



India's health transitions

Country impact profile

April 2022

India has embarked on a journey to provide universal health coverage (UHC) to its citizens with the National Health Policy, 2017 and the introduction of the Pradhan Mantri Jan Arogya Yojana (PMJAY) scheme for the poorest and vulnerable populations in 2018. At the same time, India faces increasing burdens of non-communicable diseases and changes in its demographic profile which has consequences on health investments and delivery. India is undergoing four crucial transitions—in demography, disease patterns, donor spending on health, and domestic health financing (the “4Ds”)— which will have a profound impact on the country’s ability to move towards UHC. In the face of these transitions, there are many challenges that the country needs to tackle to successfully achieve UHC.

1 Demographic transition

Three key demographic transitions stand out in India: (1) An increase in the share of ageing populations with the proportion of people over the age of 65 years expected to double to 14% by 2050. However, 30% of the elderly live below the poverty line and over 62% of those who need palliative care are not receiving it. (2) With rapid urbanization, urban populations are expected to double by 2050. High levels of urban poverty and very low insurance coverage are critical challenges for India to reach universal health coverage. (3) One third of India’s population is in the 10-24 years age group and the working age population is expected to grow by roughly 9.7 million per year during 2021-31. India’s youth face an increasing burden of non-communicable diseases (NCDs), including mental health disorders.

2 Disease (epidemiological) transition

India is undergoing a disease transition with a growing burden of NCDs. NCDs are emerging as a leading cause of death and accounted for 60% of total deaths in 2016 compared to 38% in 1990. Three NCDs emerged as the leading causes of death in 2017: ischemic heart disease, chronic obstructive pulmonary disease (COPD), and stroke. The changing disease burden also affects household health expenditures. Household out of pocket expenditures (OOPE) on NCDs contribute towards an increasing share of the financial burden, with distress financing (e.g., through borrowing or sale of personal assets) being highest for cancer, genito-urinary disease and heart disease.

3 Domestic finance transition

Public health expenditures (PHE) in India are only 1.18% of gross domestic product, well below the global average of 6% and the 2.5% recommended by the High-Level Expert Group for Universal Health Coverage in India. Low PHE have led to high and inequitable OOPE on health by households which accounts for more than 60% of current health expenditures. Health sector performance is driven to a large extent by state-level implementation. Inequities in regional health inputs and outcomes point towards the need for better harmonization of public health investments and state implementation capacity for UHC.

4 Donor health aid transition

India is scheduled to transition from concessional financing by major health donors such as Gavi, the Vaccine Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the World Bank in the next few years. Transition planning for financing, technical inputs, and programmatic support from external partners remain crucial for ensuring smooth functioning of disease programs in India, especially given the additional threats to public health services due to the COVID-19 outbreak.

This is one in a series of profiles focusing on middle-income countries that are transitioning out of official development assistance for health. The profiles are part of a broader study, [Driving health progress during disease, demographic, domestic finance, and donor transitions](#), led by the Center for Policy Impact in Global Health.



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Background

India is the second most populous country in the world with a population of over 1.34 billion.¹ Although it is one of the fastest growing economies, the country has poor socio-economic and health outcomes (*Table 1*). Around 600 million people fail to access the health services they need, and 63 million Indians are living in poverty because of healthcare costs.² A chronically low level of public health spending at 1.18% of gross domestic product (GDP) has resulted in high out of pocket expenses (OOPE) for households.³ Health is a state subject in India where the implementation of all major health programs is the responsibility of state governments. The health inequities in India are further aggravated by poor infrastructure and inadequate planning and implementation capacity across the states.

Over the past few years, the government has recognized the importance of better health for India's development and is taking action to improve services and increase financial protection – especially for the poor.^{3,4} In 2005, the National Rural Health Mission was introduced with a focus on improving health outcomes in high priority states, i.e. states with poor infrastructure and poor public health indicators. This program was expanded to urban areas in 2014, and came to be known as the National Health Mission. In 2010, the government introduced its first non-communicable disease (NCD) policy, called the Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke. India was successful in eradicating polio and completed 5 years as a “polio free nation” in 2016.⁵

The National Health Policy, 2017 sets out a universal health coverage (UHC) roadmap for India with an emphasis on increasing public financing of health to 2.5% of GDP by 2025.³ In September 2018, the government of India launched the Ayushman Bharat Yojana, to provide comprehensive need-based healthcare. One of the two pillars of the Ayushman Bharat program is the Prime Minister's Jan Arogya Yojana (PMJAY) program, the largest publicly financed health insurance program in the world. The PMJAY is expected to increase government spending on health, while also reducing OOPE on in-

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patient health services for the poorest 40% of families in India, amounting to over 500 million poor and vulnerable people.⁶ The other pillar is improved primary health care through the health and wellness centers. While these initiatives show great promise, India's health system development and progress towards UHC is also greatly affected by four major transitions that are happening within the health sector:

- a rapidly changing demography
- an epidemiological transition
- changing patterns in domestic financing such as increased need for domestic resources for health, and
- transition from concessional donor financing for health.

These transitions will have a profound impact on India's progress towards universal health coverage (UHC). In this profile, we examine the impact of these four transitions on the three dimensions of UHC—population coverage, service coverage, and financial risk protection (FRP). Our aim was to understand the challenges in achieving UHC in India and the opportunities that can help manage these challenges.



Table 1: Snapshot of India's key development and health indicators

Economic indicators	Gross domestic product (GDP)	\$ 2.95 trillion
	Gross national income per capita	\$ 1927.81
	Government expenditure % GDP	11%
Social indicators	Human Development Index	0.640
	Poverty headcount ratio at national poverty lines (% of population)	21.9
	Literacy rate	73%
Health indicators	Public health expenditure, % GDP	1.15%
	Impoverishment due to catastrophic OOPE (% of total population; poverty line at PPP \$1.90)	4.16%
	Infant mortality rate (per 1000 live births)	33
	Maternal mortality ratio (per 100,000 live births)	167
	Doctor- population ratio	1:10,926

Source: World Development Indicators, India health profile, 2019. OOPE: out of pocket expenditures; PPP: purchasing power parity

Implications of health transitions on UHC in India

Demographic transition

Situational summary

India is undergoing a demographic transition with the proportion of people aged 65 years and above expected to double from 6.6% in 2020 to 13.8% of the total population by 2050 (Figure 1). Some Indian states, such as Tamil Nadu, Karnataka, Himachal Pradesh, Punjab, West Bengal, and Maharashtra, are already witnessing rapid ageing of their populations.⁷ The healthcare needs of ageing populations pose socio-economic challenges for the elderly, while also putting a strain on the health system with the age-related transition towards NCDs. The WHO Survey on Global Ageing and Adult Health showed that households with people older than 50 years suffered a greater financial burden due to health costs compared to households without older people.⁸ This burden includes higher rates of impoverishment, catastrophic health expenditures and borrowing of money to pay for health services.

Currently, one third of India's population is in the 10-24 years age group and the working age population is expected to grow by roughly 9.7 million per year during 2021-31. Huge demographic dividends can be reaped from a bulge in the working-age population (people between 15 and 64 years of age)⁹ by maintaining a healthy young workforce. The health needs of the young and adolescents in India need to be prioritized given the expected increase in the 15-64 years age group over the next decade.

