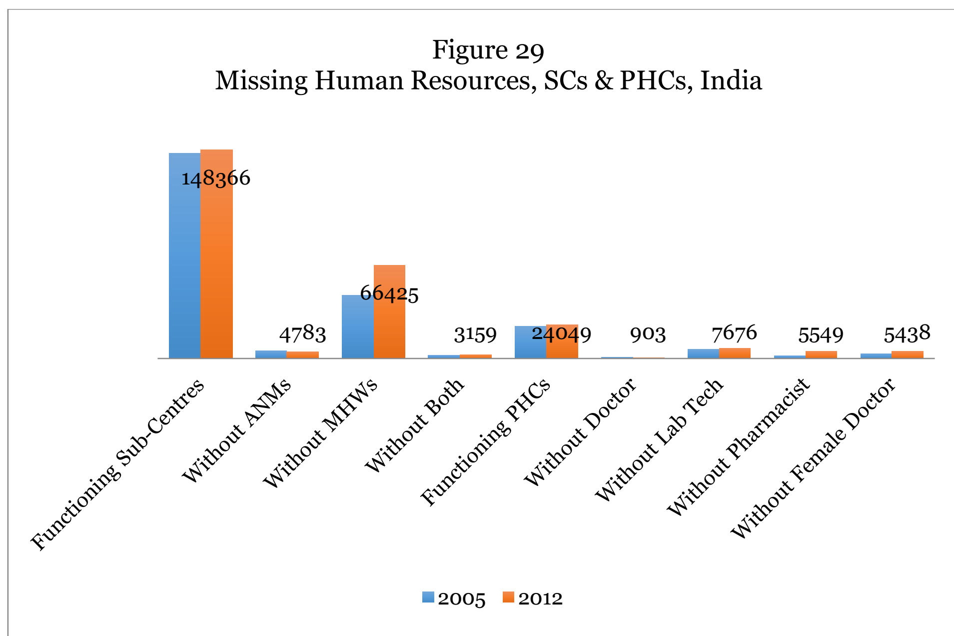
[161] *RHS 2006*, Tables 36 and 37, pp. 55-56; and *RHS 2012*, Tables 36a, 36b and 36c, pp. 93-95. Note: 2006 figures calculated using state figures: no all-India figure was given.
[162] *RHS 2012*, Tables 37a-b, pp. 96-97.
[163] Interview, senior government official, New Delhi, 4 August 2016.



Third, the most serious deficit in the rural health system remained its human resources. Again, the picture was complex (see Figures 28 and 29).[164] In aggregate terms, staff-related shortages continued to afflict SCs and PHCs across the country in 2012. On the one hand, the shortfall of auxiliary nurse midwives was extremely small, constituting less than four percent of officially required number. Moreover, the number of SCs that lacked an auxiliary nurse midwife had fallen since 2005. The shortage of doctors in PHCs, constituting approximately ten percent, was somewhat higher. Yet the number that lacked a doctor had also declined since 2005. On the other, the respective shortfall of female health assistants, male health assistants and male health workers comprised roughly 38, 53 and 65 percent of prescribed norms in 2012, a staggering gap. And the number of SCs that lacked a male health worker, and the number of PHCs that did not have a pharmacist, lab technician or female doctor, actually rose between 2005 and 2012, despite the absolute increase in the number of facilities at both tiers.

[164] *RHS 2012*, Tables 16-17, 19-21 and 33, pp. 68-73 and 86. Note: the number of male health workers in 2012 only comprises SCs, unlike 2005, when the tally included PHCs. The data on missing health workers is drawn from Tables 18 and 22, pp. 70 and 74.





In aggregate terms, the shortage of more specialized personnel in the rural health system was even more severe (see Figure 30).[165] The lack of pharmacists, nurses and lab technicians among PHCs and CHCs comprised 18, 23 and 43 percent of their requisite levels, respectively. The shortfall of radiographers, specialists and physicians at the highest level was grave, constituting 53, 70 and 76 percent of the prescribed norms.

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[165] *RHS 2012*, Statements 7-11, pp. 35-39, and Table 26, p. 78. Note: Data on pharmacists, lab technicians and nurses includes PHCs.

