

From Bhore Committee to National Health Policy of 2017: A Drive Towards Universal, Comprehensive and Basic Health Care in India

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Abstract

India's journey towards "universal comprehensive primary health care" system marked by a series of landmark policy interventions and institutional reforms, which ranges from Bhore Committee Report of 1946 to National Health Policy (NHP) of 2017. The study seeks to analyse India's major health policies and programs and to examine their collective role in shaping public health in the country. The study is analytical in nature and based on available secondary sources like books, journal articles, government reports, and newspapers etc. India, though has made some notable progress in health sector, especially in reducing IMR, MMR and in terms of life expectancy, yet, there is lot to be done to meet the global standard of health. In fact, India firstly needs to resolve all the problems with primary health care, and must accelerate health spending growth, ensure efficient allocation, and gradually raise expenditure to 5% of GDP, if really wants to achieve universal health coverage at al.

Keywords: Bhore Committee, Universal Health Coverage, NHPs, Primary Health Care, Health Outcomes, India.

Introduction

Health is fundamental to national progress in any sphere and nothing can be considered of higher importance than the health of the people in terms of resources for economic development. (Planning Commission, 1951, as cited in Hota & Dobe, 2005, p. 107). As per WHO, health is not just an absence of disease or infirmity, rather it is a state of complete physical, mental and social wellbeing. Moreover, Alma Ata Conference of 1978 agreed that health is a fundamental human right and the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector; and committed themselves to achieve Universal Health Care i.e., "Health for All" by the year 2000.

India's journey towards "universal comprehensive primary health care" system marked by a series of landmark policy interventions and institutional reforms, which begun with the Bhore Committee (1946) recommendations – set the tone of Indian healthcare system towards

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universal, comprehensive, and primary health care for all the citizens irrespective of their ability to pay for it. Thereafter, independent India's health care system evolved with the successive National Health Policies (NHPs) of 1983, 2002, and 2017 – where it sought to redefine its priorities or preferences to match the changing epidemiological, socio-economic, and demographic realities. Apart from these policy milestones, several health programs and initiatives such as National Rural Health Mission (NRHM) / National Health Mission (NHM), Ayushman Bharat and PMJAY etc., shaping public health in India.

The base of India's health i.e., primary health care system, structured through Sub-Centres (SCs), Primary Health Centres (PHCs), and Community Health Centres (CHCs). For the rural community which form 70% of the total population, SC is the first contact point with basic health care system and PHCs is the first contact point with medical officer and hence, they embody the operationalization of policy goals into tangible health outcomes in India. This article seeks to analyse the major health policies and examine their collective role in shaping public health in India. Moreover, it seeks to conceptualize that how far India is from the target of UHC. India has made appreciable progress in the reduction of mortality rates, increase of average life expectancy, controlling of both communicable and non-communicable diseases, as well as in health infrastructure development and so on. However, it seems that there is still a long way to go to get even close to universal health care. In fact, India firstly needs to resolve all the problems with primary health care, and must accelerate health spending growth, ensure efficient allocation, and gradually raise expenditure to 5% of GDP, if really wants to achieve universal health coverage.

Materials and Methods

The present study used analytical methods. And it is exclusively grounded on secondary data gathered from various sources like books, journal articles, government reports, newspaper etc.

Colonial Care and the Marginalization of Indigenous Care

In India, traditionally public health has been perceived in a holistic manner, and its comprehension of disease and its causation is superior to the allopathic system of medicine in many ways where treatment is largely symptomatic (Rao, 2017). For instance, there are bonesetters who can still outclass the trained orthopaedics in even modern world. Moreover, the practitioners of traditional system of medicine- particularly Yoga and Ayurveda- are known for its unique ability to provide relief from several illness. Indeed, the people of Indian villages were largely dependent on the traditional practices followed by the Vaid, Hakims, and Midwives for healthcare, unless and until the British has imposed the modern healthcare on them. However, it was the Portuguese, who introduced modern healthcare in India for the first time. It is evident that health was never a priority for the British colonial government, as they merely spent 0.15 percent of their revenues on health compared to the 4 percent on education. They termed the traditional form of medicine as irrational and its practitioners as quacks. In fact, the Britishers sought to establish their superiority, dominance, and hegemony in India, with modern healthcare (Rao, 2017).

