# Demand for Grants 2026-27 Analysis
## Health and Family Welfare

**Highlights**
- Public spending on health is 1.8% of GDP, lower than the recommended level of 2.5%. Out of pocket expenditure by individuals is 39% of total health expenditure.
- Shortages seen across both primary infrastructure and human resources.
- Schemes like the National Health Mission, PM-ABHIM, NHM (for primary health infrastructure), and PMSSY (setting up new AIIMS) saw under-utilisation in 2025-26.

Public health is an entry in the state list of the Constitution. This means that the primary responsibility to provide health care lies with the state government. The Union Ministry of Health and Family Welfare (MoHFW) formulates policies and schemes related to healthcare, and assists states in healthcare delivery. The Ministry seeks to improve primary healthcare infrastructure through schemes like National Health Mission (NHM) and Pradhan Mantri Ayushman Bharat Infrastructure Mission (PM-ABHIM). It supports medical education by funding institutions like All India Institute of Medical Science, Jawaharlal Institute of Postgraduate Medical Education and Research, etc. It also seeks to reduce the financial burden of healthcare on individuals through insurance schemes like Pradhan Mantri Jan Arogya Yojna (PM-JAY). The National Health Policy, 2017 which seeks to achieve universal health coverage, provides the policy framework for these schemes.

This note examines the allocation to the Ministry in year 2026-27. The note also highlights some of the key challenges in the sector.

## Overview of finances

In 2026-27, the Ministry has been allocated Rs 1,06,530 crore.[1] This is 10% higher than the revised estimates of 2025-26. The Ministry has two departments: (i) Department of Health and Family Welfare, and (ii) Department of Health Research. The Department of Health and Family Welfare receives 95% of the total budget allocation to the Ministry (see Table 1).

**Table 1: Expenditure of the Ministry (in Rs crore)**

| Department | 2024-25 Actuals | 2025-26 RE | 2026-27 BE | Change RE to BE |
|---|---|---|---|---|
| Health and Family Welfare | 87,300 | 92,926 | 1,01,709 | 9% |
| Health Research | 3,384 | 3,928 | 4,821 | 23% |
| **Total** | **90,684** | **96,854** | **1,06,530** | **10%** |

Note: BE is Budgeted Estimates. RE is Revised Estimates.
Sources: Demand No. 46 and 47, Expenditure Budget 2026-27; PRS.

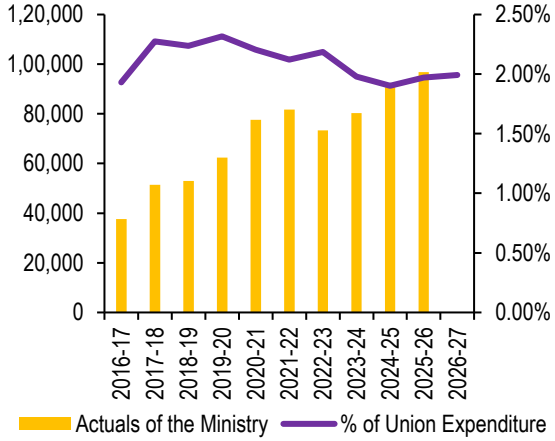
**Announcement in the budget speech 2026-27**
- New Allied Health Professional institutions will be established in both public and private sectors.
- To promote medical tourism, five regional medical hubs will be established.
- National Institute of Mental Health and Neuro Sciences will be established in northern India.

Of the total spending by the Ministry, 3% (Rs 2,928 crore) will be towards capital expenditure.[1] This will include spending on establishment and upgradation hospitals and medical colleges.

### Trends in expenditure

Between 2016-17 and 2024-25, the compound annual growth rate (CAGR) of the Ministry's expenditure is 12%. CAGR is the annual growth rate over a certain period. However, allocation in the union budget to the Ministry has decreased since 2019-20 (see Figure 1). The Union government spent around 2% of its total expenditure towards health.

**Figure 1: Share of Ministry's allocation in the union budget (in Rs crore)**




Note: Ministry's expenditure includes expenditure by the Department of Health and Family Welfare and Health Research. It does not include expenditure by Departments of AYUSH and AIDS Control. Expenditure on vaccination for COVID-19 was incurred by the Finance Ministry. Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budgets 2016-17 to 2026-27; PRS.

In 2026-27, the Ministry will spend 37% of its total budget on NHM. The mission aims at strengthening public health services in rural and urban areas. The next highest allocation at 21% is towards autonomous bodies which includes funding of AIIMS, New Delhi and some other medical colleges. New AIIMS are being set up under the Pradhan Mantri Swasthya Suraksha Yojana. The Pradhan Mantri Jan Aarogya Yojana, which provides for health insurance coverage, will receive 9% of Ministry's budget (see Table 2).