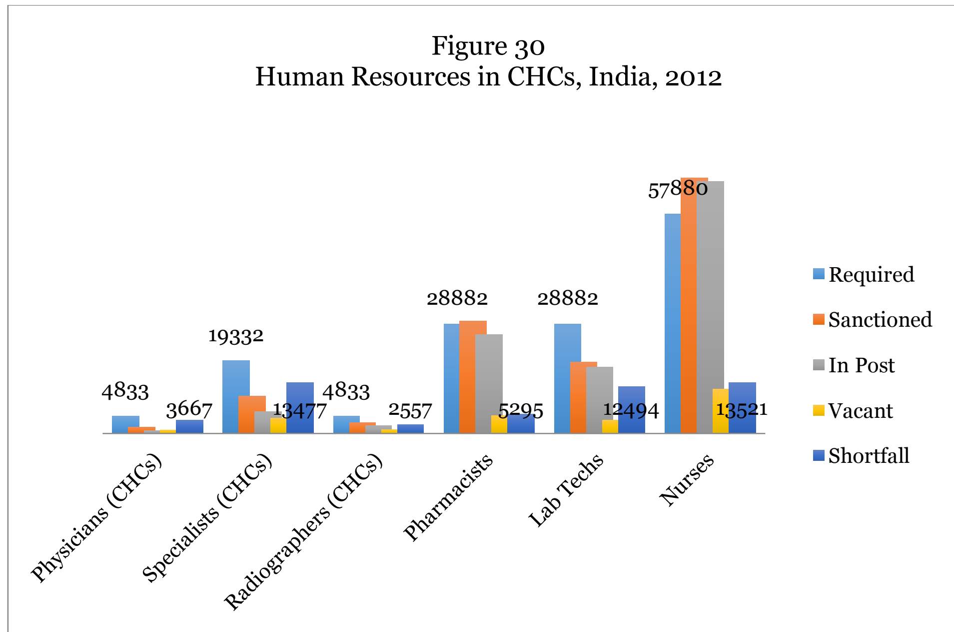

Figure 30
Human Resources in CHCs, India, 2012

In sum, the general burden placed on staff in post at all three levels of the rural health system was acute. Moreover, these sobering figures most likely underestimated the real human resource deficit, since they captured neither the problem of absenteeism nor the quality of care. The disinclination of doctors and specialists in many states to serve properly in non-metropolitan areas, due to lower salaries, less desirable working and living conditions, and few opportunities for their families, was an old well-known problem. Indeed, a very high ratio of graduates from private medical colleges emigrated to settle in advanced industrialized countries, driven by high capitation fees and personal life preferences.[166] In addition, the reluctance of many states to appoint regular staff entitled to salaries, benefits and unionization led to greater reliance on contractual workers with poorer economic incentives and less social recognition.[167] According to public health activists, the creation of such parallel structures produced greater incoherence and lower morale, preventing a much-needed "systems approach".[168]

Thus it was unsurprising that according to the NFHS-4 in 2015-16, only 45 percent of the country accessed public health facilities. Of the three most important reasons given by respondents, 48 percent mentioned the poor quality of care offered, 45 percent cited their relative inaccessibility and 41 percent stated excessive waiting times.[169] The 71st round of the National Sample Survey Organization, conducted in the first half of 2014, depicted an even more

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[166] Rao et al, "Human resources for health in India," pp. 591-592.
[167] Interview, senior government official, New Delhi, 17 August 2015.
[168] Interview, public health activist, New Delhi, 14 August 2015.
[169] Anoo Bhuyan, "More than half of India rejects government medical care," *The Wire*, 12 January 2018: https://thewire.in/health/half-india-rejects-government-medical-care.

negative situation. Approximately 58 and 72 percent of rural households had sought in- and out-patient care in the private sector.[170]

Health policy reforms since 2012

The United Progressive Alliance, re-elected to office in the 2009 general election, had originally envisioned the NRHM would run for seven years. Recognizing the important gains made in various domains, but also glaring persistent deficits, the Government extended the Mission for another five years (2012-2017). Yet it introduced several changes. First, starting in 2013, the Centre would offer 75 percent of total funds. Second, it launched the National Urban Health Mission (NUHM), targeting population centers greater than 50,000.[171] Henceforth the NRHM and NUHM would together constitute the National Health Mission (NHM). Third, it rolled out several new initiatives under the NRHM between 2012 and 2014. The Janani Shishu Saraksha Karyakram provided all pregnant women free transport, delivery and medication in a public facility. The Rashtriya Bal Swasthya Karyakram offered free healthcare to all children suffering from birth defects, diseases and deficiencies and developmental delays. And the Rashtriya Kishor Swasthya Karyakram provided guidance for adolescents regarding nutrition, sexual health and gender-based violence.[172] Finally, in 2014-15, the Government decided to release funds to state treasuries rather than autonomous State Health Societies. The reason was twofold. On the one hand, disbursing funds to the health societies was "procedurally complicated", requiring several approval processes involving the state assemblies that often failed to meet on schedule. On the other, the switch to state treasuries "helped the Government" limit spending.[173] Indeed, evidence of funds being misappropriated by health societies in certain states, most notably Uttar Pradesh, persuaded the Centre to clamp down.[174]