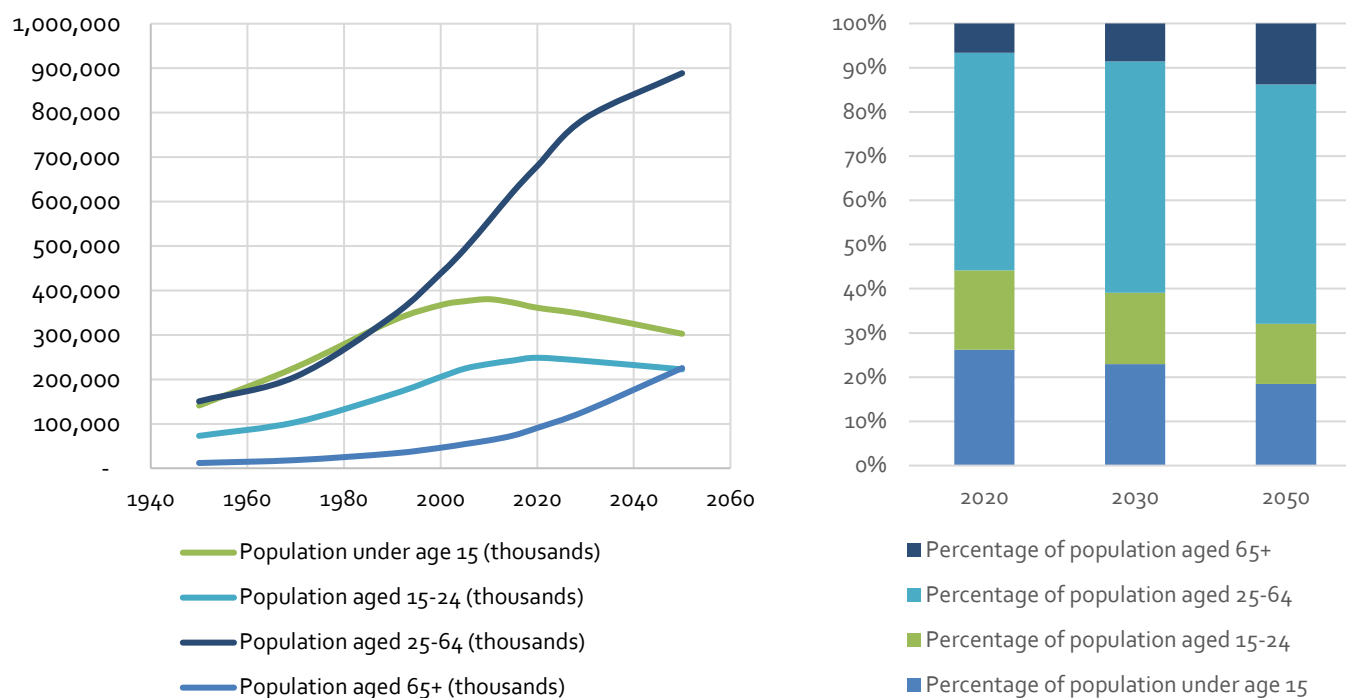
Although 70% of India's population live in rural areas, this proportion is projected to change dramatically with rapid urbanization in India. By 2040-50, urban India will constitute 50% of the total population with a doubling of the urban population from 461 million to 877 million by 2050.¹⁰ Urban populations are facing a greater share of the burden of NCDs resulting from hypertension, unhealthy lifestyles, pollution, and greater risks of road crashes and other injuries.^{11,12} Urbanization is also one of the leading causes for the increasing burden of injuries as a share of the total disease burden in India.¹³

Challenge: Addressing the needs of vulnerable ageing populations

The rising number of elderly people will require greater provision of elderly care services such as nursing homes, day-care centers, out-patient services, or intensive care, depending on the health issue. Over 30% of older persons in India are estimated to live below the poverty line, another 33% are at risk of poverty, 80% live in rural areas, and about 73% are illiterate.¹⁴ There are also huge gaps in healthcare provision to the elderly. A 2018 survey showed that over 62% of elderly people do not receive long-term palliative care when they need it, of which 52% lack primary family support to meet their health needs.¹⁵ With large sections of the elderly population living in rural areas and in poor economic conditions, the limited elderly care service coverage can put this age group at risk



Figure 1: Population trends in India by age-group



Source: Authors' creation based on data from [World Population Prospects, India 2019](#)

Challenge: Meeting healthcare needs of the urban poor

With rapid increases in urban populations, India will need to provide adequate urban health facilities, especially for the urban poor. India's 2011 census found that 13.7 million households live in slums in India.¹⁶ The urban poor in India face many challenges related to healthcare delivery. First, the incidence of communicable diseases such as tuberculosis and NCDs, including diabetes, is higher among the urban poor compared to rural areas.^{17,18} Second, 35% of urban households survive on less than a dollar per person per day.¹⁹ Third, as a consequence of high poverty, 30-40% of urban residents live in overcrowded slums or slum-like conditions with poor access to sanitation, clean water, and hygienic conditions.²⁰ The presence of large numbers of migrant laborers and daily wage earners in big cities adds further complexity to disease control in India. A 2014 UNAIDS report showed that the HIV prevalence among low-wage labor migrants in urban areas was four times higher than the national prevalence rate.²¹ Healthcare provision and socio-economic improvements in urban India have not been able to keep pace with the country's rapid urbanization. About eight million children under the age of 6 years live in urban slums and around 47% of the children of the urban poor are malnourished.¹⁶ Almost 60% percent of urban poor

children have not received all recommended immunizations before the age of one year.²² Primary healthcare facilities in urban areas serve a higher share of the population than India's Public Health Standards norm of one facility per 50,000 people.¹⁶ Although the publicly-funded National Urban Health Mission (NUHM) was launched to improve healthcare access in urban areas, the performance of the scheme has not been satisfactory due to poor performance by the states in using the funds for this program.

Finally, from a healthcare financing perspective, out of a total urban population of 438 million, an estimated 359 million (82%) people lack financial risk protection for health and at least 97 million people lack financial protection from catastrophic out-of-pocket (OOP) spending on health.²³ The 2017-18 National Sample Survey Organization data show that only 17.8% of urban residents are covered by some form of insurance mechanism (11.9% government-sponsored insurance, 3.5% private voluntary insurance, and 2.4% employer-sponsored programs). Urban households mostly depend on the private sector for their healthcare needs.²⁴ This reliance on private care leads to higher OOP, increasing financial hardships for the urban poor while also adversely affecting their health seeking behavior.²³ In the 2017-2018 survey, only 9.7% of the poorest quintile were



insured compared to 36.4% in the richest quintile. OOPE in urban areas are also growing faster with a 50% increase between 2004 and 2014 compared to rural areas where OOPE grew by 23% during the period. This disparity points towards an urgent need to provide financial protection for the urban poor whose health needs will grow due to rapid urbanization over the next few decades.

Challenge: Addressing health needs of youth and adolescents

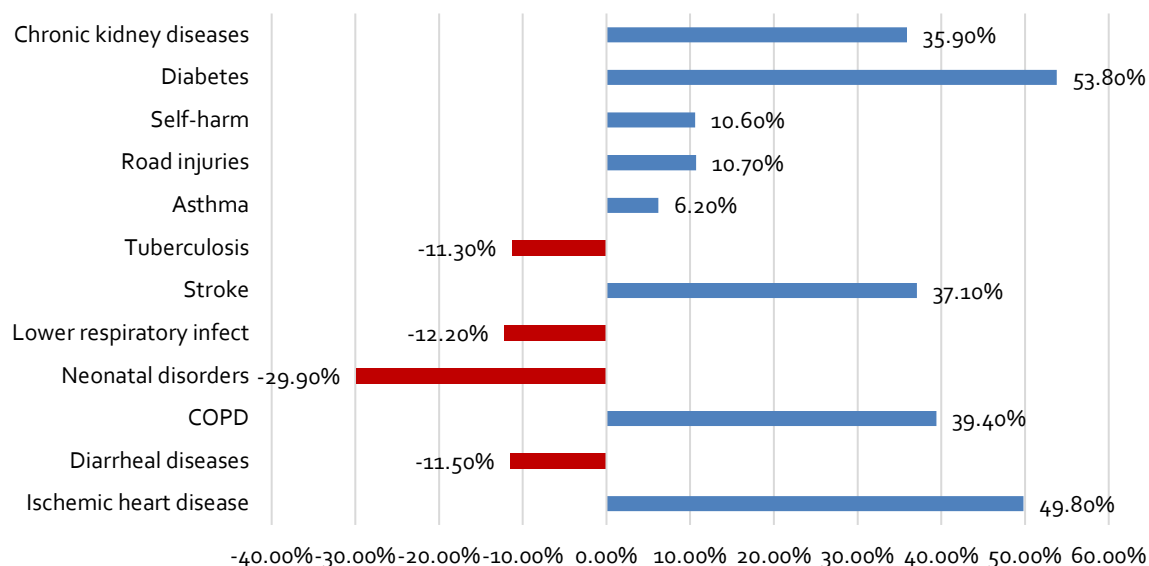
A wide range of social, personal, and lifestyle factors impact the health of young people and adolescents. According to the WHO, two-thirds of premature deaths and one-third of the total disease burden in adults is associated with conditions or behaviors initiated at a young age (e.g., tobacco use, physical inactivity, high-risk sexual behaviors, injury, and violence).²⁵ Studies show that several health problems are faced by the youth in India, including: malnutrition; increasing rates of obesity among children and adolescents; sexually transmitted infections and HIV linked to risky sexual behavior; mental illness (which has a prevalence of 20% in people aged 15-24 years in India) and suicide (40% of suicides in India are in people under 30 years); harmful substance use, including tobacco, alcohol, and other substances; and rising rates of NCDs such as hypertension, diabetes, chronic lung diseases, and traffic injuries.²⁶