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**Table 2: Main heads of the Ministry's expenditure (in Rs crore)**

| Heads | 2024-25 | 2025-26 (RE) | 2026-27 (BE) | % Change from RE to BE | Share in Ministry's Budget |
|---|---|---|---|---|---|
| National Health Mission | 38,889 | 37,100 | 39,390 | 6.2% | 37% |
| Autonomous Bodies | 19,154 | 21,902 | 22,344 | 2% | 21% |
| Pradhan Mantri Jan Aarogya Yojana | 7,179 | 9,000 | 9,500 | 5.6% | 9% |
| PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM) | 2,086 | 2,443 | 4,200 | 71.9% | 4% |
| Indian Council of Medical Research | 2,870 | 3,150 | 4,000 | 27% | 4% |
| AIDS and STD Control | 2,528 | 2,662 | 3,477 | 30.6% | 3% |
| Central Government Health Scheme | 2,104 | 2,207 | 2,358 | 6.8% | 2% |
| Pradhan Mantri Swasthya Suraksha Yojana | 1,681 | 1,500 | 2,005 | 33.7% | 2% |
| Human Resources for Health and Medical Education | 549 | 1,630 | 1,725 | 5.8% | 2% |
| Others | 13,644 | 15,260 | 17,531 | 14.9% | 16% |
| **Total** | 90,684 | 96,854 | 1,06,530 | 10% | 100% |

Note: Expenditure on Autonomous Bodies includes transfers to institutions such as AIIMS, Delhi and NIMHANS, Bangalore and expenditure on establishing new AIIMS. Others include transfers to centrally run hospitals and family welfare schemes.
Sources: Demand No. 46 and 47, Expenditure Budget 2026-27; PRS.

## Key issues and analysis

Health care services are provided at three levels: primary, secondary, and tertiary.[2] Primary care broadly includes maternal and child health, immunisation, provision of essential drugs, and treatment of common diseases and injuries. It is provided by a three-tiered public system of sub-centres (SCs), primary health centres (PHCs), and community health centres (CHCs). Secondary and tertiary health care services are provided through district hospitals, and specialised hospitals.

The National Health Policy, 2017 guides the strategy for healthcare in the country. It aims to achieve universal health coverage (UHC) through preventive and promotive health care.[3] According to the World Health Organisation (WHO), UHC means that all people have access to required quality health services, whenever and wherever required.[4] The National Health Policy, 2017 also seeks to: (i) strengthen trust in the public healthcare system by making it patient centric, effective and affordable, (ii) align the growth of the private health sector with public health goals, and (iii) close infrastructure and human resource gaps.[3]

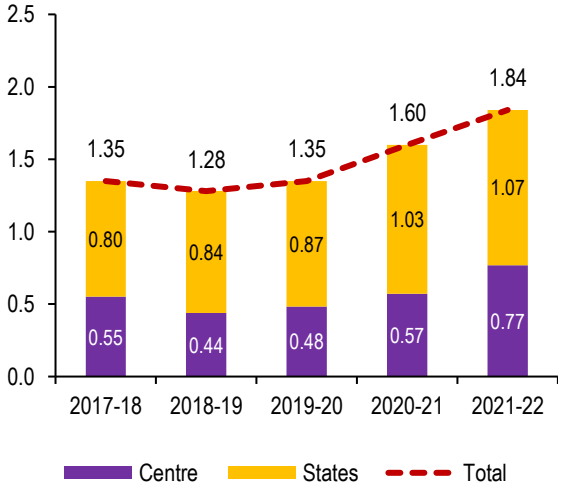
The National Health Policy, 2017 seeks to improve primary health outcomes on mortality rate, life expectancy, and disease prevalence.[3] Over the years, there has been improvement in infant mortality rate (IMR) and maternal mortality ratio (MMR). Between 2010 and 2020, IMR decreased from 47% to 28% per thousand live births. MMR decreased from 178 to 97 per lakh live births.[5] Life expectancy at birth has also improved from 62 years in 1997-2001 to 70 years in 2016-20.[5]

The country's disease profile has changed over the years. The share of communicable diseases (HIV/AIDS, tuberculosis, diarrhoea) in the overall disease burden has reduced from 61% in 1990 to 33% in 2016.[6] However, as of 2016, these still remain an issue causing nearly 28% of deaths.[6] As of 2016, non-communicable diseases (NCDs) accounted for 62% of all deaths.[6] These include diseases like cardiovascular diseases, chronic respiratory diseases, and cancer.[6]

