From Coverage to Effective Protection: Reading NSS 80, NFHS-6 and National Health Accounts for Viksit Bharat 2047

K. Madan Gopal[1], Suneela Garg[2], Manish Kumar Singh[3]
[1]Advisor, National Health Systems , New Delhi, [2]Professor Emeritus National Academy of Medical Sciences Mohfw GOI,
[3]Professor (JG), Community Medicine, Dr. Ram Manohar Lohia Institute of Medical Sciences, Lucknow, UP

Corresponding Author : Dr K. Madan Gopal, Senior Healh Sector Expert, Former Senior Consultant Health NITI Aayog, Advisor , National Health Systems , New Delhi

Email:kmadangopal@gmail.com

Citation: K. Madan Gopal, Suneela Garg, Manish Kumar Singh. From Coverage to Effective Protection: Reading NSS 80, NFHS-6 and National Health Accounts for Viksit Bharat 2047. Indian J Comm Health. 2026;38(3) : Page Number 496 - 498
https://doi.org/10.47203/IJCH.2026.v38i03.001

Article cycle: Received:04/06/2026; **Accepted:** 17/06/2026; **Published:** 30/06/2026

India has received three important health data signals in quick succession: the NSS 80th Round on Household Social Consumption: Health, the National Family Health Survey-6, and the National Health Accounts estimates for 2022-23. Each dataset looks at the health system from a different angle. NFHS-6 shows population-level changes in health, nutrition, fertility, immunisation and financial protection. NSS 80 shows where people seek care and what they pay during illness, hospitalisation and childbirth. NHA shows who finally pays for health care at the system level. Read together, these datasets provide a timely opportunity to define the next phase of health reforms for Viksit Bharat 2047.

The central message is clear. India has expanded coverage faster than it has reduced financial risk for households. The country has made visible progress in maternal and child health, immunisation, fertility stabilisation and selected nutrition indicators. However, household spending remains high, private care remains central in outpatient and inpatient care, and medicines continue to impose a recurring burden on families. The policy challenge is therefore not only to increase coverage, but to convert coverage into effective, affordable and continuous care.

NFHS-6 shows the strength of sustained public health action. Antenatal care coverage increased to 95.9%. First-trimester ANC increased from 70.0% to 76.2%, and at least four ANC visits increased from 58.5% to 65.2%. Institutional deliveries increased from 88.6% to 90.6%, and skilled attendance at birth improved from 89.4% to 91.3%. Postnatal care for newborns within two days of delivery improved from 79.1% to 85.3%. These gains show that long-term public investment, frontline workers, facility readiness, cash-benefit schemes and community mobilisation can improve service uptake when the care pathway is clear and publicly supported (1).

The survey also shows that India has entered a more mature phase of demographic and child health transition. The total fertility rate remains at 2.0, while contraceptive prevalence increased from 66.7% to 69.1%. Full vaccination coverage among children aged 12-23 months, based on vaccination cards, increased from 83.8% to 87.1%. Any vaccine coverage remains above 96%. Rotavirus vaccination coverage increased from 36.4% to 85.4%, and the second dose of measles-containing vaccine increased from 58.6% to 71.8%. Stunting among children under five declined from 35.5% to 29.3%, severe wasting declined from 7.7% to 5.2%, and underweight showed a marginal decline from 32.1% to 31.8% (1). These are important gains, but the remaining burden of undernutrition is still too high for a 2047 aspiration.

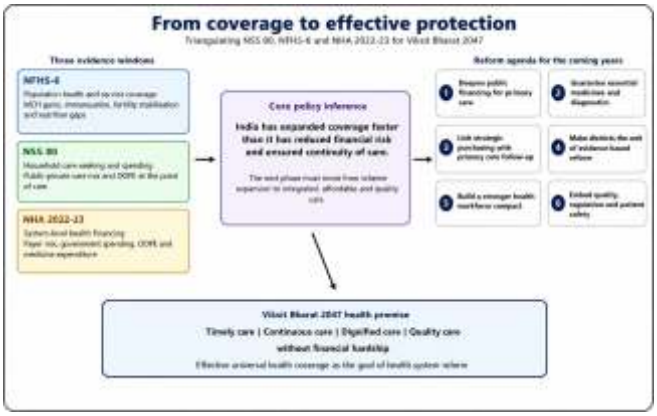

Figure 1. From coverage to effective protection: triangulating NSS 80, NFHS-6 and National Health Accounts for Viksit Bharat 2047. NFHS = National Family Health Survey; NSS = National Sample Survey; NHA = National Health Accounts; MCH = maternal and child health; OOPE = out-of-pocket expenditure; PHMC = Public Health Management Cadre.