The decision to extend the NRHM came in the wake of an important proposal. In October 2010, the Planning Commission had constituted a High-Level Expert Group on Universal Health Coverage (UHC), chaired by Professor K. Srinath Reddy, president of the

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[170] National Sample Survey Organization, *Social Consumption: Health, NSS 71st Round: January-June 2014* (Ministry of Statistics and Programme Implementation, Government of India, 2015), pp. 10-14. 71st Round: Key Indicators of Social Consumption in India, Health http://mail.mospi.gov.in/index.php/catalog/161.
[171] Twenty-two percent of its total funds would be allocated to seven major cities: Ahmedabad, Bangalore, Chennai, Delhi, Kolkata, Hyderabad and Mumbai.
[172] "Rolling out of National Health Assurance Mission," Press Information Bureau, Ministry of Health and Family Welfare, Government of India (15 July 2014): http://pib.nic.in/newsite/PrintRelease.aspx?relid=106608.
[173] Interview, public health activist, New Delhi, 17 August 2015.
[174] Interview, senior government official, New Delhi, 4 August 2016.

Public Health Foundation of India. Its fifteen members, which submitted its Report in November 2011, defined UHC in the following manner:

> Ensuring equitable access for all Indian citizens, resident in any part of the country, regardless of income level, social status, gender, caste or religion, to affordable, accountable, appropriate health services of assured quality (promotive, preventive, curative and rehabilitative) as well as public health services addressing the wider determinants of health delivered to individuals and populations, with the government being the guarantor and enabler, although not necessarily the only provider, of health and related services.[175]

Significantly, the report stressed that UHC implied a fundamental commitment to the right to health. Ten underlying principles inspired this commitment: universality, equity and non-discrimination; comprehensive care through financial protection, patients' rights and the strengthening of public health provisioning; and the empowerment of citizens through mechanisms of accountability, transparency and community participation. To realize UHC, the group proposed that all citizens be entitled to a guaranteed National Health Package, comprising a list of essential services provided either by public sector facilities free-of-cost, or contracted private actors that would be reimbursed at standardized rates and strictly regulated. This led to a series of more specific recommendations. To raise public health expenditure to 2.5 percent of GDP by 2017 and 3 percent by 2022, the Report advocated higher general taxes and salaried employee contributions, eliminating user fees and central government insurance schemes. Seventy percent of all health care expenditures should be directed towards primary care. To expand the supply of doctors, nurses and community health workers with primary care skills in rural areas, the group proposed establishing medical colleges, nursing schools and training centers in underserved regions, as well as District Health Knowledge Institutes. The proposal to introduce a three-year diploma in rural health care, to rectify the unwillingness of traditionally schooled doctors to locate in such areas, was particularly noteworthy. To enable greater community participation, the Report advocated transforming Village Health Committees into participatory Health Councils that would organize regular Health Assemblies. To improve access to medicines, it backed the domestic production and price regulation of essential drugs. Finally, the group recommended the creation of public health service cadres at the national and state level, to galvanize preventive services and address the socio-ecological determinants of decent health.

[175] The following summarizes key points of the Executive Summary of the *High Level Expert Group Report on Universal Health Coverage* (Planning Commission of India, New Delhi, November 2011), pp. 3-39: http://planningcommission.nic.in/reports/genrep/rep_uhc0812.pdf.

The core point seemed clear: to carry on and deepen the reforms initiated by the NRHM. Yet some feared that slower economic growth in this period would gradually encourage the Government to neglect basic preventive services instead of curative medical care, which had the backing of corporate sector.[176] The Twelfth Five-Year Plan (2012-2017) assessed that it would take up to fifteen years to provide UHC, given the "colossal task" of putting in place a basic health architecture. Reviewing health provisioning in other countries, it also contended that an integrated public-private health system was an effective viable model. Nonetheless, the Plan encouraged the states to establish up to three district-level UHC experiments in their NHM plans, based on a national list of essential services.[177] Supportive health officials hoped the pilots would demonstrate proof of concept.[178]