Disease (epidemiological) transition

Situational summary

India is experiencing a rapidly growing burden of NCDs. In 1990, NCDs accounted for about 38% of deaths, but by 2016 the proportion had risen to 62%.¹³ Three NCDs were the leading causes of death in 2017: ischemic heart disease, chronic obstructive pulmonary disease (COPD), and stroke. Deaths caused by diabetes and chronic kidney diseases (CKD) also saw an increase over this 10-year period (*Figure 2*).²⁷ Cardiovascular diseases led to the highest mortality in both 2007 and 2017, and caused the highest number of disability adjusted life years (DALYs) in 2017. In contrast, the number of deaths caused by communicable and maternal diseases and injuries among the top 10 causes of death fell from 2000 to 2017 (*Figure 3*). For some of the underperforming states in India, like Uttar Pradesh, there is a double burden of both infectious diseases and NCDs. These states are still in the early stages of their epidemiological transition with their burden of infectious diseases such as TB being as significant as their burden of NCDs, such as chronic obstructive pulmonary disease.¹³ While the rising burden of NCDs in India disproportionately affects older people, nevertheless the incidence of NCDs, including obesity, diabetes, and lung diseases, is also rising steadily in children and adolescents.^{28,29} The rising burden of NCDs is associated with rising exposure to behavioral, dietary and metabolic risk factors: unhealthy diets, high

Figure 2: Percentage change in top causes of deaths, 2007-2017

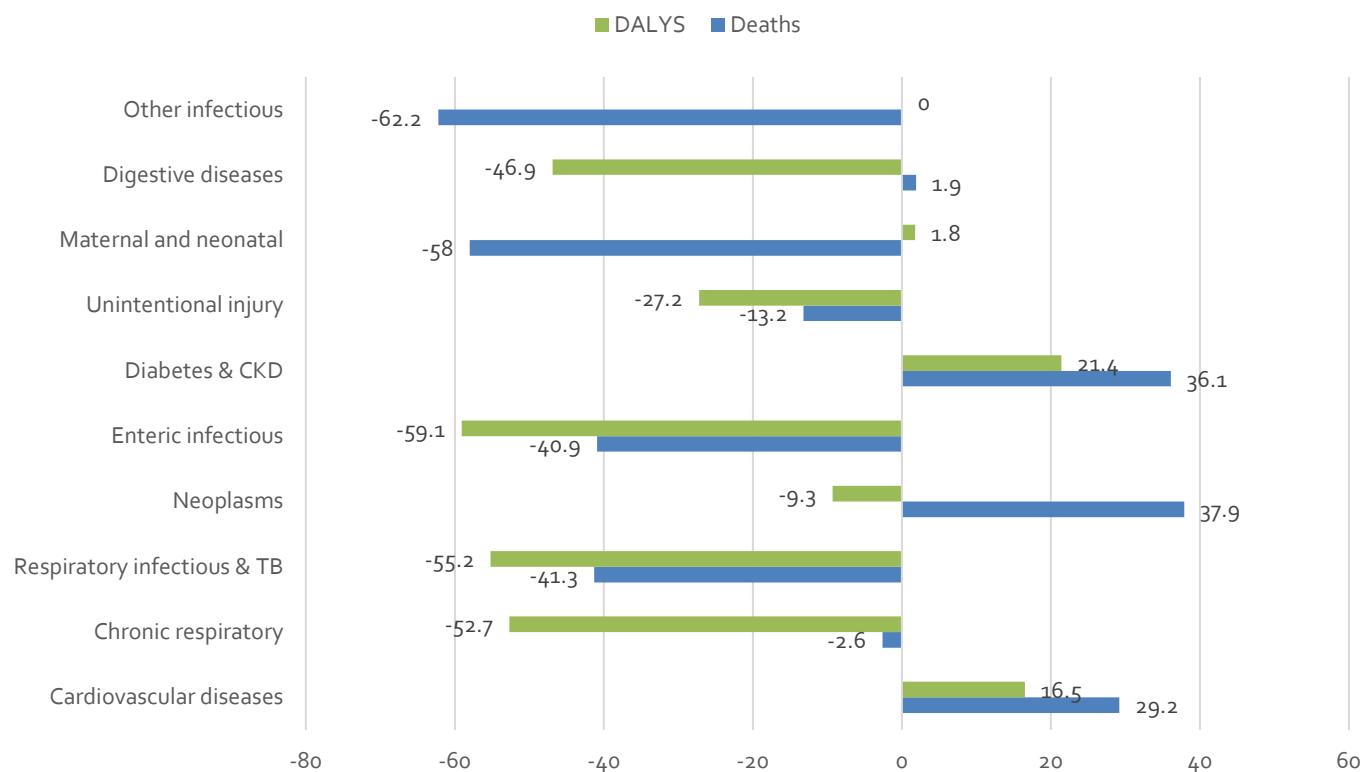


Source: Authors' creation based on data from the Institute of Health Metrics and Evaluation [Global Burden of Disease](#) 2017.



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Figure 3: Percentage change in deaths and DALYs per 100,000 population, 2000 - 2017



Source: Authors' creation based on data from the Institute of Health Metrics and Evaluation [Global Burden of Disease](#) 2017. CKD: chronic kidney diseases; TB: tuberculosis

blood pressure, high blood sugar, high cholesterol, and high body mass index. These risks are in turn linked with tobacco use, alcohol consumption, consumption of sugar sweetened beverages and highly salt foods.¹³ Moreover, the early evidence from the COVID-19 pandemic shows that elderly people and those with underlying pre-existing NCDs are more likely to become severely ill or die if they get infected with SARS-CoV-2.³⁰ Thus, the high infection rate and high burden of NCDs in India could have severe long-term impacts on the population and the country's health system.³¹

Challenge: Health service provision for growing burden of NCDs

In response to India's NCD crisis, the government launched the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases, and Stroke to provide comprehensive diagnosis, treatment, follow up, and referral services for NCDs.³² However, weak implementation capacity, poor training quality, and poor awareness about the services have been major challenges

in ensuring that NCD services reach the targeted population.³³

Challenge: Higher financial burden due to NCDs

With disease transitions resulting in a rising burden of NCDs and injuries in India, healthcare expenses have risen significantly.³⁴ Studies have shown that the proportion of OOP expenses due to NCDs rose from 32% in 1995–1996 to 47% in 2004.³⁵ Data from the household health expenditure survey 2014 showed that 58% households who used hospitalization services due to NCDs faced catastrophic health expenditure. Catastrophic health expenditures were borne by 52% households who used hospitalization services due to injuries and by 35% households who used hospitalization services due to communicable diseases. A disease-specific breakdown of catastrophic health expenditures showed that distress financing through borrowing, sale of assets and other sources was highest for NCDs. Distress financing as a percentage of catastrophic health expenditures was highest for cancer (91%), genito-urinary, and heart diseases.³⁶