NSS 80 complements this picture by showing how people actually use services and how much they pay. The survey reported 96.2% institutional childbirths overall, with only 3.8% births taking place at home. Public facilities accounted for 61.7% of all childbirths, with a stronger role in rural areas. This confirms that India's public system can deliver at scale when services are protocolised, financed and actively tracked [2].

NSS 80 also shows why public care matters for financial protection. The average out-of-pocket expenditure for outpatient care was INR 861 per treated spell, while the average expenditure in public facilities was INR 289, and the median expenditure in public facilities was zero. This means that at least half of outpatient episodes in public facilities involved no out-of-pocket payment. Public care is therefore not only a service delivery platform; it is also a financial protection instrument [2].

At the same time, NSS 80 exposes the limits of the present system. Public facilities accounted for only 34.6% of treated outpatient spells in rural areas and 25.2% in urban areas. Private doctors and clinics accounted for 39.4% of rural outpatient spells and 42.3% of urban outpatient spells. Private hospitals also accounted for 57.9% of rural hospitalisation cases and 64.6% of urban hospitalisation cases, excluding childbirth [2]. This shows that households still depend heavily on private care for routine and hospital care. A hospital-focused insurance model alone cannot address this pattern.

NHA 2022-23 adds the financing lens. Out-of-pocket expenditure as a share of total health expenditure has declined sharply over the decade, from 64.2% in 2013-14 to 43.4% in 2022-23. Government health expenditure also increased from about INR 1.3 lakh crore in 2013-14 to about INR 3.8 lakh crore in 2022-23. This is a major improvement. Yet the remaining household burden is still substantial. Medicines alone accounted for more than INR 1.6 lakh crore in 2022-23, about one-fifth of India's current health expenditure. Inpatient care accounted for 37.6%, medicines 21%, and outpatient care 18.7% of current health expenditure [3].

These findings point to one conclusion: India's next health reform must move from scheme expansion to system integration. The first generation of universal health coverage reforms expanded entitlement, insurance coverage, institutional deliveries, immunisation and primary care platforms. The second generation must reduce out-of-pocket spending on outpatient care, medicines, diagnostics and chronic disease management. It must also improve the quality, continuity and accountability of care across primary, secondary and tertiary levels.

This shift is especially important because India's disease profile is changing. Maternal and child health gains must be protected, but the next burden will increasingly come from diabetes, hypertension, cardiovascular diseases, cancers, mental health conditions, injuries and geriatric care. These conditions do not require only episodic hospitalisation. They need early detection, regular follow-up, assured medicines, diagnostics, lifestyle counselling, referral support and continuity of care. If these services remain underfunded, households will continue to spend from their own pockets despite higher insurance coverage.

The reform agenda for Viksit Bharat 2047 should therefore rest on six pillars.

1. India must deepen public financing for primary care. Public spending should not remain concentrated only on visible infrastructure or hospital packages. It must finance the daily costs of care: drugs, diagnostics, follow-up, counselling, outreach, home-based care and referral transport. Ayushman Arogya Mandirs should become the first point of assured care, not only a screening platform. They should provide continuity for common NCDs, elderly care, mental health, rehabilitation and palliative care.

2. India needs an essential medicines and diagnostics guarantee. The NHA signal on medicine expenditure is too strong to ignore. Drug policy is a health financing policy. A credible financial protection strategy must ensure free or affordable essential medicines and diagnostics through public facilities, pooled procurement, rational prescription, stock-out monitoring and Jan Aushadhi linkages. This is the fastest route to reduce routine household spending, especially for chronic diseases.