But a change of administration in New Delhi, following the 2014 general election, inaugurated a new policy direction. During its decade in office, the United Progressive Alliance had achieved the highest rate of economic growth since independence. But a series of major public scandals involving the allocation of contracts to favored business groups inspired a groundswell against corruption in civil society. The reluctance of the Government to respond decisively, obstruction of parliament by opposition parties and aggressive media coverage soon paralyzed New Delhi. And declining private investment and adverse global conditions induced a substantial economic slowdown. The Bharatiya Janata Party exploited the sense of crisis, attacking the ruling coalition for pursuing a rights-based 'welfarist' agenda at the cost of growth and modernization. Led by the controversial Hindu nationalist chief minister of Gujarat, Narendra Modi, the party captured a parliamentary majority in May 2014, leading a new avatar of the National Democratic Alliance. Upon taking office, the Modi administration pledged itself to the principle of sabka saath, sabka vikas, 'taking everyone along, development for all'. Yet it also championed the slogans of 'empowerment over entitlement' and 'minimum government, maximum governance'. In general, the new Government has taken a dual approach to social welfare provisioning. On the one hand, it has invested in expanding financial inclusion, technological capabilities and public infrastructure. On the other, it has sought to enhance the scope of individuals and families to choose the provision of goods and services in the marketplace, by promoting the use of cash-based transfers and various publicly financed insurance programmes. This dual approach clearly manifested itself in the domain in health. In the summer of 2014, the Modi administration pledged to implement a National Health Assurance Mission. Parties across India traditionally renamed government schemes in order to

[176] Rao, *Do We Care?* p. 26.
[177] See *Twelfth Five-Year Plan*, pp. 1-46. The quoted remark is on the last page.
[178] Interview, New Delhi, 2 August 2016.

distinguish themselves vis-à-vis rivals. Yet the newly branded initiative presaged important shifts.

On the one hand, the Government unveiled the Swachh Bharat, an ambitious five-year mission to eliminate open defecation in India by 2 October 2019, the 150th birth anniversary of Mahatma Gandhi. It was a significant initiative. According to the 2011 census, an estimated 72 percent of rural inhabitants, roughly 600 million, lacked access to proper toilets. Yet everyday cultural attitudes, notably select religious precepts and caste-based discrimination among many Hindus, played a crucial role too.[179] Hence the mission had a two-pronged strategy. First, the Government invited gram panchayats, district administrators and state governments to develop and submit proposals for funds from the Centre, to build and upgrade individual household latrines and community sanitary complexes. Second, to promote behavioral change, the Government exhorted ordinary citizens to help clean public spaces, encouraged gram panchayats to appoint local volunteers, Swachhagrahis, to encourage new social habits, and apportioned some funds for information, education and communication. Given that enteropathy, encephalitis and diarrhea were major contributing factors to the very high rates of morbidity, malnourishment and stunting among children in India, ending open defecation was a vital public undertaking. Prime Minister Modi deserved great credit for addressing the topic squarely.

On the other, however, the Government pushed a more market-driven approach to improving the health system. Key economic advisors to the new ruling dispensation expressed its commitment to implementing UHC, strengthening the health system comprehensively and addressing the social determinants of health. Despite the commitment of the Twelfth Plan to encourage the provision of UHC through district-level pilots in the states, none had been initiated by the start of 2016.[180] Yet they questioned the national public sector-led strategy laid out by the previous administration on several grounds. Strained fiscal resources, the narrow tax base and limited health personnel made it difficult to expand public financing effectively. In addition, absenteeism, non-adherence to standard treatment protocols and corrupt informal practices marred the existing public system. Hence they proposed encouraging state-level approaches, competition and choice between providers, and public financing of private health

[179] Unless otherwise noted, all preceding notes from "The final frontier," *The Economist* (19 July 2014), pp. 35-36.
[180] Abhay Bang, "Health insurance, assurance, and empowerment in India," *The Lancet*, 386, 10011 (12 December 2015): 2372-2373.

provision.[181] Indeed, the inaugural director of the NITI Aayog doubted the desirability of the NRHM on similar grounds.[182]

The skepticism of the new Government towards public health services found support in some independent studies. The Medical Advice Quality and Availability in Rural India project compared the level of care offered by different health providers in 80 villages across 19 states. In general, they found the level of competence across each group "disturbingly low". Private MBBS doctors performed relatively better, and unsurprisingly, private non-MBBS doctors generally worse. But public doctors' performance varied tremendously depending on the location of service: it was high in well-respected public hospitals but very low in PHCs, where they performed only somewhat better than private non-MBBS doctors.[183] Hence the researchers concluded that simply allocating more trained doctors in rural health clinics, and building more of the latter, would not solve the problem of low quality care.[184] Indeed, given that it was extremely costly to provide high-quality care in remote areas, they counseled not to do so unless the incentives could be changed.[185]

These findings were extremely sobering. Indeed, if no correlation existed between the quality of facilities and quality of care, they were damning. Yet it was revealing that states in the study that had the lowest access to healthcare providers—Himachal Pradesh and Tamil Nadu—still had better health outcomes than other states.[186] Political parties and social organizations in both states channeled demands for universal social policies and effective public services for all. Moreover, each had relatively good bureaucracies, with sufficient power and autonomy to deliberate how best to deliver both well.[187] A more egalitarian public ethos, rather than private economic incentives, shaped their more progressive health outcomes.