Bhore Committee (1946): The Foundation

The most comprehensive health policy and plan document ever prepared in India is not a post-independent thing rather it is a pre-independent phenomenon. It was in 1943, when a committee under Joseph Bhore was constituted to examine the state of health in India and to submit a blueprint for action, which submitted its report in 1946 i.e., Health Survey and Development Committee Report. In fact, such a well-studied and minutely documented plan has not yet been prepared in Independent India (Duggal, 2001). The committee has envisaged a detailed plan of a National Health Service for the country, which would provide a universal coverage to the entire population free of charges through a comprehensive state-run salaried health service (Duggal, 2001).

The committee made some crucial recommendations, based on principles that must guide a health system: being close to the people, provision of care regardless of the ability to pay, and the active promotion of positive health through community involvement and linking ill health to environmental hygiene. Significantly, it has envisioned an ambitious architecture consisting of one bed for every 550 people and one doctor for every 4,600 people to be provided in every district that was to be the unit of implementation (Rao, 2017). Most of the recommendations were approved by the conference of provincial ministers held in October 1946. However, the conference had diluted the proposed coverage norms as it resolved to make plans for establishing a health centre for every 40,000 people, 30 beds for every five centres, 200 beds in every district. Moreover, it resolved to recognize, integrate, and support traditional medical practice; provide safe water to 50 per cent of the population in the next 20 years and 100 per cent in 35 years; and ensure adequate sewerage in towns having a population of 50,000 within 10 years (Rao, 2017). In essence, the committee has prescribed for a 3-tier health care system, namely, Primary Unit (75-bedded hospital for every 10,000 to 20,000 population), Secondary Unit (650-bedded hospital) and District Hospital (2500-bedded hospital). Apart from the basic infrastructure the Committee has also recommended a wide range of other health programs that would provide support and strength to this health organisation.

India's Health in the Initial Years After Independence

It must be noted that "India inherited a substantial disease burden: a crude death rate of 22.4 per 1,000 with 50 per cent of these deaths among children under five, infant mortality of 165 per 1,000 live births, maternal mortality of 2,000 per 100,000 live births, and life expectancy among men being 26.9. There were few doctors (1 for 6,500), nurses (1 for 40,000), and midwives (1 for 60,000) and barely 0.24 beds for every 1,000 people against a requirement of 10. Reducing the disease burden required strong implementation of public health measures" (Rao, 2017).

As per Duggal (1991: 395), the causes of this low level of health in India were the same causes which are responsible for poor health of Indians even today, viz., (i) insanitary conditions; (ii) defective nutrition; (iii) inadequacy of the existing medical and preventive health organisation; and (iv) Lack of general and health education etc (Duggal, 1991: 395). And health services today are as inadequate and underdeveloped as they were during the time of the Bhore Committee, especially for the underserved of the society (poor, villagers, women etc.) (Duggal,

1991). Most of the suggestions of this committee were also approved by the governments of Independent India though but in selective terms. However, even after a half century of independence, only one target has been materialised i.e., the production of doctors, but unfortunately, they have not been produced to serve the general public under governmental terms, rather for adding to the ranks of private medical practitioners though they have been produced at the expense of the public exchequer (Duggal, 1991). In words of Duggal (1991), “majority of the households do not have a surplus, after spending on their basic necessities such as food, clothing, water and shelter to take care of their basic social needs such as education and health care.... We have to demand that health becomes a right which the state must provide for unconditionally from the revenue it collects from citizens” (Duggal, 1991).

India's health system was being shaped by three broad approaches during the three initial decades of India's planned development. Firstly, there was dominant focus on controlling infectious diseases and family planning. And the programmatic needs of these priorities then influenced the organization of primary health. Secondly, the focus was on teaching hospitals to produce the required human resources. And the third focus was on investments required for building a sound foundation of primary care which were patchy and grossly inadequate due to limited resources and weak prioritization (Rao, 2017).

There was a tendency to appoint expert committees with specialists and clinicians to deliberate upon issues that were largely of public health significance, instead of basing the development of the health system on principles or a vision. Hence, there were issue based expert committees like Mudaliar Committee (1959), Chadha Committee (1963), Mukherjee Committee (1965), Kartar Singh Committee (1972), Shrivastava Committee (1975), and so on have been formed over the years, provided patchy solutions. Significantly, it was the time when nutrition, water, and sanitation were separated from the health department. Nutrition had attached to the Department of Women and Child Development, while water and sanitation brought under the control of panchayati raj.