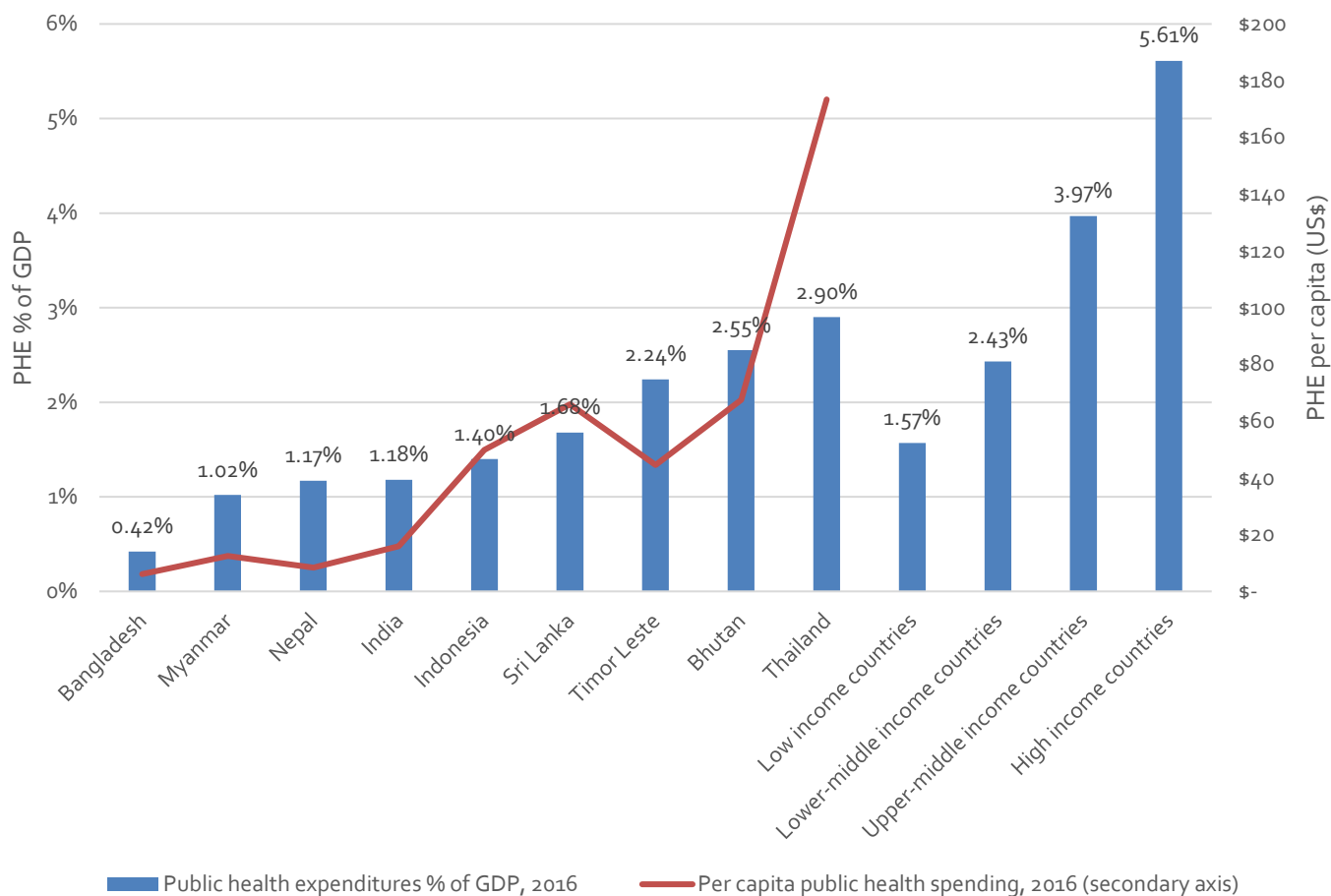
Domestic financing transition

Situational summary

Public health expenditure (PHE) in India is very low at 1.18% of GDP³⁷, far below the global average of 6%, and is one of the lowest in the South East Asian region (SEAR) (Figure 4). Government health expenditures are less than 4% of total government spending in India, and less than the proportion for other sectors such as education. Low levels of government financing of health lead to acute health service shortages, and put poor families at financial risk (Figure 5). As per the 2015-16 National Health Accounts (NHA) of India, government health expenditures stood at 23% of current health expenditures (CHE), equivalent to 4.07% of general government expenditures in 2015-16. However, the share of household OOPe is very high at 60.6% of CHE and amounts to 2.3% of India's GDP.³⁷

To help provide protection against catastrophic expenditures, there are a number of different government-sponsored insurance schemes that provide coverage to different population groups (Table 2). The most prominent ones are the Central Government Health Scheme (CHGS), which provides coverage to central government employees and families,³⁸ and the Employees' State Insurance Scheme (ESIS), which covers low wage salaried employees.³⁹ Before the introduction of PMJAY, the Rashtriya Swasthya Bima Yojana (RSBY) was a publicly financed health insurance program aimed at providing coverage to people living below the poverty line against in-patient costs.⁴⁰ Yet, one quarter (23%) of India's population lives in poverty and more than 17% of the total population faces catastrophic health expenditures, spending more than 10% of their household income on health expenses (Table 3).¹