3. Strategic purchasing must link hospitals with primary care. PM-JAY and state health insurance schemes have expanded access to hospital care, but they should not function as isolated reimbursement platforms. Purchasing should reward appropriate referral, discharge planning, follow-up at the primary care level, prevention of avoidable admissions and quality outcomes. A patient treated for stroke, cancer, diabetes complications or heart disease should return to a functional primary care team for long-term follow-up.

4. District health systems must become the unit of reform. National averages hide local gaps. NFHS provides district-level evidence; NSS shows utilisation and spending patterns; NHA shows financing trends. These must be linked with HMIS, HDI/Rural Health Statistics, HRMIS and claims data. Each district should prepare an annual health system scorecard covering service coverage, financial protection, quality, workforce, medicine availability, referral performance and equity. Such triangulation will help policy move from reporting to correction.

5. India needs a stronger health workforce compact. The three recent datasets do not fully capture workforce distribution, skills and performance. This itself is a policy gap. Viksit Bharat 2047 will need filled posts, rational deployment, functional teams, public health managers, nurses, mid-level providers, specialists, laboratory staff, emergency care teams and community workers. The Public Health Management Cadre and district-level HRH planning should become central to health reform, not an administrative add-on.

6. Quality and regulation must become part of universal health coverage. Financial protection without quality can become wasteful. Quality without affordability can remain inaccessible. India needs stronger standards for public and private providers, rational treatment protocols, patient safety systems, grievance redressal, transparent empanelment, clinical audits and price regulation for high-burden services. The private sector will continue to provide a large share of care. Therefore, the state must purchase, regulate and guide private care in the public interest.

The 2047 vision should not be limited to more schemes or more infrastructure. It should aim for effective universal health coverage. This means that every person should receive needed promotive, preventive, curative, rehabilitative and palliative care without financial hardship. WHO's UHC framework also emphasises service coverage and financial risk protection, along with service capacity and access [4]. For India, this means three measurable goals: more people should use quality public or publicly financed care; fewer households should suffer financial stress due to illness; and every district should show improvement in service readiness, workforce and outcomes.

The latest datasets show both confidence and caution. Confidence, because India has demonstrated that public health programmes can deliver measurable gains when there is political commitment, financing, frontline capacity and monitoring. Caution, because insurance coverage and service contracts do not automatically translate into financial protection, quality or continuity. The household remains the shock absorber of many health system gaps.

The path to Viksit Bharat 2047 should therefore be built around a new health compact: protect the gains in reproductive, maternal, newborn, child and adolescent health; reduce undernutrition with renewed urgency; make primary care the foundation of NCD and elderly care; reduce medicine and diagnostic-related out-of-pocket expenditure; integrate insurance with public health systems; and make district-level evidence the basis of accountability.

India does not need a completely new health architecture. It needs better alignment of the existing architecture. NHM, Ayushman Bharat, PM-JAY, Ayushman Arogya Mandirs, free drug and diagnostics initiatives, digital health systems, public health cadres and quality assurance programmes must work as one system. The NSS, NFHS and NHA releases together remind us that the next leap will not come from counting beneficiaries alone. It will come from ensuring that every contact with the health system gives people timely care, dignified care, quality care and protection from financial hardship.

That should be the health promise of Viksit Bharat 2047.

References

1. Ministry of Health and Family Welfare, Government of India. Union Health Ministry releases National Family Health Survey-6. Press Information Bureau; 2026.
2. Ministry of Statistics and Programme Implementation, Government of India. NSS Report No. 596: Household Social Consumption: Health, NSS 80th Round, January-December 2025. National Statistics Office; 2026.
3. National Health Systems Resource Centre, Ministry of Health and Family Welfare, Government of India. National Health Accounts Estimates for India 2022-23. NHSRC; 2026.
4. World Health Organisation. UHC service coverage index: SDG indicator 3.8.1. WHO; accessed 2026.
5. Ministry of Health and Family Welfare, Government of India. National Health Policy 2017. New Delhi: MoHFW; 2017.
6. National Health Systems Resource Centre, Ministry of Health and Family Welfare, Government of India. National Health Accounts Estimates for India 2021-22. NHSRC; 2024.