



India's public health spending stands at around 2.1% of GDP as of 2023, below BRICS peers and the National Health Policy target of 2.5% by 2025.

Out-of-pocket expenditure constitutes about 47% of total health spending, leading to catastrophic expenditures that push roughly five crore people into poverty annually.

State variation is stark, with some states like Kerala spending proportionately more on health and others like Bihar spending less than one percent of state GDP on health.

Health is a State subject under the Seventh Schedule, but the Union has expanded roles through centrally sponsored schemes, standards setting and epidemic management responsibilities.

NHM exemplifies cooperative federalism by combining central funding with state implementation, while pandemic-era tensions highlighted the limits of coordination without institutional mechanisms.

ARC-II and other committees recommended creating bodies like a National Health Council to facilitate Centre-State collaboration, strengthen PHC and link funding with outcomes.

Marginalised groups including SC/ST communities, tribals, migrants and persons with disabilities experience systemic under-service and poorer health outcomes, requiring targeted outreach and scheme design.

Ayushman Bharat's portability features aimed to assist migrants, while NHM includes tribal sub-plans and state-led tribal outreach examples such as Kerala's targeted health initiatives.

Gender disparities remain an issue in access and outcomes despite schemes reporting near-equal female beneficiary shares in some programmes, necessitating gender-sensitive service delivery.

Comparative models include the UK's tax-funded NHS, Brazil's decentralised SUS, Thailand's UHC with strong primary care focus, and Rwanda's community health worker model resembling ASHAs.

Recommended reforms include raising spending to 2.5% of GDP, universalising PMJAY to include near-poor groups, regulating private sector through clinical establishments legislation and creating public health cadres.

Ethical considerations tie to dignity, justice and responsibility in crises, emphasising transparency, empathy for community health workers and integrity in regulating the pharma-doctor nexus.

COVID-19 served as a stress test exposing critical gaps in infrastructure such as hospital beds, oxygen supply systems and logistics for essential medical supplies.

The oxygen crisis and distribution bottlenecks revealed shortcomings in preparedness and prompted emergency interventions and judicial scrutiny over allocation decisions.

Centre-State tensions around vaccine procurement, oxygen and resource allocation highlighted the need for clearer roles, cooperative mechanisms and robust pandemic governance frameworks.

Digital platforms like Aarogya Setu and CoWIN enabled large-scale contact tracing and vaccination management, while Vaccine Maitri showcased India's international health diplomacy.

Public-private partnerships accelerated vaccine production and distribution, and local governments such as Kerala and Odisha led effective containment strategies leveraging community resources.

Community participation, including SHGs producing masks and sanitizers, demonstrated the role of grassroots mobilisation and local manufacturing in crisis response.

The National Digital Health Mission promotes Unique Health IDs, digital health records and interoperability to enable continuity of care and better health system analytics.

e-Sanjeevani recorded over 12 crore teleconsultations by 2023, expanding remote healthcare access and reducing geographic barriers for primary consultations.

Expansion of digital health raises concerns around privacy, data protection and regulatory frameworks to safeguard patient information and ensure secure usage of AI for surveillance.

India administered over 220 crore COVID-19 vaccine doses, illustrating mass mobilisation capacity but also pointing to logistics and equity challenges during rollout.

Measures like PMGKP insurance for frontline health workers and judicial oversight of crisis management underscored the need to protect and incentivise the healthcare workforce.

The pandemic reinforced the imperative to build resilient supply chains, local manufacturing capacities and decentralised stockpiles to handle future public health emergencies.

Public health financing snapshot with expenditure levels, out-of-pocket share, targets and state-level variations informing fiscal strategy

Federalism dynamics in health: state subject status, central scheme roles, cooperative federalism examples and ARC-II recommendations for institutional mechanisms

Equity and inclusion considerations for marginalised groups, migrants, tribal populations, gender disparities and targeted programme provisions

Global health system comparisons, reform proposals and ethical linkages to governance, public trust and GS-IV ethical responsibilities

Financing, Federalism, Equity, Global Comparisons, Reforms and Ethical Links

Rationale and Constitutional Judicial Basis for Health Governance



Constitutional provisions framing health as a right under Article 21 and a state duty under Article 47, anchoring policy and programmatic commitments in fundamental and directive provisions

Key Supreme Court judgments expanding right to timely medical aid, emergency care and linking social rights to health outcomes in governance jurisprudence

Pandemic-era judicial pronouncements and constitutional responses highlighting oxygen denial, migrant issues and systemic accountability under Article 21

Article 21 has been interpreted by the Supreme Court to include the right to health as part of the right to life, forming a legal basis for state action in health governance.