Figure 4: International comparisons of public health expenditure, 2016

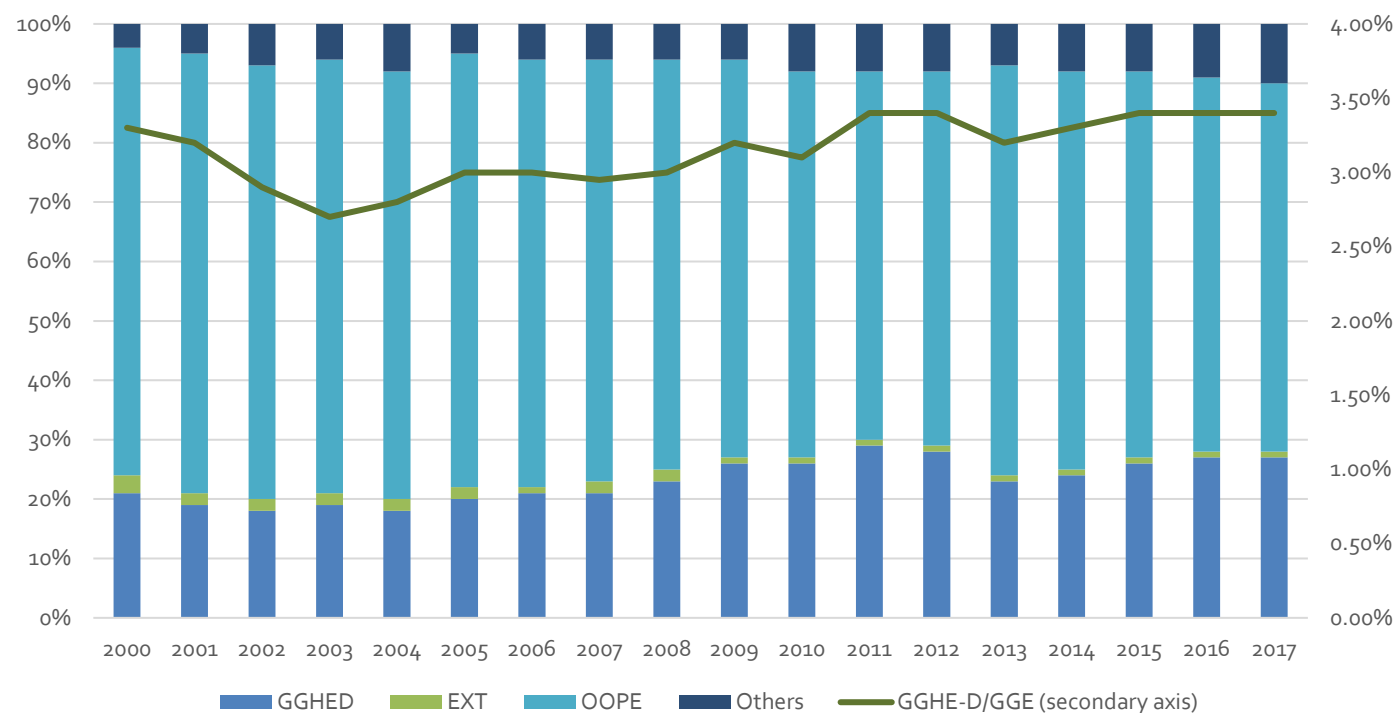


Source: Authors' creation based on data from the National Health Profile of India, 2019



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Figure 5: Health expenditure trends in India, 2000-2017



Note: GGHED: Domestic general government health expenditure; EXT: External health expenditure; OOPE: Out-of-pocket health expenditure; GGE: General government expenditure

Source: Authors' creation using data from the Global Health Expenditure database, WHO 2018

Table 2: Population coverage under three main government sponsored insurance programs in India

Coverage under three main government sponsored insurance programs in India			
	Pradhan Mantri Jan Arogya Yojana	Central Government Health Scheme	Employees State Insurance Scheme
Who is covered?			
Population coverage	Poor, deprived rural families and certain categories of urban workers' families as per the latest Socio-Economic Caste Census data. The estimated number of beneficiaries is 500 million.⁶	Central government employees, dependents, and pensioners. 3.1 million beneficiaries as of 2016-17.⁴¹	Low wage salaried employees earning less than INR 21,000 per year. ³⁹ 124 million beneficiaries as of 2016-17.
Government subsidy	100% (60% from the central government, 40% from the state government)	95% from the central government	12.5% from the state government
What is covered?			
Service coverage	Cover of INR 5,00,000 per family per year In-patient care received at both public and empaneled private hospitals and includes pre- and post- hospitalization and follow-up care expenses. A total of 1,350 medical	No upper limit 1900 medical packages covering inpatient and outpatient care. ³⁸	No upper limit 1900 packages including chronic, maternal, preventive and wellness care, out-patient and inpatient care. Also includes compensatory



	packages have been defined that can be availed by PMJAY beneficiaries. ⁶		cash benefits for loss of wages, disability benefits for permanent and temporary disability, and a maternity cash program
How much financial protection is available?			
Beneficiary contribution	No; 100% coverage	Yes Rate of beneficiary contribution: 5% of wages and salaries	Yes Rate of employer contribution: 3.25% of the wages payable to employees. Rate of employees' contribution: 0.75% of the wages payable to an employee.
Premium	No	Average premium: INR 600-6000 based on base salary	Average premium: INR 440 - 750
Government Subsidy	100% (60% from central government, 40% from state government)	95% from the central government	12.5% from the state government
Point of care expenses	Beneficiaries are issued PMJAY cards and all transactions under PMJAY are cashless and paperless. The NITI Aayog is helping to set up an information technology platform to facilitate this. ⁴	Cashless facility available for treatment in empaneled hospitals and diagnostic centers. Reimbursement of expenses for treatment availed in government or private hospitals under emergency. Reimbursement of expenses incurred for purchase of hearing aids, artificial limbs, appliances etc. as specified.	Cashless facility available for treatment in empaneled hospitals and diagnostic centers.

Source: Authors' creation based on data from various government websites

Challenge: Low levels of public financing of health & its impact on poor and vulnerable population groups

A recent study looked at if and how poor and vulnerable populations in India gained from government initiatives and health reforms like the National Health Mission (NHM) and government-funded insurance programs, compared to the rich sections of society. The study compared policy reform impact in the pre-policy reform era, in 2004 and the post-policy reform era, and in 2018 across three categories of Indian states - high-focus states, high-focus north eastern states, and non-focus states. The study found that the NHM led to improvement in public infrastructure and service provision relatively benefited the poor. Use of healthcare services, except outpatient care visits, significantly increased in 2018 compared to 2004.

Utilization rate differences between the poorest 20% and richest 20% declined significantly during the same period.

The poor received a relatively smaller health subsidy compared to the rich when using inpatient and outpatient health services. The distribution of the public subsidy for curative services (inpatient and outpatient) remained mostly pro-rich in the period 2004 – 2018 with some decline in the pro-rich distribution in 2018. While the NHM remained committed to broader expansion of health care services, a singular focus on MCH conditions, especially in the least developed regions of the country, has yielded desired results. Nevertheless, poor access to health services and low service quality persist.⁴²



Challenge: High levels of out of pocket expenses

Currently, the total insurance coverage is 0.3% of the population through CHGS, and 17% of the formal workforce through ESIS and PMJAY covering 40% of the population below poverty line. Almost two-thirds of OOP

Table 3: Catastrophic health expenditures and poverty due to health spending

Population		% of total population	Headcount (millions)
Catastrophic health expenditures	10% of household expenses	17.33%	216.11
	25% of household expenses	3.90%	48.51
Impoverishment due to OOPE	Poverty line at PPP \$1.90	4.16%	51.9
	Poverty line at PPP \$3.10	4.61%	57.5

Source: World Bank World Development Indicators

expenses in India are directed at outpatient care and over 55 million people are estimated to be impoverished annually on account of health care spending. The PMJAY covers the costs of treatment and hospitalization for secondary and tertiary care (Table 2), and disincentivizes the use of more cost-effective PHC.⁴³ Overuse of tertiary care services might adversely affect public financing of PHC in India, although the NHP 2017 sets a target of two-thirds of public health spending on primary care. The National Household Morbidity Survey of 2014 showed that 58% of OOPE was spent on outpatient care, compared to 32% on in-patient care. Moreover, 51.7% of OOPE by households was spent at pharmacies compared to 25.0% at hospitals.⁴⁴ In fact, OOPE on medicines takes up the largest share of the total OOPE by households. About 82% of the total OOP medicines expenditure and 67% of total OOP diagnostic expenditure was for outpatient treatment. However, when we compare per capita government health expenditures, we see large disparities in terms of benefits of government expenditures for different population groups. As per the National Health Accounts (NHA) 2014-15, while average per capita government health expenditure was only INR 1944, it was six times higher at INR 6,300 for the CGHS scheme, showing that the well-off government employees benefitted more than general households did from government health expenditures. These statistics indicate a mismatch in government spending and a financial burden of healthcare expenses on households.

Donor health aid transition**Situational summary**

India receives concessional development assistance for health (DAH) from a number of key external funders. The top five donors that provide official development assistance (ODA) to India are the World Bank International Development Association (IDA), the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund), Gavi, the Vaccine Alliance (Gavi), the United States and the United Kingdom. Out of total ODA of US\$ 422 million received in 2018, these top five donors account for almost 90% of all DAH in India. (Figure 6). With an increase in per capita income level and improving health outcomes, India is transitioning, or set to transition, from receiving concessional ODA from a number of key multilateral and bilateral funders. Thus, concessional funding from external sources will decline gradually over the next few years and budgetary allocations for these donor-supported programs will need to be significantly increased. The declining ODA can be seen in Figure 6. The current transition status of India from the top multilateral health donors is summarized in Table 4.