National Health Policy – 1983

The drive of coercive family planning during the 1976 Emergency and the resultant fall of congress's hegemony in 1977, followed by the Alma-Ata Declaration in 1978 – where all countries committed themselves to providing universal access to comprehensive primary care marked a significant shift in health thinking in India. Notably, Alma Ata Declaration is one of its famous declarations to strengthen primary healthcare specially in developing countries (Satbhai and Jayasankar, 2018). And as a signatory of the declaration, India responded with the introduction of its first National Health Policy in 1983. The declaration is aimed to achieve ‘Health for All by 2000’.

In tune of the Directive Principles of the constitution, India's first NHP prescribed for universal and comprehensive primary health care services that are relevant to the actual needs and priorities of the community at an affordable cost (Duggal, 2001). Hence, the notable features of the 1983 health policy, are as follows –

- It stresses on a preventive, promotive and rehabilitative primary healthcare approach;

- It was against the western model of health care which is curative-oriented;
- It lays a high emphasis on decentralised system of healthcare – featured with community participation, de-professionalisation (use of volunteers and paramedics), and high affordability;
- It welcomes the expansion of the private curative sector that would help reducing the stress on government sector;
- It also suggested the establishment of a nationwide network of epidemiological stations that would facilitate the integration of various health interventions;
- Moreover, it set up targets for achievement that were primarily demographic in nature (see Duggal, 2001 - for detail).

The 1983 NHP successfully attract special attention towards rural health care and herald a massive program of expansion of primary health care facilities during and through the 6th and 7th Five Year Plans to achieve the target of one PHC per 30,000 population and one subcentre per 5000 population; and more or less the targets has been achieved. But, as per various studies, though the infrastructure is in place in most areas, they are grossly underutilised due to poor facilities, inadequate supplies, insufficient effective person-hours, poor managerial skills of doctors, faulty planning of the mix of health programs and lack of proper monitoring and evaluatory mechanisms (Duggal, 2001). And limited success though has been achieved in terms of decentralisation and deprofessionalisation but the policy had missed the targets in terms of community participation in health care, since rural population continues to use private care and whenever they use public facilities for primary care it is the urban hospital they prefer (Duggal, 2001). Moreover, the policy did not live up to the promise with regards to the demographic and other related goals. In fact, there have been resurgence of communication diseases took place. However, unfortunately, the policy did not miss its target in welcoming the privatization of curative care. Indeed, there is no doubt that the 1983 NHP was a big push towards privatization, as when it talks about affordability that inherently prove its stance towards making healthcare to be not free of cost. Thus, the 1983 NHP did not reflect the ground realities adequately and the tasks enunciated in the policy were not sufficient to meet the demands of the masses, especially for those residing in villages. In essence, the primary goal of 1983 NHP i.e., universal and comprehensive primary healthcare services is far from being achieved (Duggal, 2001).

Likewise, Qadeer (2000) evidenced the transition of Indian health sector (may be due to international dependence and failure to address health problems) and observed that the Indian health system has been opened to the entire gamut for the structure adjustment policies of IMF and World Bank. And the key aspects of the transition include reduction of health investments in public sector, strengthening of private sector in medical care, introduction of user fees and private investments in public hospitals, and purely technocentric public health interventions etc. Moreover, she pointed out that the reforms are essentially premised on the false hope that countries like India, with their burden of poverty and illiteracy and malnutrition, can afford to cut back on social sector investments and rely on the free market and the private sector in health to provide answers to its public health problems. Most significantly, she urged for actual

decentralisation i.e., devolution and not merely delegation with appropriate public health measures, state support and deployment of efficient personnel, since the transition has not been able to provide relief for the majority of Indians, especially those residing in villages (Qadeer, 2000).

National Health Policy – 2002

In 2002, Government of India introduced a new NHP to serve the changing health needs, as the previous policy has yield limited and varied health outcomes across different parts of the country. It has been noted that “the policy, while being holistic, undertakes the necessary risk of recommending differing emphasis on different policy components. Broadly speaking, NHP – 2002 focuses on the need for enhanced funding and an organizational restructuring of the national public health initiatives in order to facilitate more equitable access to the health facilities. Also, the Policy is focused on those diseases which are principally contributing to the disease burden – TB, Malaria and Blindness from the category of historical diseases; and HIV/AIDS from the category of newly emerging diseases” (MoHFW, 2002).

