Reinventing Public Healthcare in India

Milind Kokje

Abstract—: The outbreak of COVID-19 exposed the gaps and shortcomings in the Indian public healthcare System. The Indian healthcare system is a glaring example of two extremes of positive and negative. The Constitution of India does not guarantee health as a fundamental right, though the Indian judiciary, through its several judgements, has interpreted the concerned articles to expand their scope to include the right to health. India's achievements in developing healthcare infrastructure, having more health personnel in service etc. are still much less than the requirement and below global benchmarks. It has launched the world's largest health insurance scheme. Still, the country lags behind on several factors in healthcare and will have to move with real pace to improve the overall system. The COVID-19 outbreak has stressed that need with urgency. It will be worth knowing if the same pandemic can now become a cause for overall improvement of the healthcare system with speed.

Keywords : Public Healthcare, India, COVID-19, health insurance scheme

Introduction

The outbreak of COVID-19 laid bare the state of affairs of the public healthcare system in India. The pandemic became a catalyst in unravelling the set narrative that all is well in the country, most notably, that pertaining to healthcare. The spin, set in motion by the Federal government and the State governments couldn't be further from the truth. The exposé of the initial scramble to formulate a decisive strategy against the pandemic and the deep-set rot in the healthcare system remained the only positive outcome.

A pronounced shift towards healthcare in the private sector, bereft of insurance or welfare cover became evident. Little wonder then those millions were infected by the deadly coronavirus, claiming several thousand lives, as per official figures. Citizens, literally, had to run from one hospital to another, as most healthcare units were overwhelmed by the sheer number of patients within a short period of time. Inadequate services, lack of beds and the sudden lack of medical Oxygen further added to the already grim situation. What's even more curious and inhuman was, as it turned out, was the black marketing and artificial scarcity created by hoarders of Oxygen cylinders and drugs such as Ivermectin and Remdesivir. Cashing-in on the dead and dying became a dark reflection of the society at large.

Indian healthcare, similar to several other areas, is a glaring example of a paradox of two extremes. It has been successful in eradicating smallpox, polio, controlling HIV and reducing the effects of some epidemics. Some of the most complicated and difficult surgeries are performed in India, even in its public hospitals, attracting patients from abroad. It has a pool of very high-skilled and globally recognised expert medical professionals. It is the pharmacy of the world and it has its own over 5,000-year-old traditional system of medicine such as Ayurveda.

But the other side of the coin is very bleak. It consists of lack of even basic medical facilities in several inaccessible areas, children

dying or being stunted due to malnutrition, women suffering from anaemia, and the high burden of Non-Communicable Diseases (NDCs). It is a country where 46.6 million children are stunted and nearly half of all under-5 child mortality is due to malnutrition. In all 68.4% children and 66.4% women were found to be anaemic in the National Family Health Survey -5 (2019-20). As a result, the bane of child and maternal malnutrition is responsible for 15% of India's total disease burden.

When it comes to healthcare only 31.5% hospitals and 16% hospital beds are situated in rural areas where 75% of the population resides. The World Health Organisation (WHO) had said that in India the density of doctors in urban areas was four times the rural areas. It also estimated that 469 million people in India do not have regular access to essential medicines. Indians are the sixth biggest out-of-pocket (OPP) health spenders in the low-middle income group of 50 nations as per IndiaSpend report of May 2017.

This diametrically opposite picture of India's health segment, preventive as well as curative, appears to be an outcome of neglect of the different aspects of the country's healthcare system, from legislative to financial, and infrastructure to human resource. One of the important reasons for the weak public health system is because the constitution does not guarantee health as a fundamental right.

Health as a constitutional right

India is known for its best law-making, from one of most debated and the best constitutions to various other laws enacted to achieve the goals in the constitution. The preamble to the Indian constitution states the objects which the constitution seeks to establish and promote. It outlines the objectives of the constitution along with socio-economic goals. These goals are then given a concrete shape in the form of six Fundamental Rights enshrined under Articles 14 to 30 and articles 32 and 226 in part III of the

constitution, guaranteeing certain rights to the people.

Although health/healthcare is not included in the fundamental rights, Article 21 ensures protection of life and personal liberty. It says, "No person shall be deprived of his life or personal liberty except according to procedure established by law."