Ultimately the Government extended the NHM for three years when its second phase ended in 2017. But it gradually squeezed the funding for the NRHM, and expanded publicly financed insurance for curative medical care, thereby entrenching the role of the private health sector. The rate of increase in allocations to the NHM as a whole by the Centre began to slow in 2012 under the UPA. Yet its share vis-à-vis the total amount given to the Ministry of Health

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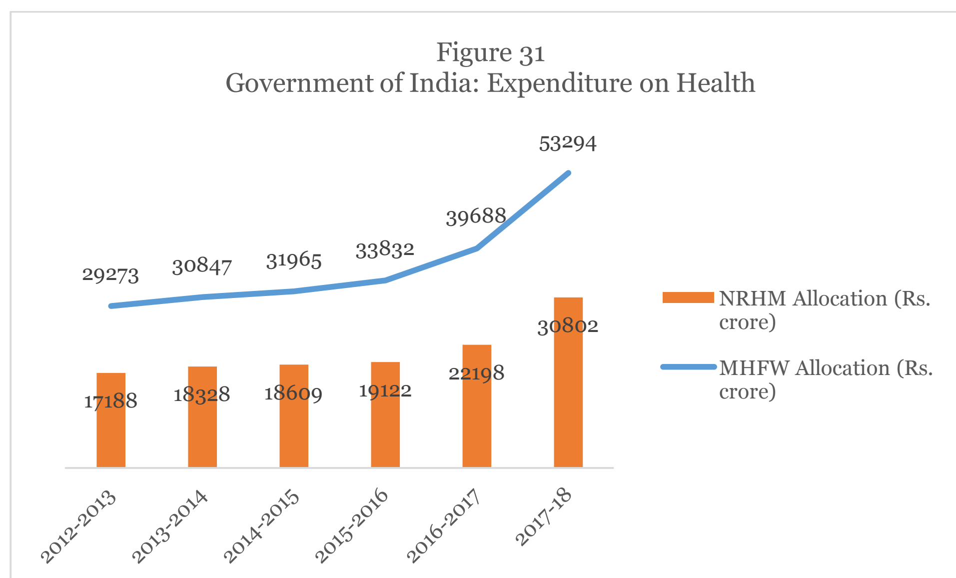
[181] Bibek Debroy and Alok Kumar, "The road to universal health coverage in India," *The Lancet*, 386, 10011 (12 December 2015): e56-e57.
[182] See Arvind Panagariya, *India: the emerging giant* (New York: Oxford University Press, 2008), pp. 415-431. The NITI Aayog superseded the Planning Commission, which the Modi administration closed shortly after coming to power.
[183] Das and Hammer, "Health and health care policy in India," pp. 440-441.
[184] Ibid, p. 454.
[185] Ibid, p. 436.
[186] Ibid, pp. 427-428.
[187] See Drèze and Sen, *An Uncertain Glory*, pp. 76-80.

declined after 2016. Moreover, the provision for the NRHM component fell in 2014-15, which had never previously happened (see Figure 31).[188]



To some extent, these lower allocations were offset by unspent funds that continued to bedevil the NRHM (see Figure 32), revealed by the Comptroller and Auditor General in a second major evaluation.[189] But the release of funds from New Delhi after 2016 also took longer than before. And many state treasuries further delayed transferring these funds to their respective health societies far beyond the mandated fifteen days. Thus, by March 2017 the percentage of SCs functioning per IPHS norms actually fell to 11 percent, while the corresponding ratio for PHCs and CHCs was 16 percent.[190]