### Low public spending on health care

In absolute terms, the spending of the centre and state government on health care has increased between 2018-19 and 2021-22 (see Figure 2).[3] In 2021-22, the combined spending on overall health care constituted 1.8% of Gross Domestic Product (GDP).[7] However, it is lower than spending recommended by the National Health Policy, 2017 at 2.5% of GDP by 2025.[3]

**Figure 2: Increase in government health expenditure as % of GDP**




Sources: National Health Accounts, 2021-22, MoHFW; PRS.

According to the National Health Accounts (2021-22), the total health expenditure (THE) for India

was estimated at nine lakh crore rupees (3.8% of GDP).[7] This includes spending by government, private sector and donors/external resources.[7] Health expenditure is utilised to meet preventive and curative care, medicines, laboratory services, and health financing.[7] Government's share of THE was 48% (with the Centre spending around 48% of this expenditure, and the remaining by states).[7] Capital expenditure was 13% of THE (Rs 1.1 lakh crore), and the remaining was current health expenditure (CHE).[7]

CHE refers to recurrent spending on health care services (excluding capital expenditure).[7] In 2021-22, households (including insurance contributions) contributed the most towards CHE, at about four lakh crore rupees (51% of CHE).[7] The central government's share in CHE is 15% (Rs 1.25 lakh crore), and the state government's share is 22% (Rs 1.72 lakh crore).

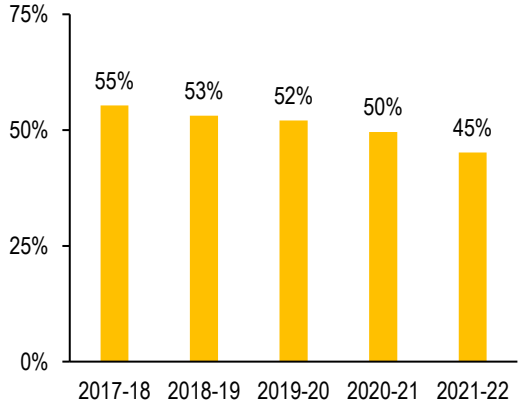
As of 2025-26, states on average spent 6.2% of their budget towards health care. The National Health Policy, 2017 recommended that by 2020, states allocate at least 8% of their budget towards health care.[3] As of 2025-26, only three states have allocated 8% or more of their budget towards health care. These are Delhi, Odisha, and Rajasthan (see Figure 12 in the annexure).

The high-level expert group (HLEG) (2011) on UHC also recommended that government spending on health care be 3% of GDP.[8] It also recommended that at least 70% of this budget be allocated towards primary health care.[8] According to the National Health Accounts, 2021-22, government spending as share of CHE on primary health care was 50%.[7]

## High out-of-pocket expenditure

Out-of-pocket expenditure (OOPE) refers to the health expenditure made by the households at the point of receiving health care. OOPE as a proportion of CHE has declined from 55% in 2017-18 to 45% in 2021-22 (see Figure 3).[7]

**Figure 3: OOPE (as % of CHE) has declined**




Sources: National Health Accounts, 2021-22, MoHFW; PRS.

As per the Ministry reasons for the decrease in OOPE include: (i) increased government health expenditure, (ii) expansion of government health insurance schemes, and (iii) improved health infrastructure and human resources.[9]

Although India's OOPE is decreasing, it is higher than that of several other countries. According to the World Bank, as of 2022, India's OOPE as share of CHE remains higher than in countries like China and South Africa (see Table 3).

**Table 3: Public spending and OOPE of India and selected countries (as of 2022)**

| Countries | Public spending as % of GDP | OOPE as % of CHE |
|---|---|---|
| India | 1.3 | 46 |
| China | 3 | 34 |
| South Africa | 5.4 | 7 |
| Australia | 7.4 | 15 |
| United States | 9.1 | 11 |

Sources: World Bank; PRS.