The goals in the constitution are also further strengthened by the inclusion of Directive Principles of the State Policy (DPSP) under Articles 36 to 51 in part IV of the constitution. Among them, article 47 describes the state's duty regarding nutrition and health as, "The state shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties."

Some other provisions in the constitution, too, provide for the health of different groups of citizens. For instance, article 39 (E) recommends securing the health of workers, article 42 directs about the just and human conditions of work and maternity relief, article 47 puts responsibility on the State to raise the nutrition levels and the standard of living of people and to improve public health. The constitution asks local-self-governments like village Panchayats (an elected body for each village for the governance of that village) and Municipal Corporations (a civic body for the governance of major cities) to strengthen public health. "The legislature of a state may endow the panchayats with necessary power and authority in relation to matters listed in the eleventh schedule." Some of the entries in this schedule having direct relevance to health are health and sanitation, including hospitals, primary health centers & dispensaries; family welfare; women and child development and public health, sanitation conservancy and solid waste management.

One important difference between the Fundamental Rights and DPSP is that the former is justiciable. The Fundamental Rights are legally enforceable by courts in case of their violation. But the DPSP are not, they are not justiciable. Article 37 specifically states: "the provisions contained in this part shall not be enforceable by any court, but the principles therein laid down

are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws." But it does not mean that directive principles are less important than fundamental rights or they are not binding on the various organs of the state.

Though the DPSP are not justiciable, they are fundamental in governance in the country. While debating DPSP in the Constituent Assembly in 1948, Dr B R Ambedkar, the then law minister who drafted the constitution, had said, "It is the intention of this (constituent) Assembly that in future both the legislature and the executive should not merely pay lip service to these principles enacted in this part, but that they should be made the basis of all executive and legislative action that may be taken hereafter in the matter of the governance of the country." Though the DPSP are non-justiciable rights of the people but fundamental in the governance of the country, it shall be the duty of the State to apply these principles in making laws as per article 37. The executive agencies should also be guided by these principles.

Thus, the Right to Health in a way has not been given explicit recognition in the constitution, unlike several other rights included in the Fundamental Rights. But, the judiciary in India has played an important role in treating health on par with the other Fundamental Rights. In several constitution related matters, the Supreme Court of India and various High Courts have interpreted the concerned articles in the widest possible manner to expand their scope to include different types of rights into fundamental rights. The judiciary expanded the scope of the word 'life' incorporating the right to live with nobility and right to health.

In State of Punjab & Others Vs Mohinder Singh Chawla the Supreme Court held that-the right to life ensured under Article 21 incorporates inside its ambit the right to health and clinical consideration. In another case, Bandhua Mukti Morcha v Union of India, it put the right to health under article 21 that guarantees the right to life. In Francis Coralie v. Delhi, the Supreme Court observed, "The right to life includes the right to live with dignity and all that goes along with it…..".

Though the judiciary by its interpretation of terms used in different articles of the constitution has time and again expanded its scope, amounting to treating right to health as like a Fundamental Right, the ground level practical situation, as seen earlier is, nowhere near the treating health as Fundamental Right for millions of disadvantaged people. Probably, that is the reason the High-level group on health sector appointed for the 15th Finance Commission, among its various recommendations to the commission has the very first recommendation as 'Declare right to health as fundamental right.' It has asked the government to do it on this year's Independence Day – 15th August, 2021.

The question is what is so sacrosanct about the fundamental rights? The word 'fundamental' suggests that these rights are so important that the Constitution has separately listed them and made special provisions for their protection. The Judiciary has the powers and responsibility to protect the fundamental rights from violations by actions of the government. Executive as well as legislative actions can be declared illegal by the judiciary if these violate the fundamental rights or restrict them in an unreasonable manner.

As a result, a rights-based approach for health would need to look at the availability of infrastructure and human resources and the state's capacities to provide basic preventive, curative and rehabilitative healthcare services, the High-level group on health sector has pointed out. Still, the question remains: will, in reality, changing the status of health to a fundamental right change the current situation of neglect of public healthcare?

Causes of Neglect

The neglect of public healthcare in India begins with a resource crunch. The first financial resource crunch automatically leads to a human resource crunch and infrastructure inadequacy.