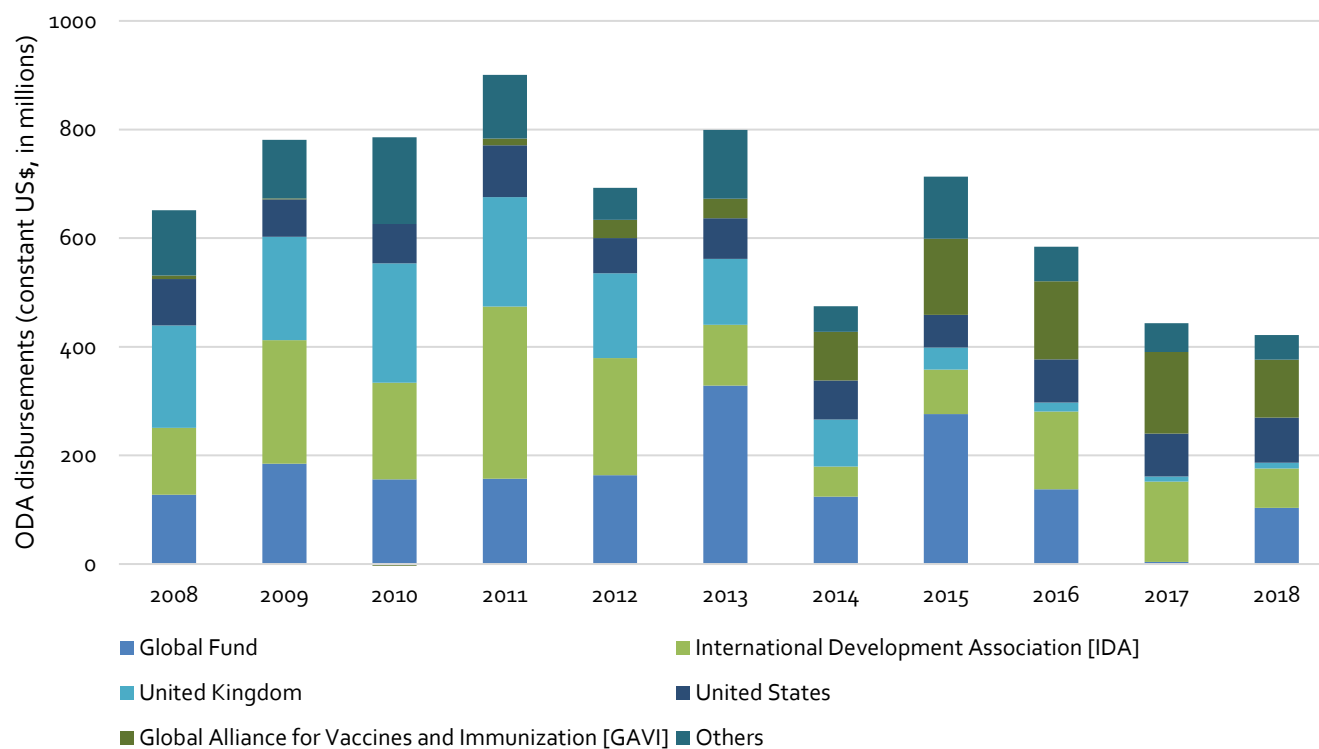
Table 4: India's transition status based on transition criteria of key multilateral health donors

Donor	World Bank International Development Association	Gavi, the Vaccine Alliance	Global Fund for AIDS, TB and Malaria
Transition criteria	Based on country's gross national income per capita (GNI p.c.) and credit worthiness	Based on GNI p.c. and national immunization coverage	Based on GNI p.c. and disease burden
India's transition status	Transitioned fully from IDA support in 2014 ⁴⁵	Entered accelerated financing transition phase in 2017 and expected to fully self-finance Gavi-supported vaccines by 2021 ⁴⁶	Not projected to transition from HIV, TB or malaria components until 2025. However, Global Fund is in discussions with the government of India to transition out over a nine-year period from 2018-2026. ^{47,48}

Source: Authors' creation based on data from various websites



Figure 6: Development assistance for health from top 5 donors in India, 2008-2018



Source: Authors' calculations based on data from the Organization for Economic Co-operation and Development, Creditor Reporting System

Challenge: Sustaining health programs after donor exits

Although external health expenditures are less than 0.7% of total health expenditures in India, donor transitions without adequate transition planning could threaten the gains made through donor support. External financing constitutes 25% of the central government expenditure, which disproportionately impacts health policy and priorities. Moreover, there is a risk that transition away from donor assistance could make it harder to reduce the burden of several infectious diseases and could reverse some of the recent progress in improving health outcomes. For example, India has the largest number of TB cases in the world and accounts for a quarter of the global TB and multidrug-resistant TB (MDR-TB) burden. In 2016, in India 2.79 million people became ill from TB and there were 435,000 TB deaths.⁴⁹ India is in the accelerated transition phase of receiving immunization support from Gavi. This means that Gavi financing for immunization will fall sharply by 2022 and domestic financing will need to be ramped up significantly to maintain immunization coverage for India's children. More than 26 million children are born in India every year, one of the largest annual birth cohorts in the world. India also accounts for more than 20% of child

mortality worldwide. Even though some progress has been made in terms of immunization coverage, 7.4 million children in India are not immunized, accounting for the largest number of unvaccinated children in the world.⁵⁰ The transition from donor support can put health systems and sustainability of health programs at risk if not managed properly.

Challenge: Impact of donor exits on service delivery and vulnerable populations

Like most lower middle-income countries that have a high disease burden and low investments in health and healthcare, India has adopted a selective primary healthcare approach. In this approach, the country invests in disease control programs for reproductive, maternal and child health and major infectious diseases, such as TB, malaria and HIV, which contribute to a substantial burden of disease in the country. These national disease programs, which have made a significant contribution to disease control, have functioned largely as vertical programs with a long history of donor engagement and investment.⁵¹ Although donor funding



is a relatively small share of the overall total health expenditures in India, donors continue to play an important role in service delivery and determination of health policy and priorities in India. Apart from health donors like Gavi and the Global Fund, philanthropic organizations like the Bill and Melinda Gates Foundation have made a major contribution to disease control programs such as the highly successful Avahan HIV control program.⁵² India continues to receive a significant share of funding from these international donors for HIV, TB and malaria programs with key contributions to national programs such as the National AIDS Control Program (NACP), the Revised National Tuberculosis Control Program (RNTCP) and the National Vector Borne Disease Control Program (NVBDCP) for malaria control.^{53–55} The exit of donors from these different programs will likely result in implementation challenges for the programs and will also have major implications for long term funding, planning and sustainability.

Challenge: Ensuring continuity of services for vulnerable groups

Donor support and engagement of non-government organizations (NGOs) and civil society organizations (CSOs) go a long way towards addressing stigma related to HIV and TB by creating awareness and providing healthcare access to these populations. People living with HIV or TB can face stigma and discrimination in India. HIV in India is mainly concentrated among key populations—sex workers, migrant workers, drug users, transgender people, and men who have sex with men⁵⁶—who are highly stigmatized.^{57,58} Women diagnosed with TB report that their families, employers, and communities shun them. Donors like USAID support TB stigma awareness through joint efforts with NGOs, CSOs, companies, and healthcare providers. Initiatives have also been undertaken to improve outreach to high-risk groups and increase HIV testing and access to care, counseling, and treatment. USAID partners with NGOs, community-based organizations, and municipal corporations to raise awareness about the disease and prevent stigma.⁵⁹ Donor transitions could adversely impact vulnerable populations, unless in government programs to ensure that healthcare access and service coverage continues to be available for stigmatized and vulnerable groups.