The policy (2002) was primarily aimed to improve the access to decentralised public health system, secure equitable access, enhance public health investment through contribution of central Government, to enlarge the contribution of NGO and private sector in health care, to regulate the services of private and public sector, to initiate user charges and above all strengthen the delivery of primary health care in public sector (Satbhai and Jayasankar, 2018).

This policy has set several time bound goals like eradication and elimination of diseases (Polio, Yaws and Leprosy), increase the use of public health facilities, the GDP on health expenditure to 2 per cent, central grants share to constitute at least 25 percent of total health spending, and state sector health spending from 5.5 percent to 7 percent of the budget by 2005 and further increase to 8 percent by 2010 (Ramabrahmam and Chitrapu, 2019). It strongly holds for the involvement of PRIs for management of public health especially at the primary level; and expected necessary assistance from personnel like Anganwadi workers, health workers - male and female, gram sevikas, school teachers, development and agriculture workers for the effective implementation (Satbhai and Jayasankar, 2018).

NRHM 2005 – A Drive for Decentralization

Following the 2002 NHP, India’s notable health program for the rural population i.e., National Rural Health Mission (NRHM) was launched in 2005, which was subsumed under National Health mission in 2013. It has envisioned community participation in health planning, execution, and supervision by decentralized mechanisms like Village Health Sanitation and Nutrition Committees (VHSNC) and Rogi Kalyan Samitis (RKS), so that greater efficiency and accountability be ensured in health sector. Moreover, the elements of this initiative were integrated district health plans including integration of health concerns with determinants of health like safe drinking water, sanitation and nutrition; ASHA program; strengthening of public health infrastructure; partnership with NGOs; flexible funds for state and local governments etc. (Singh, 2008). In essence, the introduction of NRHM marked a significant landmark in healthcare decentralization in India.

With these measures altogether, India has made significant achievements in terms of health outcomes in the past two decades – per capita prevalence of disease has been reduced by 30 per cent; Life Expectancy at Birth has gone up from 62.5 years in 2000 to 68.8 years in 2017; the Infant Mortality Rate has been halved from 68 to 34 per 1,000 live births during the same period; and the Maternal Mortality Ratio has fallen from 254 to 167 per 100,000 live births (Seshadri and Kothai, 2019). India successfully declared itself as a polio free country by 2014, and largely contained the spread of epidemics like HIV/AIDS.

However, this policy has faced severe criticism as – the NHP 2002 has completely omitted the provision of comprehensive and universal healthcare, in contrast to the Alma Ata Declaration and NHP 1983. The other grounds of criticism include – neglected the role of village health workers, ignore some important health concerns like child health and nutrition; lacking an effective programme for population control and regulation of medical education; inadequate health funding; over emphasis on privatisation, and above all the policy broadly captured by top-down prescriptions showed its biasness toward centralization (Gupta, 2002). In essence, “the NHP 2002 identifies many of the gross deficiencies of the existing healthcare scenario, proposes a substantial rise in Central Government expenditure on healthcare and has some other positive features such as the proposed regulation of the private sector. However, in operative terms, it constitutes an abandonment of the Alma Ata Declaration, and legitimizes further privatization of the health sector” (Gupta, 2002, page. 216).

National Health Policy – 2017

Despite India’s remarkable achievements in the health sector with the earlier NHPs and others health-related measures as mentioned above, there is still a long way to go, particularly with the emerging epidemic of non-communicable diseases and the growing gap in health outcomes based on the social determinants of health (Qadeer, 2008). Health is relatively a complex and dynamic issue. Further, the needs and priorities of India’s health sector have changed today especially with economic growth, growing burden of non-communicable and some infectious diseases, rising health care cost leading to catastrophic impact on majority of the households etc.

Therefore, in 2017, Government of India came up with a new (third) health policy (NHP) responsive to these contextual changes; with the aim to achieve, “highest possible level of health and well-being for all at all ages, through a preventive and promotive healthcare orientation in all developmental policies, and universal access to good quality healthcare services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery” (MoHFW, 2017). The key principles of NHP 2017 include - Professionalism, Integrity and Ethics; Equity; Affordability; Universality; Patient centric and quality health care; Accountability; Inclusive Partnerships; Pluralism; Decentralization; and Dynamism and Adaptiveness etc.