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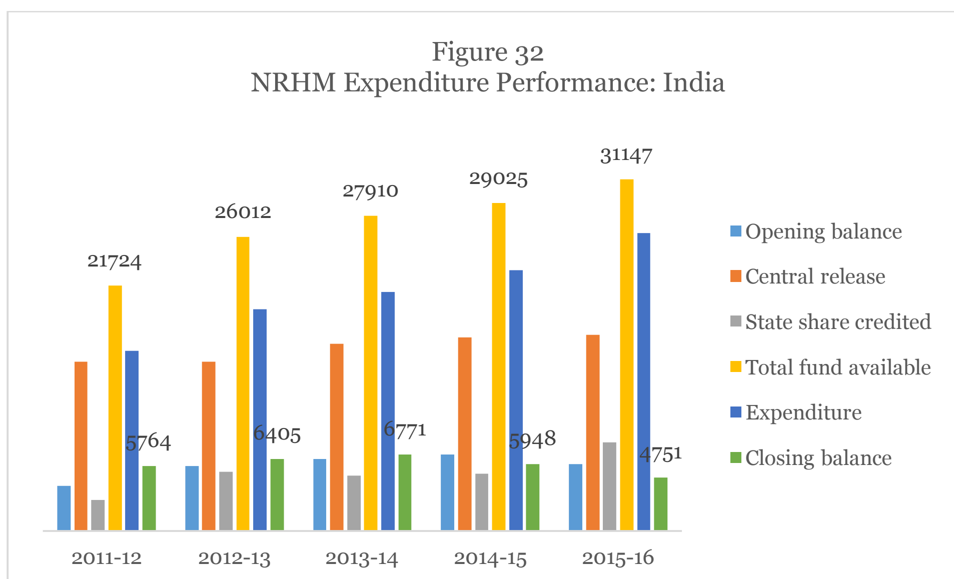
[188] Data compiled from *Budget Brief: NHM, GoI, 2015-16* and *Budget Brief: NHM, GoI, 2018-19* (Accountability Initiative, Centre for Policy Research, Delhi). Note: Figures for all years are revised budget estimates in crores of rupees.
[189] See Comptroller and Auditor General of India, *Performance Audit of Reproductive and Child Health Mission under National Rural Health Mission, Report No. 25 of 2017*, p. 12.
[190] *Budget Brief: NHM, 2018-19*, pp. 4 and 9.



Instead, the Modi administration expanded the role of health insurance coverage and curative hospital care, consuming the higher outlays to the health sector overall in the last two years. The 2016-17 Union budget unveiled the Rashtriya Swasthya Suraksha Yojana (RSSY, or National Health Protection Scheme (NHPS)), offering poor households Rs. 100,000 per annum for health-related costs. The initiative was a renaming of the Rashtriya Swasthya Bima Yojana (RSBY), which the UPA had launched in 2008, providing such families Rs. 30,000 annual coverage for inpatient care managed by private insurance companies. The Government also expanded the Pradhan Mantri Swasthya Suraksha Yojana, proposing to establish twelve new All India Institutes of Medical Sciences in various states. Lastly, the budget publicized the Pradhan Mantri Jan Aushadhi Yojana, which sought to expand the availability of affordable genetic medicine at 3000 stores across the country.[191] Again, the Jan Aushadhi Scheme had been launched in 2008 by the UPA, but the new Government sought to scale it up massively.

The general objective of these initiatives was clear: to protect vulnerable families from extremely high out-of-pocket health expenditure. Providing greater financial security from such costs, and expanding the availability of hospitals with trained medical staff, was absolutely essential. Whether such a strategy could address the severe health deficits still confronting India, however, was genuinely debatable. First, expanding public insurance for targeted social groups to receive curative medical treatment in a system dominated by private health practitioners carried many well-known risks of adverse selection and moral hazard.[192] Unless

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[191] Jyotsna Singh, "Budget 2016: health insurance for all," *Livemint*, 1 March 2016: https://www.livemint.com/Politics/hQihM87Emz6wxsieuIUZvO/Budget-2016-Health-insurance-for-all.html.
[192] The following summarizes Drèze and Sen, *An Uncertain Glory*, pp. 152-157.

properly regulated, private health providers could screen out chronically ill or very sick patients, charge excessive fees, or administer unnecessary remedies. In addition, targeting benefits to poor families raised many problems, from the measurement of poverty to the reliability of below-poverty-line lists, leading to errors of inclusion and exclusion. Even if such lists were accurate and reliable, a health crisis could still drive a family into poverty, depending on the treatment cost. Second, extending medical insurance for hospitalization bolstered neither preventive medicine nor primary care in rural areas. Indeed, by failing to buttress lower tiers in the public system, an insurance-based model reinforced the dominance of private health services, which demonstrated little interest in primary care due to the greater financial payoffs of tertiary care. Third, allocating greater funds towards insurance coverage within a limited budget effectively diminished the resources available for public healthcare.[193]