Opportunities to address challenges posed by health transitions

Although India faces several challenges due to ongoing and upcoming health transitions, there are also opportunities to address them through relevant policies and programs:

Improving effectiveness and use of current health programs

Several government and publicly funded programs have been in place in India that address the challenges described above. For example, to address the healthcare needs of elderly populations, the National Programme for Healthcare of Elderly (NPHCE) was introduced in 2011. The NPHCE is implemented under the NCD arm of the NHM with an objective to provide preventive, curative, and rehabilitative services to the elderly, develop a specialized workforce, and promote research in the field of diseases of old age.⁶⁰ The recently launched PMJAY scheme also emphasizes the healthcare needs of the elderly through the Health and Wellness Centers (HWCs) being set up across the country to provide a wide range of health services at the primary health care level. The Senior Citizen Health Insurance Scheme (SCHIS) for Senior Citizens aged 60 years and above has been brought under the PMJAY umbrella extending more than 1300 benefit packages to the elderly.⁶ Similarly, policies to address the health needs of youth and adolescents, including healthy lifestyle and health promotion policies, have been launched. The government of India launched the Rashtriya Kishor Swasthya Karyakram (RKSK) in 2014 to improve the health of adolescents,⁶¹ addressing nutrition, injuries and violence (including gender-based violence), NCDs, and mental health and substance misuse. India also launched a comprehensive reproductive, maternal, newborn, child and adolescent health strategy in 2013.⁶²

The National Health Mission (NHM), which has been in place since 2005, allows need-based allocations based on disparities in capacity and health outcomes. This program prioritizes 18 high priority states with poor health outcomes – eight of these states receive higher allocations to address health inequities.⁶³ There is much

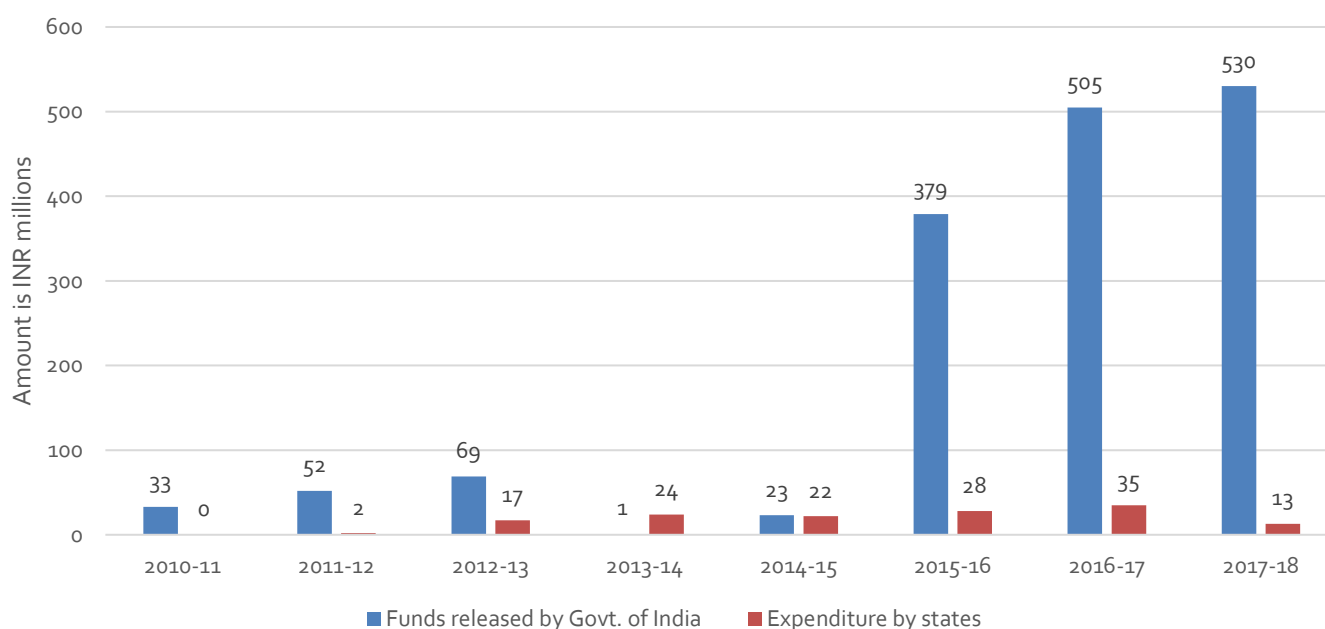


scope for improvement in the implementation of the NHM through greater technical support and capacity development in poor performing states.

Almost 70% of total public health expenditures in India are spent at the state level and states are responsible for implementing these healthcare programs. However, underutilization of funding of government programs at the state level has been impacting health prioritization and overall health spending. For example, the utilization of the NHM budget, which accounts for almost one-third of

India's health expenditures, has been as low as 55% in major states like Bihar and Maharashtra as a result of complex and rigid processes of budget execution, and low fiscal capacity and prioritization by the states.^{64,65} In recent years, only 7% of the funds allocated under NPHCE have been used (*Figure 7*).⁶⁶ The underuse of NPHCE also results from poor planning and implementation capacity at the state level. Improving the capacity of state governments to use these programs to their full capacity will provide opportunities to improve service coverage and better respond to the challenges posed by transitions.

Figure 7: State level spending on NPHCE since 2010



Source: [India Spend, April 4, 2018](#)

Strengthening primary health systems through Health and Wellness Centers

Strengthening PHC facilities is foundational to achieve UHC in India and to mitigate impacts of ongoing health transitions. The push for improving PHC in India has been a continuous process. The National Health Policy, 2017 emphasizes the importance of strengthening primary care, and the High-Level Expert Group Report on UHC calls for a 70% budgetary allocation to PHC.

The revamping of the primary health care system through the health and wellness centers provides an opportunity to improve coverage of primary health services for the rural and urban poor. The HWCs included in Ayushman Bharat

are an effort try to transform the existing PHCs and sub health centers to provide free comprehensive and primary health care and operationalize a comprehensive PHC strategy. The services provided through the HWCs include family planning; maternal and child healthcare; NCD screening, prevention and control; elderly health care; mental health; first level care for emergencies and trauma; outpatient services; and free essential drugs and diagnostics. So far, 30,696 HWCs have been set up across India, with a plan to establish 150,000 across the country by 2022.⁶⁷

Considering the health needs of urban populations, the National Health Policy 2017 includes provisions to expand



PHC centers through the National Health Mission over a five-year period from 2017–2021. These provisions include setting up:

- one urban primary health center for every 50,000 to 60,000 population
- one urban community health center for every five to six urban primary health centers in big cities, and
- one accredited social health activist or a community-link worker for every 200 to 500 households.

Various states in India have adopted multiple initiatives to address health needs in urban areas. For example, the Mohalla Clinics in Delhi offer a basic package of essential health services, including 110 medicines and 212 diagnostic tests free to clients. The Urban Health Kiosk initiative under the NHM in Punjab is funded through property taxes and provides limited medical services for slum dwellers and the poor at their doorstep.²³ The provisions under the NHP and examples of successful initiatives undertaken by individual states provide opportunities to improve access to urban primary health care in India, especially to improve the conditions of the urban poor.

Improving financial protection through publicly funded programs

The recently introduced Ayushman Bharat initiative has a two-pronged strategy to improve financial protection for households. The PMJAY targets the health needs of 40% of India's poorest families. This publicly financed health insurance scheme creates a large risk pool of over 500 million beneficiaries. The pool comprises poor, deprived rural families and an identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census data covering both rural and urban areas. PMJAY also covers all citizens above the age of 65 years who will benefit from this program for inpatient tertiary care.⁶ The NPCHE has potential to improve health services for the elderly through a focus on strengthening implementation capacity at the state level.⁶⁰ Other government programs such as the National Policy on Older Persons, the National Old Age Pension Programme, and the Annapurna Programme have been introduced to improve the socio-economic status of the elderly.^{68–70}

The Ministry of Health and Family Welfare also aims to

implement the National Free Diagnostic Services Initiative under the NHM.⁷¹ This initiative aims to reduce OOP spending on diagnostic services by providing free health screening for key health risks and free essential diagnostic services for each facility level. The services encompass hematology, serology, biochemistry, clinical pathology, microbiology, radiology, and cardiology. State governments are also allowed to add more services based on epidemiological considerations and available financial resources.