High OOPE increases financial burden and pushes families into poverty.[9] It may also discourage people from seeking timely health care.[9] This could lead to worsened health conditions and higher treatment costs in the later period of time.[9]

### Expenditure on medicines

As per the National Sampling Survey (NSS) 2017-18, medicines constituted 70% of the medical expenditure in non-hospitalisation cases.[10] According to World Health Organisation (WHO), medicines are one of the causes of catastrophic OOPE.[11] A household is said to be catastrophically affected if its health expenses as a share of overall expenses exceeds a predefined limit. As of 2017, 17.5% of population spent more than 10% of their household expenditure on health.[10]

Through a public-private partnership approach, the Ministry launched AMRIT pharmacy scheme in 2015 to make branded medicines available at discounted prices.[12] As of November 2025, nearly 250 such pharmacies are operational.[12] To make generic medicines affordable and accessible, the Department of Pharmaceuticals (under the Ministry of Chemicals and Fertilizers) is implementing Pradhan Mantri Janaushadhi scheme since 2008.[13] As of November 2025, 17,610 Janaushadhi Kendras have been opened.[14] The Standing Committee on Chemical and Fertilizers (2021) noted that the sales of Janaushadhi medicines account for a fraction of total medicine sales.[15] According to the Ministry, in 2025-26, sales of medicines worth Rs 1,409 crore were registered (as of November, 2025).[16] This led to savings of Rs 5,637 crore, to the citizens[16]

## Insurance coverage remains low

According to NITI Aayog (2021), nearly 30% of the population does not have any health insurance.[17] This population is referred to as the 'missing middle'.[17] This includes people self-employed in agriculture in rural areas, those

employed in informal and unorganised sectors in urban areas.[17] They are not eligible for government health insurance schemes, social health insurance, or state extension schemes.[17] They are also not covered by private voluntary health insurance, despite their ability to pay nominal premiums.[17]

There has also been an increase in the private voluntary health insurance market marked by high premium costs.[17] As per NITI Aayog (2021), this market has nearly doubled between 2013-14 and 2018-19.[17] Measures recommended by NITI Aayog to provide insurance coverage to this missing middle include: (i) building awareness about health insurance, (ii) making insurance premiums affordable, and (iii) lowering delays in covering treatments.[17] It also recommended reducing the premium coverage of standard health insurance policies by 50% to 66%.[17]

### Insurance schemes do not cover OPD services

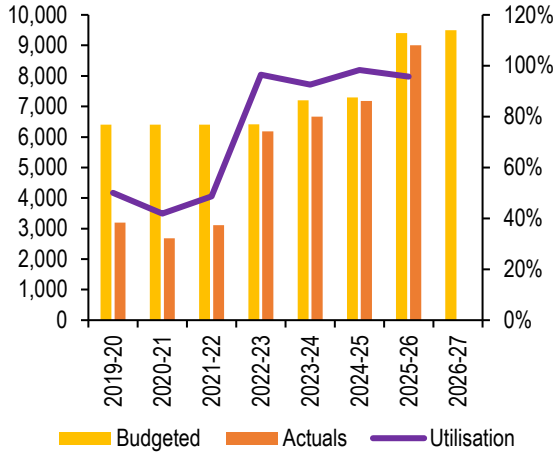
Outpatient care is one of the reasons for catastrophic OOPE.[11] According to NSS 2017-18, around 66% of the OOPE is towards out-patient care.[10] According to NITI Aayog (2021), about 80-85% of households are catastrophically impacted by outpatient expenses.[17] More than 70% of people seek OPD services in private hospitals/clinics, where expenses are higher.[10] However, most insurance schemes do not cover OPD services.[18] Certain countries implement health insurance programmes which cover a wider range of services. For instance, Thailand's universal coverage scheme covers inpatient and outpatient care, and the cost of essential medicines.

### Ayushman Bharat PM-JAY scheme

The PMJAY scheme, launched in 2018, provides insurance coverage of up to five lakh rupees per family annually for secondary and tertiary care.[19] The scheme targets to provide insurance to the bottom 40% of the population according to Socio Economic Caste Census, 2011.[19]

An outlay of Rs 9,500 crore has been allocated to the scheme for 2026-27.[1] This is 6% higher than the revised estimates of 2025-26. The utilisation of funds remains same between 2022-23 and 2024-25 (see Figure 4). It however increased in 2022-23. This may be due to increase in hospitals empanelment. Around six crore hospitals were empanelled as of August, 2023.[20] The allocation increases between 2024-25 and 2025-26. In September 2024, the scheme was been expanded to six crore senior citizens.[48] It was also announced to be extended for gig workers. As of November 2025, nearly 15 crore unorganised workers were registered for the PMJAY scheme.[21]

