Communication

Shifting Priorities: Budgetary Changes in Healthcare System in India

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Introduction

A strong healthcare system is vital for a country's development, as it ensures a healthy, productive population capable of contributing actively to economic growth. Accessible and equitable care not only reduces poverty and inequality but also enhances social stability and fosters longer healthier lives. India, a large and diverse country, is marked by socio-economic and cultural disparities (Dhingra & Dutta, 2011). However, the availability, accessibility, and affordability of healthcare facilities in rural areas are far from satisfactory, placing its health indicators critical levels. India has a mixed healthcare system comprising public and private service providers. There is a pressing need for increased public health expenditure to strengthen the health infrastructure, reduce financial hardship and progress towards universal health coverage (UHC). In India, states are responsible for public health and sanitation including infrastructure, while the Central Government, specifically the Ministry of Health and Family Welfare (MoHFW), focuses on funding major initiatives like the National Health Mission (NHM).

For decades, health policies in India have been shaped by the recommendations of various expert committees, most of which have advocated for increasing the demand-side indicators, such as maintaining an adequate skill mix of health workers, strengthening physical infrastructure at the community level, and reducing maternal and child mortality rates through several healthcare initiatives. Following these recommendations, the government included this in the National Health Policy (NHP) 2017, aiming to increase public health spending as a share of GDP by 2-3% by 2025 (Press Information Bureau, Government of India, 2018). Despite these efforts, the country continues to struggle with shortages and uneven distribution of the health workforce.

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To provide the much-needed boost to the inadequate public health services, one of the largest flagship schemes, the National Rural Health Mission (NRHM) was launched on April 12, 2005. The goal of the NRHM was to strengthen the supply-side factors of the healthcare system, ensuring universal access to equitable, affordable & quality healthcare services that are accountable and responsive to people's needs (Government of India, 2014). Additionally, the mission aims to address a wide range of health determinants such as water, sanitation, education, nutrition, social and gender equality and reduction of out-of-pocket expenditure (OOPE). The mission operates under six broad categories: RCH flexi-pool, Mission-flexi pool, Communicable Diseases, Non-Communicable diseases and National Urban Health mission (NUHM). In order to address the health concerns of the urban populations, the ministry proposed to launch a NUHM on 1st May 2013, the aim being to address the health concerns of the urban poor by facilitating equitable access to available health facilities by rationalizing and strengthening of the existing capacity of health delivery for improving the health status of urban poor by establishing and improving the existing urban health infrastructure, urban PHCs/ UHCs. Later the two have been combined and named as National Health Mission (MoHFW, 2013).

Significant achievements under the NHM include reducing the Maternal Mortality Ratio (MMR) from 212 per 100,000 live births in 2007-09 to 97 per 100,000 live births in 2018-20, decreasing the Infant Mortality Rate (IMR) from 58 to 33 per 1,000 live births over the same period, and lowering the Total Fertility Rate (TFR) from 2.9 to 2.0 during 2005 and 2009 (National Health Mission, 2018). Parallelly, the Government of India also launched the early health insurance schemes to provide financial assistance for health care.

This article attempts to analyze the trends in government health budget allocations following the implementation of the NHM. It will explore how the financial commitments and priorities have shifted and expanded in response to the goals set by the NHM, with a particular focus on assessing the allocation efficiency and the impact on various health outcomes across India.

Evolution of Health Policies in India

In India, the government has parallelly been operating health insurance schemes alongside the NHM to protect lower-income households from financial risks. These schemes have experienced significant expansion since the 2000s. While the modern health insurance schemes have expanded significantly in recent years, the foundation for such programs was laid much earlier. The first health insurance scheme post-independence was introduced in 1954, named the Central Government Health Scheme (CGHS), exclusively for Central Government employees and their respective families. This was later followed by the Maternity Benefit Act of 1961. However, these initial health insurance policies were designed solely for formally registered

government employees with the primary goal of protecting these employees. In 1997, the Parliamentary Committee on Human Resource Development, in their 31st report concerning the functioning of Central Government Hospitals under the MoHFW, raised concerns over the inadequate facilities available to treat major life-threatening diseases for economically disadvantaged patients and emphasized the role of public-funded health insurance schemes as a means to protect families from out-of-pocket spending.