The healthcare market in India is expected to reach US$ 372 billion by 2022 due to rising income, better health awareness,

lifestyle diseases and increasing access to insurance, according to Indian Brand Equity Foundation (IBEF). As against this, in the Union Budget 2021-22 the total health sector allocation stood at US$ 30.70 billion. One factor that appears to be good in this year's budget is that the total allocation for the Department of Health and Family Welfare has increased by 9.6% over the previous year's budget estimate - from US$ 8.71 billion (INR 65012 crore - 650.12 billion) to US$ 9.55 billion (INR 71,269 crore – 712.69 billion). By this step taken this year, the Government of India has tried to show that it has implemented one point in the National Health Mission which stipulates a 10% increase in health outlay each year. But, if compared to the revised estimates of 2020-21, which is US$ 10.59 (INR 78,866 – 788.66 billion), it implies that the allocation for 2021-22 has come down by 9.6%.

The Government of India also announced in the same budget US $ 8.80 billion for the healthcare sector over six years to strengthen the existing National Health Mission by developing capacities of primary, secondary and tertiary care. Still, in the budget, public expenditure on healthcare is just 1.2% of the GDP.

Among 191 nations, India ranks 183 in terms of per capita government spending on healthcare and it ranks 176 in government expenditure on health. Even Ghana & Brazil (6.8% each), Philippines (10%), Sri Lanka (11.2%), Mexico (11.6%) and Thailand (13.3%) were spending more on health as against India which was spending only 5.1% of total expenditure as per 2014 figures. Of the total health expenditure in India, public expenditure is 17.3% while in China it is 24.9%, in Sri Lanka it is 45.4% and in the USA it is 44.1%.

As a result, out of total health expenditure, government health expenditure is only 30% against 62% out of pocket expenditure in India. In Sri Lanka, government expenditure is 56.1% and in Thailand it is 77.8%. When it comes to different states in India, the National Health Mission advocates states to spend 8% of their budget on health, the actual expenditure is 4.7%, according to the Reserve Bank of India (RBI).

The National Health Policy of 2017 envisaged health expenditure to be 2.5% of the GDP. The Minister of Health and Family Welfare, Government of India, Dr Harsh Vardhan has reiterated the goal to reach 2.5% of the GDP by 2025. Even the High-Level Group of Health Sector reminded to raise the expenditure to the level of 2.5% of the GDP. The group's other important recommendation is to bring Public Health and hospitals under the concurrent list of the seventh schedule of the constitution from the existing assignment of the state list.

Impact of low outlay

The most important adverse impact of low budgetary allocation is obviously on infrastructure and human resources. Slow implementation and delayed completion of infrastructure, like hospital buildings, laboratories, equipment etc. are common examples. One of the important states of India, Maharashtra is in talks with the Asian Development Bank seeking a long-term, low interest loan to complete its infrastructure projects in healthcare that have remained incomplete due to paucity of funds. This is probably the post-COVID realisation of the Government of Maharashtra. On the national level, allocation for investment in health infrastructure was increased 137% year on year in the 2021-22 budget.

The country had 8.5 hospital beds and eight doctors for 10,000 people before the COVID-19 outbreak. According to a Brookings estimate, such a huge country had only 17,850 to 25,556 ventilators when the outbreak started. The number of Oxygen supported beds increased from 57,924 to 2,65,046 from April to October 2020 and the number of ICU beds and ventilators increased over three times during the period.

Actually, India has a well-defined system of a level of healthcare right from the primary tier for a prescribed population. It consists of a Sub-Centre (SC) for 5,000, a Primary Health Care Centre (PHC) for 30,000 people and a Community Health Centre

(CHC) as a referral centre for every four PHCs covering a population of 120,000 (for hilly, tribal and difficult areas the norms are 3,000 people, 20,000 people and 80,000 people respectively).

Despite such a well-defined system, the inadequate infrastructure results in shortage. According to the 2019 report of the high-level group on healthcare sector to 15th Finance Commission, the country had 156,231 sub-centres with a shortfall of 34,946 (19%), 25,650 PHCs with a shortfall of 6,409 (22%) and 5,624 CHCs having shortfall of 2,168 (30%).

When it comes to Human Resources in healthcare various estimates are being made over the availability of doctors and nurses. But they all, even the highest among them, are still less than the WHO benchmark of one doctor and three nurses for 1,000 people. India has only one physician for every 1,404 people and 1.7 Nurses per 1,000 population, according to the Ministry of Health and Family Welfare. The high-level group on the healthcare sector claimed India had 1 nurse for 670 people. By December 31, 2017, 2,900,000 (29 lakh) nurses were registered in India.