**Figure 4: Utilisation of funds under PMJAY scheme (in Rs crore)**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

As of December, 2025, nearly 42 crore people have enrolled under the scheme.[22] Some of the most availed PMJAY services include treatments related to eyes, female reproductive health, cancer, general surgery, and medicines.[22] In the same period, 33,121 hospitals have empanelled under PMJAY.[22] Nearly 47% of these hospitals empanelled are private.[22] There were instances of hospitals de-empanelment under PMJAY. As of November 2025, nearly 1,184 hospitals were de-empanelled from the scheme due to fraudulent activities.[23] There were also instances of private hospitals de-empanelling themselves from the schemes in some states. Nearly 650 private hospitals in Haryana de-empanelled themselves from the scheme due to delay in payments.[24] As of March 2025, more than 600 hospitals voluntarily de-empanelled from the scheme between 2019-20 and 2024-25.[25]

The Standing Committee on Health (2023) noted limited coverage of the scheme and disparities across states.[26] The Committee also observed that the scheme does not cover OPD services. The Committee recommended: (i) inclusion of population above the poverty line in the scheme, (ii) timely payment to the hospitals empanelled, (iii) providing medicines free of cost, especially for cancer treatments, and (iv) creation of funds to cover high-cost surgeries.[26] The Committee also recommended revising health benefit package rates under the scheme as per the present market rates.[26]

### Preference for private health services

The average cost of hospitalisation in private hospitals is seven times greater than that in public hospitals (see Table 4).[10] Despite high hospitalisation cost in private hospitals, as of 2017-18, more than 50% of hospitalisation cases are registered in private hospitals.[10] This proportion is higher in urban areas than rural areas.[10] Increase in private hospitalisation may increase OOPE. As per NSS 2017-18, nearly 80% of hospitalisation cases were financed from household income.[10]

**Table 4: Average cost per hospitalisation and share of population accessing (as of 2017-18)**

| Type of hospital | Rural | | Urban | |
|---|---|---|---|---|
| | Average cost | % population | Average cost | % population |
| Government | 4,290 | 45.7 | 4,837 | 35.3 |
| Private | 27,347 | 51.9 | 38,822 | 61.4 |

Sources: India- Social Consumption: Health, NSS (75th Round); PRS.

The preference for availing government facilities is lower in urban areas than in rural areas. According to NFHS-5, 50% of household do not prefer using government health facilities.[27] This figure was higher in states like Bihar (80%), Punjab (68%), and Maharashtra (64%).[27] Many households reported that lack of quality care is one of the reasons for them not availing health care in government services (see Table 5).[27]

**Table 5: Reasons for not using government health facilities**

| Reasons | % of household |
|---|---|
| Poor quality care | 47.6 |
| Long waiting time | 45.7 |
| No nearby facility | 40.2 |
| Inconvenient timings | 25.3 |
| No health personnel | 15.0 |

Sources: NFHS-5, MoHFW; PRS.

## Lack of health infrastructure in rural areas

The Indian Public Health Standards (IPHS) establishes norms for setting up SCs, PHCs, and CHCs.[28,29,30] It sets the number of people a health facility should cover (see Table 6).

**Table 6: Average rural population covered vs IPHS Standards (as of 2022-23)**

| Health facility | Norm for population to be covered | Average population covered |
|---|---|---|
| SCs | 5,000 | 5,450 |
| PHCs | 30,000 | 35,602 |
| CHCs | 1,20,000 | 1,64,388 |

Sources: Health Dynamics of India 2022-23, MoHFW; PRS.

The population covered by a primary health facility is more than the prescribed norm. This may lead to over-crowding and lack of quality care. As of 2022-23, there is a shortfall of facilities in rural areas (see Table 7).[2]

**Table 7: Shortfall in health facilities**

| Health facility | Total number as of March, 2023 | Shortfall (in %) |
|---|---|---|
| SCs | 1,69,615 | 22 |
| PHCs | 31,882 | 30 |
| CHCs | 6,359 | 36 |

Sources: Health Dynamics of India 2022-23, MoHFW; PRS.

States like Bihar (59%), West Bengal (58%), and Uttar Pradesh (49%) have the highest shortfall in PHCs.[2] Existing SCs, and PHCs were upgraded to Ayushman Aarogya Mandirs (health and wellness centres).[31] As of November 2025, nearly 1.8 lakh such centres were operational.[31]