Another significant development in this period was the introduction of government-sponsored health insurance programs, which protected households from the high cost associated with inpatient care. The primary objective of these programs has been to provide access to affordable health care to lower-income households. For example, in 2003, the Government of India introduced the Universal Health Insurance Scheme, designed to offer financial protection to lower-income and Below Poverty Line (BPL) households.

In an effort to safeguard the marginalized sections of the population who faced financial risk due to hospitalization and their daily expenses, the Government of India launched the Rashtriya Swasthya Bima Yojana (RSBY). Initiated by the Ministry of Labor, this program aimed to provide affordable and accessible healthcare services, along with insurance coverage for secondary care (Malhi et al., 2020). It also involved the financial assistance of Rs. 30,000 per member up to five members through the RSBY card. The most notable achievement of the RSBY scheme was its enrolment of around 34 million families, significantly expanding coverage for secondary hospital care. Prior to RSBY, only 5 percent of India's population had health insurance; following the program's implementation, this number doubled to 10 percent (110 million) people, marking a substantial achievement for India (Fan, 2013).

However, RSBY faced several limitations, such as challenges in accessing government subsidies by people from BPL categories due to lack of awareness, missing identification documents, slow processing of applications, and caps on beneficiaries (Kamath & Kamath, 2020; Rao, 2022; Taneja & Taneja, 2016). Owing to these limitations in providing financial protection to the impoverished, several states introduced their own health insurance schemes. This included schemes like Tamil Nadu's Chief Minister's Comprehensive Health Insurance Scheme, Kerala's Karunya Aarogya Suraksha, Maharashtra's Mahatma Jyoti Rao Phule Arogya Yojana, West Bengal's Swasthya Saathi and Gujarat's Mukhyamantri Amrutam Yojana etc., however there were other states who were relying only on the Centre funded health insurance schemes.

PM-JAY

To address the shortcomings of RSBY, the Central Government launched the Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PM-JAY) in 2018. This national publicly funded health in-

surance scheme subsumed the ongoing RSBY and the Senior Citizen health insurance schemes (SCHIS) on 23rd September 2018. Ayushman Bharat introduces a comprehensive approach to healthcare, launching two interrelated components: (i) Health and Wellness Centers (HWCs) and (ii) Pradhan Mantri Jan Arogya Yojana (PMJAY). The primary goal of Ayushman Bharat is to ensure health and continuity of care, where PMJAY provides secondary and territorial hospital care, and HWCs are focused on delivering comprehensive primary care for upgrading sub-centers and primary health centers.

The implementation of PM-JAY in India marks a critical step taken towards achieving UHC in India. States are required to establish State Health Agencies (SHAs) and are given the autonomy to choose whether to operate the scheme as an insurance model, a trust model, or a mixed model. PM-JAY, a centrally sponsored scheme is fully funded by the Government with financial contributions divided between Central and state governments as per the guidelines of the Ministry of Finance. The scheme offers health coverage of up to Rs. 5 lakhs per family per year for secondary and territory hospitalization. It features no restrictions on family size, ensuring that all members, especially girl children and senior citizens, are covered. As an entitlement-based scheme, PM-JAY targets poor and vulnerable families identified through the Socio-Economic Caste Census (SECC) based on deprivation and occupational criteria. The primary objective of the PM-JAY scheme is to reduce the catastrophic expenditure of poor and vulnerable sections of society as well as to improve access to quality health care by providing financial protection for different secondary and tertiary care hospitalizations for nearly 120 million impoverished families (Joseph et al., 2021).

Over the past five years, PM-JAY has achieved several milestones. As of 2024, more than 35.4 crore Ayushman cards have been issued. Additionally, about 14.6 crore cards have been issued to women, with 49% of the treatments under the scheme utilized by women, and 3.61 crore hospital admissions have been utilized by women, highlighting the scheme's focus on gender equity (PIB, 2024). Budgetary allocations specific to the PM-JAY within the total health budget of Ayushman Bharat are shown in Table 1 (Union Budget, 2024).

Shifts in Budgetary Allocations

However, it has been observed that since the introduction of the PM-JAY scheme, there has been a noticeable shift in the health budgetary allocations toward public-funded health insurance schemes such as PM-JAY, Rashtriya Arogya Nidhi (RAN), Central Government Health Insurance Schemes (CGHIS), Medical Treatment of CGHS Pensioners (PORB) and other formal sector-based insurance schemes. Concurrently, there has been a reduction in the budgetary allocation to schemes like the NHM, which primarily focuses on strengthening public health infrastructure (Fig. 1).