Studies of the RSBY to date, although relatively few, revealed some of these problems.[194] After nine years, only half of the BPL households targeted by the initiative received coverage, according to official government data. Yet actual coverage may have been worse. The 71st round of the National Sample Survey in 2014 recorded approximately 11 percent, a far more sobering figure. In 2017, the National Health Profile released by the Ministry of Health reported that approximately 27 percent of the total population had health insurance, the vast majority under public schemes.[195] This higher figure likely encompassed state-level insurance schemes. Nonetheless, the gap between the official number of intended RSBY beneficiaries and these other estimates remained striking. Some health scholars suggested it revealed the creation of fake recipients by insurance companies, which received a premium subsidy for covering all eligible households, as well as the reluctance of insurers to reach out to the latter. In addition, problems of misidentification appeared to be serious. According to the NSS, the poorest quintile comprised approximately 26 percent of all RSBY enrolled households in 2014. But roughly 37 percent of the latter came from the richest 40 percent of the sample, while almost half were above the poverty line. If true, these estimates suggested massive exclusion of genuine beneficiaries. Lastly, while the RSBY indirectly allowed a proportion of families to increase spending on non-medical expenses to some extent, it failed to reduce in aggregate terms out-of-pocket health spending. This was partly due to rising service costs.[196] But it was largely because

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[193] Interview, public health activist, New Delhi, 18 August 2015.
[194] The following summarizes Soumitra Ghosh, "Not a prescription for the poor," *The Hindu*, 17 February 2018: https://www.thehindu.com/opinion/op-ed/not-a-prescription-for-the-poor/article22777746.ece.
[195] Abantika Ghosh, "Only 27 percent of Indians have health insurance," *The Indian Express*, 12 December 2017.
[196] Pritha Chatterjee, "Impact evaluation: why flagship BPL health insurance scheme is in rather poor health," *The Indian Express*, 9 October 2017: https://indianexpress.com/article/explained/health-

outpatient services comprised approximately two-thirds of all out-of-pocket spending on healthcare in India.[197]

The unveiling of the National Health Policy 2017 (NHP 2017), committed to achieving Universal Health Coverage, captured the tensions at the heart of this vision.[198] On the one hand, it had many progressive features. First, the new Policy vowed to extend comprehensive primary healthcare through several measures, ending the "selective" approach that had dominated official thinking since the 1980s. This entailed upgrading a spectrum of SCs and PHCs into 150,000 'Health and Wellness Centers', capable of addressing infectious and non-communicable diseases as well as child and reproductive health, managed by a new public health management cadre. Primary care would receive two-thirds of all funding—as the High-Level Expert Report on UHC had recommended—through a capitation fee system to encourage a preventive approach. Second, the NHP 2017 committed all public hospitals to supplying free drugs, diagnostic care and emergency services, rather than pursuing "cost-recovery". Third, recognizing the multiple inter-sectoral determinants of good health, the Policy called for greater synergy between efforts to improve water and sanitation, reduce traffic accidents and tackle gender-based violence, engendering a social movement for Swasth Nagrik Abhiyan—'Health in All'.

On the other hand, the NHP 2017 continued to envisage a strong role for private health providers in the near term, particularly through "strategic purchasing" in the secondary and tertiary sector where public facilities were inadequate. Given the state of the latter in many regions, this was sensible. Yet a contemporaneous proposal by the NITI Aayog to allow private health providers to treat several non-communicable diseases in district public hospitals through a sub-contracting arrangement, with the state bearing the financial risks, would likely exacerbate the asymmetries of accessibility and quality of care in each sector.[199] Indeed, the Policy was relatively silent on how it would regulate professional councils and clinical establishments. Second, the NHP 2017 envisioned public health expenditure rising to 2.5

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insurance-rashtriya-swasthya-bima-yojana-bpl-card-population-india-4881038/; Anup Karan, Winnie Yip and Ajay Mahal, "Extending health insurance to the poor in India: an impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare," *Social Science & Medicine*, Volume 181 (March 2017): 83-92.

[197] Editorial, "Promoting private for-profit healthcare," *Economic & Political Weekly*, 53, 6 (10 February 2018): 8.

[198] The following assessment integrates the views of three critical appraisals: Kunal Shankar, "We are still not serious about health care," an interview with K. Sujatha Rao, *Frontline*, 14 April 2017: https://www.frontline.in/cover-story/we-are-still-not-serious-about-health-care/article9604527.ece; Yogesh Jain, "In 2017, India was caught between private exploitation and public sector callousness in healthcare," *The Wire*, 30 December 2017: https://thewire.in/health/healthcare-aadhaar-national-health-policy; and T. Sundararaman, "National Health Policy 2017: a cautious welcome," *Indian Journal of Medical Ethics*, 2, 2 (April-June 2017): 69-71; http://ijme.in/articles/national-health-policy-2017-a-cautious-welcome/?galley=pdf.