### *Availability of beds*

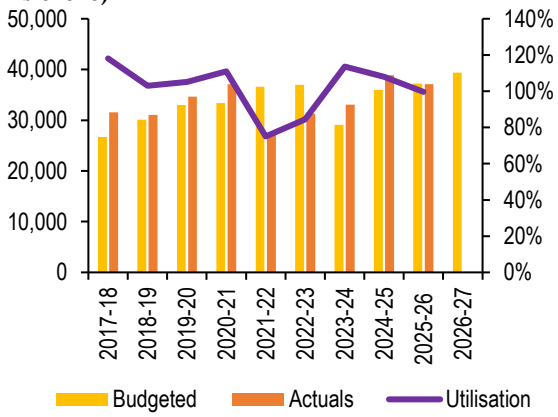
In 2020, India is estimated to have 1.4 hospital beds per 1,000 people.[32] When only government hospitals are considered, this ratio drops to 0.6 beds per 1,000 people.[5] This is half the global average of 2.9 beds per 1,000 people.[32] The National Health Policy, 2017 recommends bed availability of two beds per 1,000 people.[3] WHO has recommended 3.5 beds per 1,000 population. There is also lack of availability of beds in public hospitals. According to the 15th Finance Commission, around 60% of beds are in the private sector.[32] According to the IPHS standards, each PHC is required to have four to six beds.[29] As of 2022-23, 73% of PHCs in rural areas had at least four beds.[2] Certain states fell significantly short on this average. These include: (i) Odisha (9%), (ii) West Bengal (30%), and (iii) Assam (37%).[2]

The central government has been implementing the PM-ABHIM scheme since 2021 to bridge gaps in health infrastructure.[33]

### National Health Mission

NHM comprises of two sub-schemes: (i) National Urban Health Mission, and (ii) National Rural Health Mission. Under NHM, states are provided with financial assistance to: (i) strengthen primary and secondary health infrastructure, (ii) improve maternal, and child health, and (iii) reduce communicable and noncommunicable diseases (NCDs). The allocation to NHM decreased in 2023-24. However, since 2023-24, the expenditure under NHM has been more than the allocation. For 2026-27, an outlay of Rs 39,390 crore has been allocated to the scheme.[1] This is 6% higher than the revised estimates of 2025-26. The utilisation has lowered since 2023-24 (see Figure 5).

**Figure 5: Utilisation of funds under NHM (in Rs crore)**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

### PM ABHIM

The scheme aims at bridging infrastructural gaps in rural and urban areas. Under the scheme, health and wellness centres, block public health units, integrated public health labs, and critical care hospital blocks are established (see Table 8).

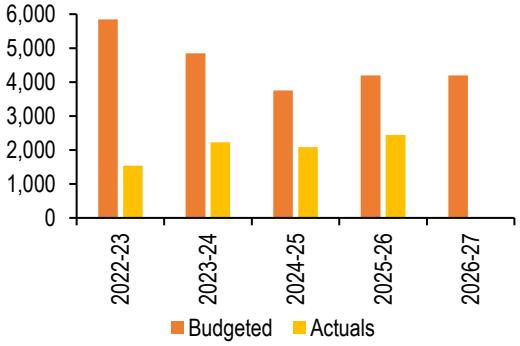
**Table 8: Progress under PM-ABHIM (as of January, 2026)**

| Vertical | Target by March 2026 | Number of construction |
|---|---|---|
| Ayushman Arogya Mandir | 17,788 | 9,519 |
| Arogya Mandirs in Urban areas | 11,024 | 5,456 |
| Block Public Health Units | 3,382 | 2,151 |
| District level Integrated Public Health Laboratory | 730 | 744 |
| Critical Care Hospital Blocks | 602 | 621 |

Sources: "Initiatives and Achievements", Press Release, MoHFW, Jan 1, 2026; PRS.

An outlay of Rs 4,200 crore has been allocated to the scheme for 2026-27.[1] This is 72% higher than the revised estimates of 2025-26. Allocation towards the scheme has been decreasing over the years. On average, 32% of the allocation are utilised (see Figure 6).

**Figure 6: Low utilisation of funds under PM-ABHIM (in Rs crore)**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

The Standing Committee on Health (2025) had noted that public-private partnerships must also be leveraged to improve health care delivery.[34] The HLEG (2011) had also emphasised an engagement model with a focus on service delivery partnership between government as a purchaser and the private sector as a provider.[8]

## Some health outcomes have improved

### *Maternal mortality and child mortality*

As per WHO, MMR in India is estimated at 80 per one lakh live births in 2023.[35] According to Sample Registration System, this figure is 88 as of 2023.[36] MMR in India has been higher than countries such as Russia (9), China (16), and the USA (17). IMR in India was 25 per 1,000 live births in 2023, also significantly higher than Russia (4), USA (6), and China(5).[37] IMR refers to the number of deaths of infants under one year of age in a year. MMR is highest in states like Odisha (153), Chhattisgarh (146), Madhya Pradesh (142), and Uttar Pradesh (141).[36] IMR is highest in states like Chhattisgarh (37), Madhya Pradesh (37), Meghalaya (34), and Odisha (30).[38]

Under the National Health Mission, the central government is implementing Reproductive, Maternal, New-born, Child, Adolescent Health and Nutrition (RMNCAH+N) strategy to improve maternal and child health.[39] It aims at reducing preventable deaths and provide integrated care across different life stages. See table 9 for progress made under the strategy.