Table 1: India's Health Budgetary Allocation Towards PM-JAY Scheme

Year	Budget Estimate (crore)	Revised Estimate (crore)	Funds released as part of central share (crore)
2018-19	2400	2160	1849.55
2019-20	6400	3200	2992.94
2020-21	6400	3100	2544.12
2021-22	6400	3199	2940.65
2022-23	6412	6412	6048.63
2023-24	7200	7200	4553.41

Source - Unstarred Question No. 7, Ministry of Health and Family Welfare, Lok Sabha, February 2, 2024; PRS.

The recent PRS (2024) report analyzing the 2024-25 health budget of MoHFW showed a significant shift in the budgetary allocations of government from supply side to demand side indicators. In 2024-25, department of health and family welfare was allocated Rs.90,659 crore, which constituted a 13% rise over the revised estimate of 2023-24. The allocation towards NHM constituted 40% of the department's budget in 2024-25. The allocation towards NHM is 14% (Rs.36,000 crore) higher than the revised estimates in 2023-24 (Union Budget, 2024).

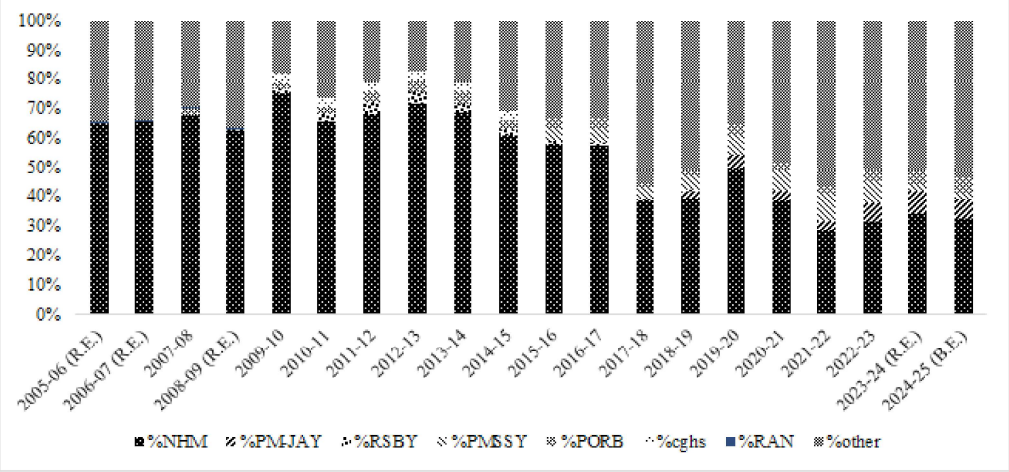
However, a careful analysis reveals that despite the importance of NHM for the supply side of health system, central releases towards NHM have been stagnant and decreasing from 2016-17. There was a significant decline in the health budget of NHM from 57% to 38% for the year 2016-17 to 2017-18. Since then, the Central Government's fund allocations have remained stagnant or falling, accounting for less than 40% of total healthcare budget allocation up to 2023-24.

Furthermore, the allocation of funds towards RSBY declined by 325% (a reduction of Rs. 2000 crore) over the revised estimate of 2017-18. In contrast, there has been a noticeable increase in budgetary allocation for Pradhan Mantri Swasthya Suraksha Yojana (PMSSY) at Rs. 3,825 crore marking a 20% increase. Additionally, there was a 5% increase in the health budgetary allocation for formal insurance schemes like CGHS for the year 2017-18. Another significant component which registered a remarkable increase in its funds is the PM-JAY. The allocation for this publicly funded health insurance scheme saw a dramatic rise from its initial budget of Rs. 1997.42 crore in 2018-19 to Rs. 7300 crore in 2023-24, an increase of 265%. Moreover, its share of the overall health budget increased from 2% to 7% from 2018-19 to 2023-24.