Thrust of NHP 2017: The core thrust areas of this policy are as follows –

- **Ensuring Adequate Health Investment:** This policy proposed for a potentially achievable target of raising public health expenditure to 2.5 percent of the GDP in a

time-bound manner, and incentives to states for incremental resources for public health expenditure. Moreover, funds under Corporate Social Responsibility to be leveraged for well-focused programs aiming at addressing health goals.

- **Preventive and Promotive Health Care:** It necessitates coordinated action on seven priority areas to improve health environment –
 - Swachh Bharat Abhiyan
 - Addressing tobacco, alcohol and substance abuse
 - Balanced, healthy diets and regular exercises
 - Yatri Suraksha- preventing deaths due to rail and road traffic accidents
 - Nirbhaya Nari- action against gender violence
 - Reducing indoor and outdoor air pollution
 - Reduced stress and improved safety in the workplace
- **Re-organizing public healthcare delivery:** The 2017 NHP proposes following policy shifts in organising health care services –
 - From selective care to assured comprehensive care with linkages to referral hospitals (Primary Health Care).
 - From an input oriented to an output based strategic purchasing (Secondary and Tertiary Health Care).
 - From user fees and cost recovery to assured free drugs, diagnostic and emergency services to all (In Public Hospitals).
 - From stand-alone to a three-dimensional mainstreaming (in AYUSH services).
 - From token interventions to on-scale assured interventions (Primary health care in urban areas).
 - Collaboration with other sectors to address wider determinants of urban health is advocated.
 - Integration with health systems for programme effectiveness and in turn contributing to strengthening of health systems for efficiency (in National Health Programmes).
 - From normative approach to targeted approach to reach under-served areas (development of infrastructure and human resource).

Policy Shifts in Indian Healthcare

India's healthcare policies have evolved to meet various emerging challenges over the years. Any discussion on India's health policies should be started with acknowledging the fact that colonial rulers were never that much concerned about public health in India, it was their army personnel and administrators. India's healthcare was bleak, lacking in infrastructure and human

resources at the time of independence. In fact, India got independence with substantial disease burden, as mentioned in the above section of this paper. However, it is also true that the blueprint for healthcare in India was laid by Bhore committee's "Health Survey and Development Committee Report (1946)" covering almost all aspects of healthcare, is not a post-independent thing rather it is a pre-independent phenomenon. Indeed, such a well-studied and minutely documented plan has not yet been prepared in Independent India (Duggal, 2001). Now, let us briefly identify the major policy shifts (focus) over the National Health Policies (1983-2017) and Programs in India.

- **A Call for Universal Comprehensive Primary Healthcare**

Bhore Committee has prescribed a universal, comprehensive healthcare system through a three-tier structure and emphasized primary health care as its base. However, for a country with fragile economy, weak infrastructure, and limited administrative capacity due to almost 200 years of colonial exploitation, the recommendations proved to be too ambitious and hence, leading to partial implementation initially after independence. Instead, India concentrated on controlling or eradicating serious communicable diseases and then on ensuring the population's immunisation. Mass campaigns were launched against tuberculosis, smallpox, malaria, leprosy, cholera, etc., country-wide. There was only one area that consistently engaged policymakers was the primary healthcare system in rural areas, as Bhore Committee recommended. However, PHC infrastructure did not keep pace with the growing population and remained deficient, especially in rural areas (Raj et al., 2025). India's healthcare decisions were largely driven by various committees' recommendations and successive five-year plans, until 1983. But this was not the case for leprosy and tuberculosis.

India has made significant progress in reducing child and maternal mortality and increasing life expectancy and also in case of eliminating or restraining smallpox, plague, malaria, and cholera and related diseases. However, leprosy and tuberculosis continued to have high incidence rates. The declining incidence of major NCDs (though not fully under control) had been allowing Indian authorities to shift their focus to improving healthcare facilities, by the early 1980s. Resultantly, an extensive network of dispensaries, hospitals, and institutions providing specialised curative care had been developed, primarily in urban areas, neglecting rural areas; and to correct these disparities, the Sixth Plan articulated that further linear expansion of curative facilities in urban areas be allowed only in exceptional matters (Raj et al., 2025).