India has a total 1,255,786 Allopathy doctors registered with the Medical Council of India and the various state medical councils as of September 2020. Of them 371,870 are specialists/ post graduates as per the information given by Minister of State for Health and Family welfare Ashwini Kumar Choubey to the Indian Parliament. In addition to the modern Allopathy doctors there are 788,000 doctors from the streams of Homeopathy and Indian traditional system of Ayurved and Unani.

Still, the number of doctors is less than the WHO benchmark. The Lancet commission had described that India needed 65 million surgeries when only 27 million were conducted and to overcome a shortfall of 40 million surgeries 18,000 surgeons were needed. In its 2016 report, WHO had said that to reach the Chinese level of density of doctors India would need additional 700,000 doctors while the capacity of universities was to produce only 30,000 doctors per year. With 479 medical institutions operating in the country, that capacity has now increased to 67,218

medical graduates (MBBS) per year. Still, it will take over a decade to have 700,000 more doctors.

The problem of shortage doctors' density is further complicated by urban rural bias among the doctors. According to a study published in 2012 on the quality of primary care in public and private clinics in rural area of Madhya Pradesh state and urban Delhi, the national capital, approximately 70% of the rural practitioners had no medical training and more than 20% were trained in AYUSH (Homeopathy or Indian traditional medicine system of Ayurved or Unani) and untrained staff (no medical training) used to attend most of the public clinics (63%). The quality of care provided was poor, in addition to brief consultation times and very limited use of correct protocols. Only 41% of the treatments provided were medically appropriate. The doctors' bias to work in urban areas resulted in more than half of the community health centers (CHC) lacking specialist doctors. The majority of the newly-qualified doctors prefer to work in hospital-based specialties instead of PHCs. This has resulted in non-physician clinicians (NPC) serving at PHCs.

The situation seemed to have not changed much later. According to the Rural Health Statistics report released by the Union ministry of Health and Family Welfare in 2016, as compared to the requirement for existing 5,510 CHCs, there is a shortfall of 84% of surgeons, 76.7% of obstetricians and gynaecologists, 83.2% of physicians and 80.1% of paediatricians. When 22,040 specialists are required the sanctioned posts are only 11,262 of which only 4,192 were filled and 7,359 were vacant. The total shortfall was 17,754. As on 31st March 2016, 8.1% of the PHCs were without a doctor, 38% were without a Lab Technician and 18.7% were without a pharmacist depicting a lower shortage of medical professionals at primary healthcare centres.

The situation has been improving with year-to-year additions in infrastructure and personnel. But the pace is slow, and the numbers are still not reaching the minimum required level. As of April 2020 the number of sub centres reached 169,031 from 168,418 in June 2019, and the number of Primary Health

Centres (PHCs) increased to 33,987 from 33,476 during the same period. Though the number of centres is growing, the shortfall of people continues.

The shortfall of specialist doctors at the CHCs in rural areas has come down from 84% in 2016 to 76.1%, as per the ministry's Rural Health Statistics Report released in April 2021. According to the report, there is now a shortfall of 78.9% of surgeons, 69.7% of obstetricians and gynecologists, 78.2% of physicians, and 78.2% of pediatricians.

The progress, albeit very slow, reflects the improvement in India's ranking on Global Healthcare Access and Quality (HAQ) index from 153 in 1990 to 145 in 2016 among 195 countries. India scored 41.2 points, improving by 16.5 points in 26 years. Still, it was well below the global average of 54.4 points and even below Bangladesh, Bhutan, Sudan and Guinea. The index is created by the Global Burden of Disease study published in The Lancet on May 23, 2018.

Though the latest figures for various other parameters are not available in detail, the still existing gaps were visible as COVID-19 set in, and particularly during the second wave from March to June 2021. The problem of Healthcare in India can be summarised in a few points like less financial allocation leading to inadequate infrastructure and shortage of medical personnel, rural urban imbalance with doctor's reluctance to work in rural areas, and expensive private healthcare services.