Impact Assessment

The reduction in budget allocation to the NHM raises significant concerns, especially in light of the burden on health infrastructure witnessed during the COVID-19 pandemic. The NHM's goal is to ensure universal access to quality healthcare by enhancing health infrastructure. With a budget cut from Rs 37,165 crore in 2022-2023 to Rs 36,785

Fig. 1: Union health budgetary allocation towards different components of health schemes



*S*ource: https://www.indiabudget.gov.in

crore this year, one must question how effectively we can prepare our healthcare system against similar future crises. Current data highlights that, even before the pandemic, there was a substantial burden on health services, with approximately 9,702 individuals per government allopathic doctor and 1,666 people per government hospital bed in India, which is way lesser than what is actually needed.

Additionally, the Reproductive and Child Health (RCH) Flexi pool, which supports maternal and child health, family planning, and the Janani Suraksha Yojana(JSY)—and now also funds immunization and iodine deficiency programs—has experienced funding decreases. This reduction in budget could negatively impact essential health metrics like the MMR and IMR, as these programs are critical in improving these indicators. These financial reductions threaten not only the structural capacity of healthcare facilities but also the broader goal of improving public health outcomes across the country. Researchers have also raised concerns that the recent budget's reallocation of funds away from NHM towards other areas, such as the establishment of new nursing colleges and a sickle cell anaemia eradication program, while commendable, does not compensate for the overall decrease in funds dedicated to critical public health services. This shift indicates a potentially troubling trend away from strengthening public health systems towards more segmented health initiatives (Gaur, 2023).

The Way Forward

The assessment reveals that overall, spending on the NHM by the MoHFW has been decreasing over the years while there has been an observed increase in the allocation for Publicly Funded Health Insurance Schemes (PFHIs), primarily

PM-JAY and PMSSY. The current government places greater emphasis on Ayushman Bharat-PM-JAY which is evident in its spending patterns. Since the introduction of PM-JAY up to the fiscal year 2024-25, real-term spending has nearly doubled, growing at an average rate of 18% per annum. It is noteworthy that even though the Centre draws a lot of mileage from these schemes, a higher proportion of the budgetary allocation is still borne by the states, predominantly for healthcare services (The Hindu, 2024).

However, the real question arises: Are these Publicly Funded Health Insurance Schemes (PFHIs) capable of reducing inter-state variations in health indicators and addressing shortages of human resources and medicines? Is the government promoting privatization in hospitalization at the expense of improving its inadequate public health infrastructure or reducing its government health provisions? The potential negative implications associated with government-funded health insurance schemes cannot be ignored.

Several plausible explanations exist for these challenges. First, these PFHIs may not be sufficient to provide complete protection from financial risks to poor households. For example, several studies have indicated that half of the eligible households were unaware of the RSBY scheme, including how and where to enroll (Sinha, 2013). Furthermore, other reviews have reported that despite being enrolled under health insurance schemes, beneficiaries still spend a major proportion of their Out of Pocket Expenditure (OOPE) on medicines and outpatient care (Malhi et al., 2020).

Secondly, studies across several states have found that PFHIs involving empaneled private hospitals often lead to additional financial burdens on patients. These hospitals have been reported to extort money from patients, compel them to purchase medications externally, and incur additional costs for diagnostic and other tests not covered by the insurance (Maurya et al., 2020; Taneja & Taneja, 2016). Concurrently, there is evidence that households have experienced an increase in non-medical health spending. This suggests that while households may have benefited from access to care, the financial relief expected from lower OOPE has not materialized; one way or another, they end up incurring OOPE. A fundamental issue with these health insurance schemes is that policymakers have not adequately explored their practical efficacy at the ground level. There is a disconnect between the intended policy outcomes and the actual experiences of the insured, highlighting a critical gap in the implementation and monitoring of these schemes.

To conclude, PFHI schemes (demand-side indicators) are powerful tools for providing protection from financial risk to poor households. However, supply-side indicators, such as public hospitals, human resources, and equipment—primarily financed through schemes like the NHM—are crucial for our country. The limited coverage of BPL individuals under insurance schemes suggests a fail-

ure of PFHIs to some extent. Although these schemes have reduced out-of-pocket spending, disparities in health equity have become more pronounced. To address this, there is a need for increased government spending on health infrastructure. The government needs to find a way to balance supply and demand-side indicators, as focusing solely on one parameter can exacerbate health inequities. If policymakers aim to engage people as co-creators of value, they must listen to what the populace values and be willing to adjust their approach when it becomes apparent that what people actually value differs from initial expectations (Ecks & Kulkarni, 2023).

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