[199] Sujatha Rao, "A strange hybrid," *The Indian Express*, 11 August 2017.

percent of GDP by 2025, instead of 2017. Significantly, it enjoined the states to raise their allocations for health in their respective annual budgets to eight percent, double the level of many.[200] It was hard to see how such a gradual increase in public funding could support the free comprehensive services that had been outlined. Comprehensive wellness centers presumed sufficient investment in a regular, well-trained public health workforce. Lastly, the 2015 draft of the Policy made a radical pledge to formulate a National Health Rights Act. The final version offered an "assurance-based approach". Public health activists felt acutely they were "losing ground" with the "shift from rights-based to evidence-based" in official government circles.[201]

The 2017-18 Union budget of the Modi administration, its last before the 2019 general election, confirmed the thrust of its approach as well as the misgivings of critics. The Government announced the launch of the National Health Protection Scheme (NHPS) in October 2018, now providing more than 10 crore (100,000,000) poor families with a portable insurance worth Rs. 5 lakhs (500,000) per annum, to help reduce out-of-pocket spending and catastrophic expenses for secondary and tertiary hospital care. The Centre would outline the general framework for the scheme together with the states, sharing the insurance premium costs 60:40, respectively. To pool resources, the former asked the latter to integrate their own health insurance programmes with the NHPS, co-branding the newly created scheme. State Health Agencies would manage its implementation, deciding whether to reimburse private insurers or establish trust-based schemes. To determine eligibility, the Government would use the 2011 Socio-Economic Caste Census, a multidimensional index of social deprivation. Families could select among empaneled hospitals, public or private, to obtain necessary care. To restrain costs, the Government would define a list of conditions to be covered, establish standard clinical guidelines and rates, and monitor costs, procedures and outcomes. Based on average family size, the NHPS would reach an estimated 40 percent of the population, and thus become "the world's largest government-funded healthcare programme".[202]

The strengths and weaknesses of the overall approach remained the same. On the one hand, a portable insurance package that offered higher financial protection would benefit vulnerable families from catastrophic health expenses that frequently induced severe poverty.

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[200] See K. Srinath Reddy, "Making health insurance work," *The Hindu*, 6 February 2018: https://www.thehindu.com/opinion/op-ed/making-health-insurance-work/article22661666.ece.

[201] Interview, public health activist, New Delhi, 14 August 2015.

[202] The preceding summary draws on Abantika Ghosh and George Matthew, "Rs 5 lakh health cover for 10 crore poor," *The Indian Express*, 2 February 2018: https://indianexpress.com/article/business/budget/union-budget-2018-arun-jaitley-national-health-protection-scheme-health-cover-narendra-modi-5048576/; and Reddy, "Making health insurance work". For basic details, see https://www.india.gov.in/spotlight/ayushman-bharat-national-health-protection-mission.

The RSBY covered Rs. 30,000 of hospital expenses, merely six percent the amount provided by the NHPS. On the other, accurately targeting the poor and effectively regulating private medical services remained serious challenges. Despite its far higher ceiling, the NHPS did not cover outpatient services, which comprised the largest share of out-of-pocket expenses. And it begged the question of whether these poor families would receive sufficient preventive care, essential for tackling the persistence of many infectious diseases and well as the growing burden of non-communicable maladies in India.

The Government reiterated its commitment to comprehensive health care by expanding vital primary services, free-of-cost, along the lines of the 2017 National Health Policy. To increase the supply of trained health professionals, it pledged to ensure more than 175 medical colleges in the country and no less than one in each state, an important corrective given the disparity across the Union. To increase resources, a new Health and Education cess of 4 percent would be imposed on households paying income taxes and corporations, another vital measure. Yet all these measures were pledges. The 2017-18 budget failed to signal a commitment to adequate financial provisioning. To reach a public health expenditure target of 2.5 percent of GDP by 2025, the Centre had to increase allocations roughly 20 percent year-on-year. Instead, the allotment to the Ministry of Health and the NHM in the 2017-18 budget declined in real terms.[203] The failure to bolster the provision and functioning of public health facilities in rural India, still desperately required, betrayed the promises of comprehensive primary care made to its most vulnerable citizens.

[203] Soham Bhaduri, "Primary mistake," *The Indian Express*, 6 February 2018: https://indianexpress.com/article/opinion/columns/union-budget-2018-healthcare-private-sector-arun-jaitley-universal-health-coverage-medical-insurance-5052724/.