The union government (ruled by right wing Bharatiya Janata Party under the leadership of Prime Minister Narendra Modi) launched in 2018 'Ayushman Bharat' – Pradhan Mantri Jana Arogya Yojana (PMJAY) (Prime Minister's mass healthcare scheme), the world's largest healthcare scheme. Over 50 crore marginalised beneficiaries will have access to hospital care opportunity under the INR 22,044 core scheme.

The official website of the National Health Authority, which operates the scheme, claimed that Since September 2018 when the

scheme was launched, till June 18, 2021, in all, 159,938,380 Ayushman cards have been issued, and in the same period 18,615,277 patients got admitted the hospitals. However there are several issues in the implementation of the scheme. For instance, an editorial in 2019 issue of Journal of Mahatma Gandhi Institute of Medical Sciences by Vikash R Keshri and Subodh Sharan Gupta quoted a study that showed that the number of private hospitals in health insurance network in Bihar was 253, whereas in contrast, Maharashtra has over 3000 private hospitals, Bihar and Maharashtra contribute to 10.4% and 8% of total beneficiaries of PMJAY, respectively. Besides, around 65% of the private hospitals in the country have strengths of 11–50 total beds, which can significantly limit their ability to function as a tertiary care center, the writers opined. They pointed out that the amount allocated to PMJAY in two subsequent annual budgets (2018–2019 and 2019–2020) is also proportionately much lower to cover the targeted 40% of the population of the country. Around INR 32 billion (US$ 0.43 billion) and INR 64 billion (US$ 0.86 billion) were allocated for the scheme in the 1st and the subsequent year. Even if only 5% of the beneficiary families claim 20% of the insurance amount (i.e., INR 500,000 – US$ 6,700) which they are entitled to, the estimated expenses would be INR 500 billion (US$ 6.7 billion) per annum, without accounting for the running cost of the scheme.

In addition to the Ayusman Baharat, the government initiated various programmes towards healthcare like the National Health Mission, Pradhan Mantri Swasthya Suraksha Yojna (PMSSY) (Prime Minister health protection scheme), and the National Digital Health Mission (NDHM). Large scale allocations have also been made in the budget for the schemes. For instance, PMSSY has been allocated INR 70 billion (US$ 0.94 billion) in FY 21-22, 16% more than the previous year, and NDHM has been given INR 300 million (US$ 4.02 million). Health research has been allocated INR 26.33 billion (US$ 0.35 billion), 27% higher than previous year. The Ministry of AYUSH (Ayurved, Unani, Sidda Homeopathy) has been allocated INR 29.7 billion (US$ 0.4 billion), 40% higher than the earlier year.

But most of the higher allocations are made in this year's (Apr 21-March 22) budget, post first wave of COVID-19. Naturally it will take time to implement the schemes using that money, even if the work is completed with very high efficiency. Schemes like PMJAY will, no doubt, help poorer segments of the society as it aims at providing INR 500,000 (US$ 6,700) per family per year for secondary and tertiary care hospitalisation to over 107.4 million families (500 million beneficiaries). But when one observes the shortage of medical personnel and inadequate infrastructure a question will be how many people will be able to take advantage of this scheme although the treatment charges will be made available by the government.

From that point of view, some of the recommendations by high-level groups in the health sector are crucial and those may lead to a better healthcare picture. In addition to suggesting to make Health a fundamental right, on the infrastructure front it has recommended to set up 3,000 to 5,000 small hospitals of 200 beds each close to the community, which necessitates the participation of the private sector and to bring public health and hospitals under concurrent list of the seventh schedule of the constitution from the existing state list. Going by the past experiences of other rights, there are apprehensions over the actual benefit of making health as a fundamental right. But one thing is sure and it is important that the rights based approach should change the perspective of healthcare from the people's mind from as a purchasable commodity in the private healthcare segment to a citizen's right in the public domain. That probably will help to ensure the improvement in adequate infrastructure and human resources.

All the gaps in the healthcare system came to the fore due to the pandemic of COVID-19. They existed before, were discussed in different forums before, and some temporary measures were initiated from time to time to whitewash them. But COVID-19 once again emphasised the urgent need to look at them and find out permanent solutions. This COVID-19 effect was also reflected in this year's budget with higher allocations. If things really im-

prove in India drastically hereafter on the public healthcare front - the chances are slim going by the past experiences of ignoring the required reforms once the danger is over - that will be the only silver lining to the dark clouds of the COVID-19 pandemic.

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