- **Eyes on Health for All**

The NHP of 1983 marked a pragmatic departure, which prioritized expansion of rural health infrastructure, disease control programs, and integration of health services with national development goals etc. Hence, it can be argued that, NHP 1983 was much more programmatic and resource-conscious, stressing preventive and promotive care alongside community participation, unlike Bhore Committee's idealistic vision. However, the limitations of India's first NHP became evident by the late 1990s, especially in underfunding, weak monitoring, and inadequate responsiveness to emerging non-communicable diseases.

- **A Drive Towards Decentralization**

Hence, a new NHP was launched in 2002 with significant shifts including decentralization of planning, health financing reforms, greater reliance on private sector involvement, and convergence of health programs etc. The 2002 NHP was also known for acknowledging the role of private provider and sought to regulate and integrate them into national health goals, unlike the merely infrastructure-heavy focus of 1983 NHP. The 2002 NHP focuses on correcting all types of imbalances, including rural-urban, and to increase public health spending to 2 per cent of GDP; and as a follow-up of this policy, two initiatives were undertaken, viz., PMSSY and NRHM. Notably, NRHM was rechristened as NHM in 2013, with NRHM and NUHM as its two constituents (Raj et al., 2025). These measures had resulted in a significant reduction of child and maternal mortality rates and helped reverse the declining trend in health spending by States. However, the burden of non-communicable and some infectious diseases had increased, over the years. Moreover, there was no evidence of a narrowing gap in health infrastructure between rural and urban areas (Raj et al., 2025).

▪ **Recall to Universal Health Coverage**

India’s most recently launched NHP of 2017 has brought back the focus to equity and universal health coverage and articulated raising public health spending to 2.5 percent of GDP. It emphasized financial risk protection, strengthening of public health systems, and digital health innovations etc. Despite these measures, the ground reality has not changed much, as India’s health spending continued to be low at around 1 per cent of GDP; and hence, OOPE (India) remained one of the highest in the world. Most importantly, health infrastructure remained inadequate as ever, especially in rural areas. And the inadequacy of health infrastructure and human resources during the Covid-19 pandemic was felt acutely.

Current Status of Primary Health Care System in India

India’s Primary Health Care Infrastructure has been developed as a three-tier system with Sub Centre, Primary Health Centre (PHC) and Community Health Centre (CHC) being the three pillars of Primary Health Care System (Ministry of Health and Family Welfare, 2021). Notably, with the launch of Ayushman Bharat programme, strengthening of SCs and PHCs are being done by converting them into Health and Wellness Centres to deliver comprehensive Primary Healthcare services through these Centres.

Table 1: Number of Primary Health Care Centres and Population Coverage Norms

Name of Health Centre	Total Numbers			Coverage Norms & Current Status			
	Rural	Urban	Total	Plain Area		Difficult Area	
SC	156101	1718	157819	5000	5734	3000	3839
PHC	25140	5439	30579	30000	35602	20000	25507
CHC	5481	470	5951	120000	163298	80000	103756

Source: Ministry of Health and Family Welfare (2021).

Although, India has an impressive network of primary health care facilities (Raut and Sekher, 2013), consists of 157819, 30579 and 5951 SCs, PHCs and CHCs respectively as of 31st March, 2021 (Ministry of Health and Family Welfare, 2021), unfortunately, “the reality is that rampant absenteeism (as many health professionals working in the PHCs and CHCs often run parallel private practice in the nearby towns) has resulted in an array of self-styled "doctors" (most who have no formal qualifications) filling the void and providing the bulk of outpatient care” (Sharma, 2018). Like many other countries in the world, India’s health is currently undergoing in transition (Qadeer, 2000; Sharma, 2018). Despite of the fact that, infectious diseases like T.B., Malaria, smallpox, dengue fever and influenza etc., are under control as overall morbidity and mortality due to these diseases have been reduced, but non communicable diseases particularly cancer, obesity, heart and respiratory diseases and diabetes have been on the march. Non-communicable diseases are fast becoming the leading cause of mortality, especially in the urban areas, due to aging, physical inactivity, unhealthy diets and lifestyles, and excessive alcohol and tobacco consumption etc. Notably, Sharma (2018) argued that India’s decrepit health-care system is not up to the mark in solving the country’s myriad and complex health issues. Moreover, constant low public spending (around 1%) on health as a percentage of GDP despite India’s high growth rates in recent years, has exacerbated these problems further.