Improved domestic resources for health

The National Health Policy, 2017 states that the goal is to increase public spending on health to 2.5% of the GDP by 2025.³ This increase is in line with the recommendations of the High Level Expert Group for Universal Health Coverage in India.⁷² The PMJAY scheme is expected to greatly increase government spending on health while also reducing OOP on in-patient health services for over 500 million poor and vulnerable citizens in India (Table 3). The budget allocation for the fiscal year 2018-19 was INR 2,400 and for 2019-20 is INR 64 billion (approx. US\$ 843 million).⁷³ The insurance coverage under PMJAY is INR 500,000 per family per year, which is also a marked improvement compared to the RSBY which only provided coverage of INR 30,000 (approx. US\$ 400).

By providing insurance coverage for hospitalization and tertiary services (Table 2), PMJAY provides financial protection for the poor. The scheme is fully funded by the government, with states playing an increasingly important role by funding 70% of the total expenses under this scheme. The introduction of the PMJAY scheme led to an 11.5% increase in the 2018-19 outlay for the health and family department.⁶

Learning from previous donor transition experiences

As donor funds decrease for some of the major health programs in India, donor efforts should focus on ensuring smooth transitions and supporting government efforts to sustain health programs in the long-run. Strategic support at the later stages of donor-funded programs can help in addressing key gaps in service provision and coverage in India's health sector. In recent years, several initiatives have been undertaken by the government of India to step up planning and financing for various health programs that have received technical and financial

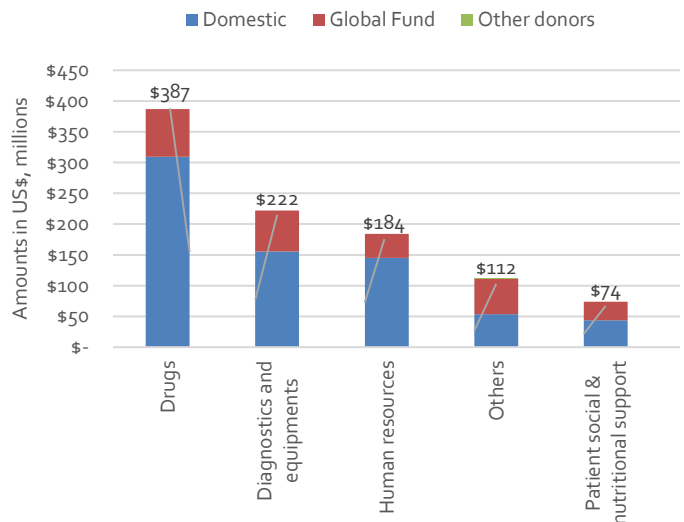
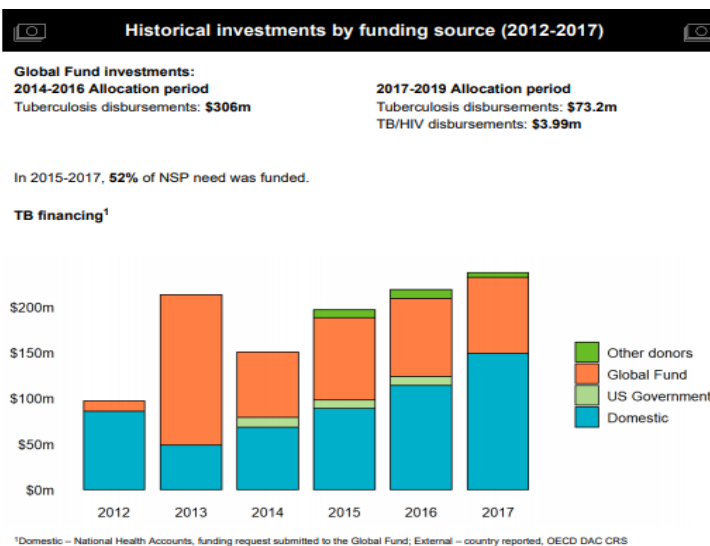


support from donors. In order to address the TB burden in India, the National Strategic Plan (NSP) 2017–2025 for TB Elimination (also known as the National Tuberculosis Elimination Program) was launched with a goal to achieve a rapid decline in the burden of TB while working towards elimination by 2025. The NSP is based on four strategic pillars of “Detect – Treat – Prevent – Build” to move towards elimination. Several donors such as the Global Fund, World Bank and USAID are supporting this government effort to eliminate TB in India (Figure 8). Gavi, UNICEF and other donors are playing an important role in supporting India's universal immunization program, Mission Indradhanush, that aims to ensure full immunization of children below two-years of age and

pregnant women in India.⁷⁴ Donor support to this program is in the form of technical support, vaccine supply chain and cold chain management, and immunization policy development.

Assessing India's transition preparedness and ensuring that donor transitions do not threaten the progress made will be important for ensuring sustainable health programs. India received US\$ 1 billion support from the World Bank to help prevent, detect, and respond to the COVID-19 pandemic and strengthen its public health preparedness. This emergency support points towards existing financing and health systems gaps that need to be strengthened.⁷⁵

Figure 8: Historical and proposed donor financing for TB in India



Source: The Global Fund http://docs.theglobalfund.org/010/ind-t_result_profile_en.pdf

There are valuable lessons from India's successful transitions from external aid, such as lessons from the Avahan HIV/AIDS initiative launched in 2011 with funding support from the Bill & Melinda Gates Foundation. The initiative involved several government, non-government, donor and academic stakeholders. The program provided HIV prevention services to key populations and covered six states in India that accounted for 83% of HIV-infected people.⁷⁶ Once the program was able to successfully scale-up, the Bill & Melinda Gates Foundation and the government prepared a five-year transition plan, with

28% of the program budget being allocated to transition activities. The Avahan transition showed that early transition planning, aligning donor efforts with government programs, technical support to build government capacity, and adequate budget support during and after transitions are all crucial for sustainable transitions from donor support.⁵² Transition planning also helped the government to incorporate key program components such as community mobilization and strategies for key populations into national programs and create a knowledge and data platform for HIV.⁷⁷



Transition planning is also underway between the Global Fund and the government of India through planned increases in health spending and domestic financing, high-level political commitment regarding TB, use of domestic resources to fund key population interventions, higher levels of government co-financing of antiretrovirals and first-line TB drugs, and greater integration of the HIV program with general health services.⁴⁷

Lessons from such successful transition experiences, tapping in to resources of existing learning networks such as the [Gavi Learning Network for Countries in Transition](#), can help to mitigate risks related to upcoming donor transitions.

Conclusion

India is facing four key health transitions in diseases, demography, donor assistance and domestic financing, which have strong implications on the country's health

system and its ability to adapt and cater to changing health needs. While the government has introduced the largest publicly-funded health insurance program in the world for its poor population, health spending is low by regional and global standards. With declining concessional development assistance from external donors, there is an urgent need to improve health investments and increase health spending by both the central and state governments. Health spending needs to be targeted in particular at reducing out of pocket health expenditures, addressing the growing burden of non-communicable diseases, and meeting the health needs of both a growing elderly as well as large youth population. Through the National Health Policy, 2017 and the Ayushman Bharat program, India has shown political commitment towards improving government health spending and universal health coverage. Increasing state level implementation capacity, transition planning with donors, addressing health inequities, and strengthening primary health care will all be critical in achieving UHC in India and addressing health transitions.

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Methods

Our research included a desk-based review of websites, strategy documents, grey literature reports, and academic literature. This project was screened for exemption by the Duke University Institutional Review Board as part of the study 'Driving health progress during disease, demographic, domestic finance and donor transitions (the "4Ds"): policy analysis and engagement with transitioning countries.'



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