Article 47 as a Directive Principle of State Policy obliges the state to raise nutrition levels and improve public health, guiding long-term policy priorities and program design.

Constitutional morality and principles of equity have been invoked to justify affirmative measures for marginalised groups in health provisioning and access.

Parmanand Katara (1989) established the duty of medical professionals to provide timely medical aid, reinforcing emergency care obligations under the Constitution.

Paschim Banga Khet Mazdoor Samity v. State of WB (1996) held that government hospitals must provide emergency medical care, underscoring state responsibility in life-threatening situations.

Mohini Jain and related cases linked socio-economic rights with health and education considerations, shaping judicial oversight of public health entitlements.

The Supreme Court in 2021 held that denial of oxygen and critical care during COVID could amount to violation of Article 21, demonstrating judicial enforcement in crisis situations.

Courts intervened on migrant worker welfare and vaccine allocation to ensure rights-based responses and administrative accountability during the pandemic.

Judicial emphasis on equitable distribution and access reinforced demands for resilient public health infrastructure and transparent governance.

NHM launched in 2005 as NRHM and later merged with NUHM in 2013 to form NHM, aiming for universal access to affordable high-quality healthcare across India.

Institutional innovations include deployment of ASHA community health workers, formation of Rogi Kalyan Samitis and decentralised flexi-funds to empower local health planning and management.

NHM integrates AYUSH, sanitation and nutrition interventions and received a budget allocation of approximately ₹37,000 crore in FY24 to support programme activities.

Infant Mortality Rate declined from 58 in 2005 to 27 in 2023, reflecting substantial gains in child survival and primary care outreach under NHM interventions.

Maternal Mortality Ratio fell from 524 in 2004 to 97 in 2020, while institutional deliveries increased from about 40% to over 90% through targeted maternal health schemes.

NHM remains underfunded relative to India's health needs, contributing to persistent shortages of doctors, nurses and skilled personnel at primary and secondary levels.

Quality gaps persist in PHC service delivery, with non-communicable diseases management relatively neglected compared to maternal and child health priorities.

Implementation varies significantly across states, with better performance in states like Kerala and weaker outcomes in states like Bihar, and accountability mechanisms such as social audits remain weak.

Ayushman Bharat Launched in 2018 comprises PMJAY for insurance-based tertiary care and a network of Health and Wellness Centres aiming to transform primary healthcare delivery and disease management.

PMJAY offers a benefit cover of ₹5 lakh per eligible family per year, designed to be cashless, portable and paperless with linkage to digital identity systems.

Health and Wellness Centres seek to expand service baskets to include NCD screening, mental health, dental care and palliative services to reduce pressure on higher-level facilities.

PMJAY covered over 5 crore hospital admissions by 2024 and is estimated to have saved approximately ₹30,000 crore in out-of-pocket expenditure for beneficiary households.

The scheme extends coverage to about 10.74 crore poorest families, approximately 50 crore people, and records near gender parity with more than 48% female beneficiaries.

PMJAY's cashless portability and integration with digital health infrastructure support continuity of care and linkage with national digital health initiatives.

Many eligible households remain unaware or unenrolled in PMJAY, leading to exclusion errors and uneven access, especially among urban informal workers and migrants.

Moral hazard and fraudulent claims in private empanelled hospitals, low package rates deterring provider participation and weak grievance redressal mechanisms undermine scheme efficiency.

Questions about long-term fiscal sustainability persist, along with debates over balancing public provisioning and insurance-based models for universal health coverage.

The goal of establishing 1.5 lakh HWCs by 2025 aims to strengthen primary care; over 1.2 lakh HWCs were reported operational by 2023, improving rural OPD access.

HWCs incorporate telemedicine solutions, early diagnosis and management of NCDs, thereby reducing referrals and easing the load on district hospitals and tertiary centres.