However, such outcome was not expected, especially when India’s foundation policy on health i.e., Health Survey and Development Report (Bhore Committee:1946) laid out plans for an ambitious public health care system with both the union and state governments committing to work together to provide free “comprehensive basic health care services” to all irrespective of their ability to pay. India’s public health sector suffers not only from poor-quality services in overcrowded/dilapidated government-run hospitals, but also from severe structural deficiencies including lack of good public hospitals, inadequate basic health infrastructures like medical clinics, pharmacies, diagnostic equipment, and essential drugs, and acute shortage of qualified doctors and health care professionals and so on (Sharma, 2018). And these challenges are far more acute in rural areas, where more than 70% of India’s population live. Hence, there is a need for a quantum jump in spending on health in the country if inequities are to be addressed and UHC to be achieved (Gupta and Ranjan, 2022).

In this context, though the National Health Mission (NHM) and the Ayushman Bharat are two major landmark initiatives in the health sector, however, it is not clear whether the benefits have trickled down enough to make a major difference in inequities. Notably, the NHM was brought to make a difference to the way government health services—particularly maternal and child health care services—are provided in the rural areas, including infrastructural development. PM-JAY is one of the two components of Ayushman Bharat, a flagship targeted health insurance cover of Rs 5 lakh to 10 crore poorer households; while the other one is the creation of 150000 “Health and Wellness Centres” (H&WC). However, empirical studies are of the fact that in case of targeted schemes, the mechanisms used for identification of the poor are often faulty and hence, end up benefiting the non-poor while excluding the needy. Moreover, there is nothing for the middle class in the scheme (AB), even though they (are more prone) incur high out-of-pocket expenditure due to the illnesses like hypertension, diabetes and cancer etc (Ghosh, 2019). On the other hand, Jean Dreze (2018) rightly pointed out that “If the beneficiaries spend just one per cent of their Rs 5 lakh quota in a year, on average, then the

annual expenditure will come to Rs 50,000 crore. This a very conservative estimate - if the scheme makes it reasonably easy for people to claim their insurance money, the actual cost could easily be twice as much, or more. There is absolutely no indication that the government is willing to spend that sort of money on PMJAY” (Drèze, 2018, para. 4). Hence, it has been argued that PMJAY trivialises the target of universal health care in India.

Conclusion

The first (5-year) plan of independent India acknowledged that health is fundamental for national progress in every aspect and nothing is more important than public health in terms of resources for economic development. (Planning Commission, 1951). Despite that, public health was never a priority in India so far. Indian health care system remains crumbling with lack of facilities and equipment, even after a diamond jubilee of independence. As critics argued that Indian politicians have paid too little attention to health and welfare in their election manifestos campaigns, on the other hand, Qadeer asserts that ‘Health for all’ does not make sense in India (Solberg, 2009). Despite, India’s remarkable economic growth, its public spending on health remains disproportionately low — even below that of less economically developed neighbours such as Bhutan, Nepal, and Sri Lanka — leaving its population vulnerable to high out-of-pocket costs and inequities in access, especially the poor and underprivileged.

It is evident that India’s healthcare system has long been prioritized curative services over preventive care, with infrastructure concentrated mostly in urban towns, fostering rural–urban disparities further. Despite repeated policy commitments to raise public spending and correct these imbalances, low investment has remained a persistent problem. It has been argued that if India really wants to achieve universal health coverage, it must accelerate health spending growth, ensure efficient allocation, and gradually raise expenditure to 5% of GDP (Raj et al., 2025). In essence, the study concludes that although India has achieved significant improvements in health outcomes in terms of mortality rates and life expectancy, and in reduction of both communicable and non-communicable diseases, but a lot more needs to be done to level the global standards of health. Moreover, it can be said that unless and until the problems with primary health care are not fully resolved, it is quite impossible for India to secure meaningful improvements to its overall health indicators or reaching close to UHC. As, there exists a strong correlation between India’s weak national public health system and the country’s extraordinary high disease burden and poor overall health outcomes (Sharma, 2018).

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