**Table 9: Key health indicators (as of 2020)**

| Indicator | NHP target | Status |
|---|---|---|
| MMR | Less than 100 by 2020 | 97 |
| IMR | 28 by 2019 | 28 |
| Neonatal Mortality Rate | 16 by 2025 | 20 |
| Under-5 mortality rate | 23 by 2025 | 32 |

Sources: "Update on Maternal and Child Health Indicators under NHM", Press Information Bureau, March 18, 2025; PRS.

### *Malnutrition*

Malnutrition is a significant public health concern in India.[40] It refers to deficiency or excesses in nutrient intake.[40] Undernutrition (deficiency in intake) in children makes them more vulnerable to disease and death.[40] Women, infants, children, and adolescents are at a higher risk of malnutrition.[40]

**Table 10: Malnutrition in children under five (as of 2019-21)**

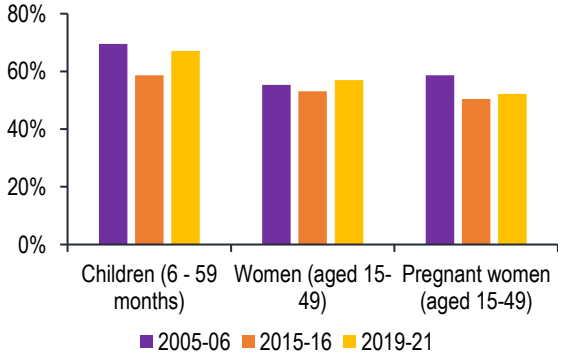
| Type of malnutrition | % of children |
|---|---|
| Stunted | 36% |
| Wasted | 19% |
| Underweight | 32% |
| Overweight | 3% |

Sources: NFHS-5, MoHFW; PRS.

### *Anaemia*

According to NFHS-5, 57% women aged 15-49 years suffer from anaemia.[27] The prevalence of anaemia among women and children has increased between 2015-16 and 2019-21 (see Figure 7).

**Figure 7: Anaemia has increased between 2015-16 and 2019-21**




Sources: National Family Health Surveys 3, 4 and 5; PRS.

The Ministry of Women and Child Development is responsible for providing nutrition to women and children. Refer to the Ministry's demands for grants analysis here for different outcomes under different schemes.

## Rise in Non-Communicable Diseases (NCDs)

NITI Aayog (2020) noted that India faces the dual burden of non-communicable and communicable diseases.[41] There has been an increase in NCD burden by 25% between 1990 and 2018.[6] Key NCDs are cardiovascular diseases, diabetes, respiratory diseases, and cancer.[6] Key communicable disease includes tuberculosis and vector-borne disease. As of 2021-23, 57% of mortalities are caused due to NCDs.[42] 31% of deaths are due to cardiovascular diseases.[42] Population aged 30 to 69 years are most affected by deaths due to cardiovascular disease.[42] WHO (2018) noted that NCDs largely affect middle-aged and older populations, and this burden is likely to rise with a rise in aging population.[43]

The government launched national programme for prevention and control of cancer, diabetes, cardiovascular diseases and stroke (NPCDCS) to prevent and control major NCDs.[44] The program aims at strengthening infrastructure and human resources, promote health, screening and early diagnosis of NCDs for population aged 30 years and above.[44] As of August 2025, nearly 4.7 crore population aged 30 years and above are being treated for hypertension under NPCDCS.[45]

### *Need for senior care*

NITI Aayog (2024) noted that the elderly population in India comprises around 10% of the total population.[47] This is expected to reach 20% by 2050.[46] It observed that a increase in elderly population will strain the healthcare system.[46] There is also lack of geriatric specialists and comprehensive programme for elderly care.[46] It also noted that 75% of all elders face at least one chronic disease.[47] It recommended the following to strengthen senior care in the country: (i) adult immunization, (ii) immunity-boosting interventions, (iii) providing mobility aids like walkers, and hearing and visual aids, (iv) expanding tele-communication services, and (v) improving rehabilitative care.[47]