Successful state pilots in Gujarat and Tamil Nadu exemplify scalable HWC models that increased outpatient utilization and community-level continuity of care.

Day 16: Health Governance — NHM, Ayushman Bharat, Pandemic Lessons

Pandemic Lessons, Policy Innovations, and Digital Health Ecosystem

National Health Mission (NHM): Design, Achievements, and Limitations

Ayushman Bharat, PMJAY and Health & Wellness Centres: Structure, Outcomes, Challenges

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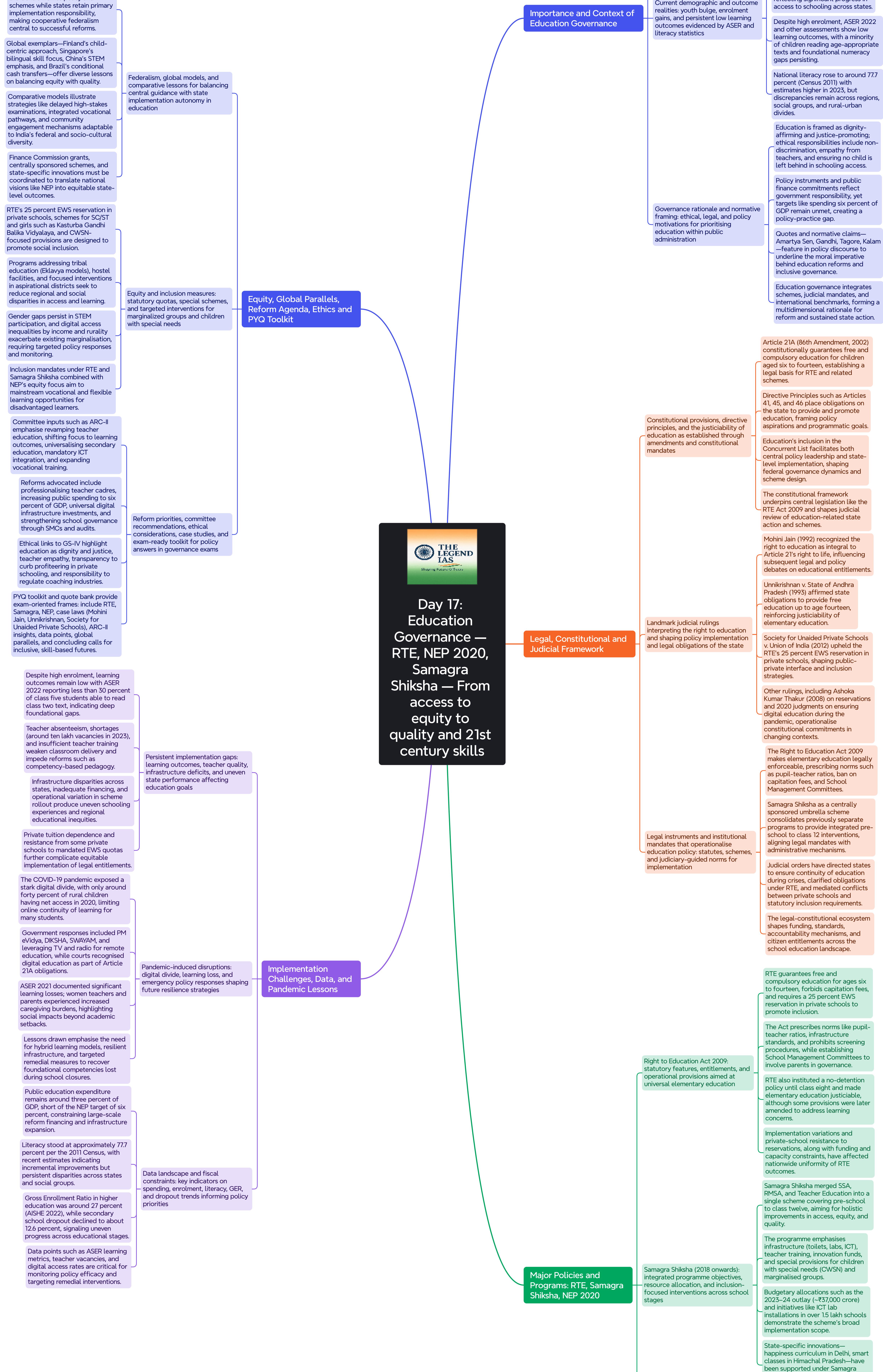
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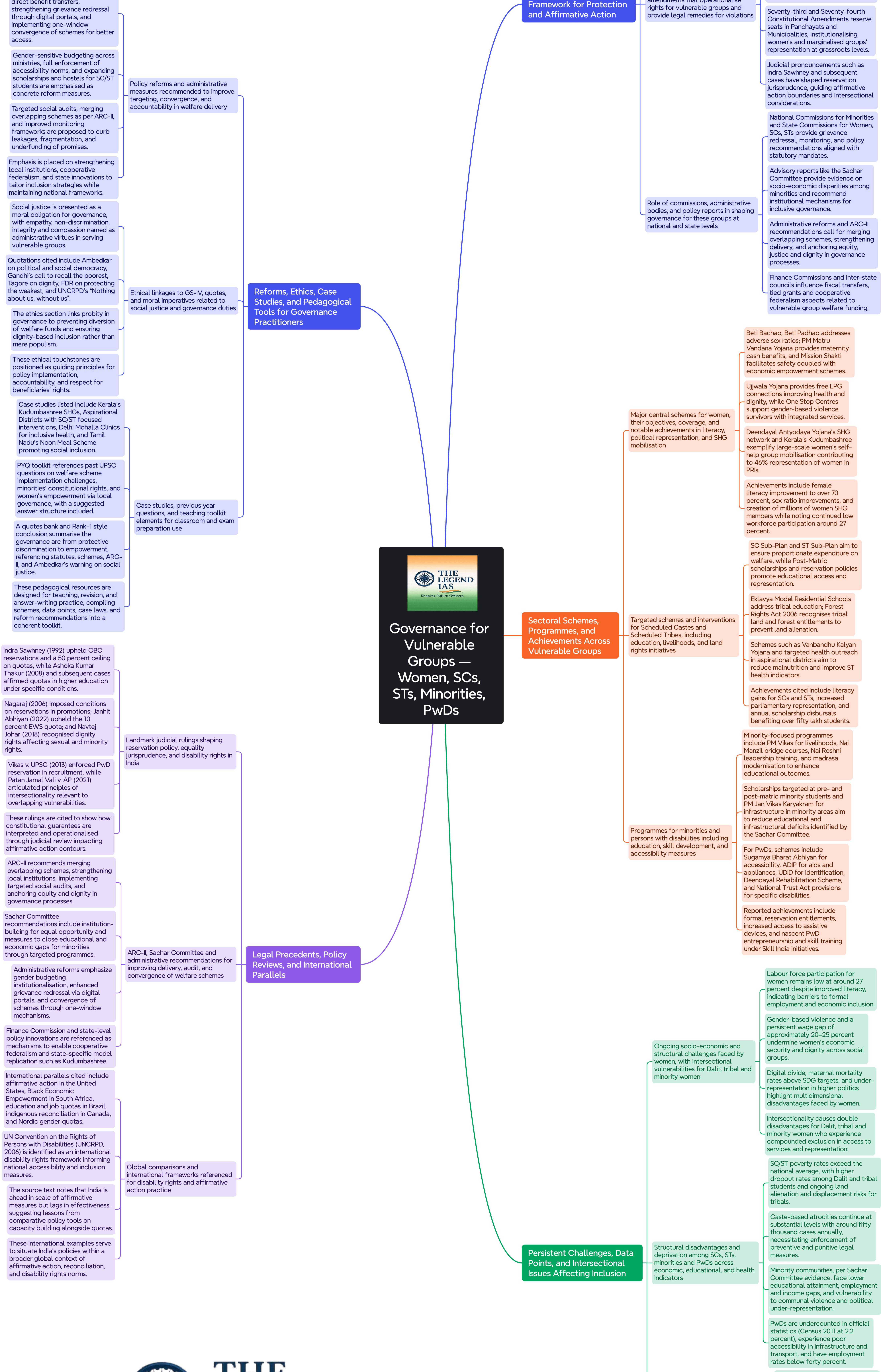


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