In 2024, the government extended the PMJAY scheme to provide health insurance coverage to all senior citizens aged 70 years and above. As of December, 2025, nearly 93 lakh senior citizens have enrolled under the scheme.[48]

## Shortfall in human resources

The Economic Survey (2024-25) noted that as of 2024, India had one doctor trained in modern medicine per 1,263 people.[49] This is lower than the WHO standard of one doctor per 1,000 people.[49] The Survey observed that the WHO norm could be attained by 2030 with an estimated 50,000 doctors being licenced every year.[49] The 15th Finance Commission noted that there is also regional and state-wide disparity in the availability of doctors.[32] In December 2023, the Ministry noted that there is one nurse per 476 people in India, again lower than the WHO standard of one nurse per 300 people.[50]

There are also vacancies in certain specialist positions in rural areas (see Table 11). For instance, 68% of positions for specialists (surgeons, physicians, paediatricians, and gynaecologists) in CHCs were vacant as of 2023.[2]

**Table 11: Shortage of specialists and radiographers in CHCs (as of 2023)**

| Human resource in rural areas | Shortage (in %) |
|---|---|
| Surgeons | 73 |
| Gynaecologists and obstetricians | 59 |
| Paediatricians | 66 |
| Physicians | 68 |
| Radiographers | 41 |

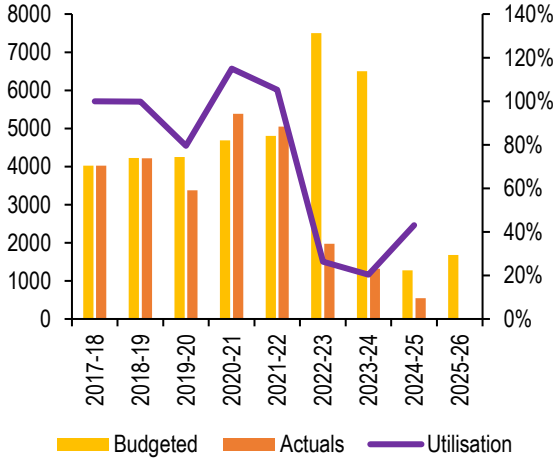
Sources: Health Dynamics of India (Infrastructure and Human Resources 2022-23; PRS.

As discussed earlier, there is a rise in NCDs particularly cardiovascular and pulmonary diseases, require specialist care. The Parliamentary Estimates Committee (2017) had noted nation-wide shortage of specialists in fields such as cardiology, diabetes, and chest medicine.

## Health Personnel

In 2026-27, Rs 1,725 crore has been allocated for: (i) establishment of new medical colleges with district hospitals, and (ii) increasing seats in state medical colleges.[1] Allocation in 2026-27 is 6% higher than the revised estimates of 2025-26. However, there has been decrease in utilisation of funds under this head since 2022-23 (see Figure 8).

**Figure 8: Under-utilisation of funds for human resources since 2022-23 (in Rs crore)**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

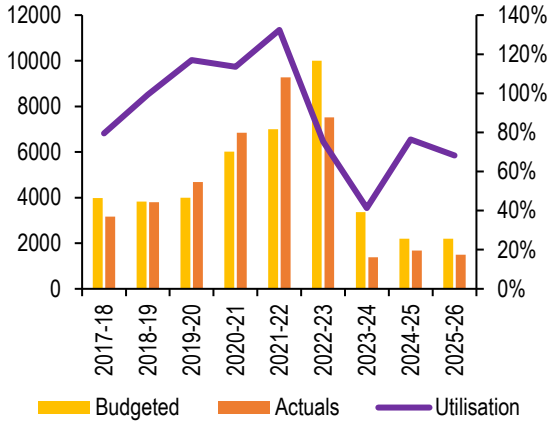
Around 157 medical colleges were approved in 2014. As of March 2025, 131 medical colleges are functional.[51] Certain existing medical colleges receive funds directly from the centre. New AIIMS

are established under Pradhan Mantri Swasthya Suraksha Yojana (PMSSY).

***Establishment of AIIMS***

The PMSSY is a central sector scheme, launched in 2003. It aims at: (i) setting up new AIIMS, and (ii) upgrading government medical colleges to build tertiary care facilities. Between 2003 and 2018, 22 AIIMS were approved under PMSSY. As of January 2026, 6 AIIMS are fully functional and 12 AIIMS have operational MBBS program.[52] In 2026-27, Rs 2,005 crore has been allocated towards establishment of new AIIMS.[1] This is 34% higher than revised estimates of 2025-26. The utilisation of funds under PMSSY has decreased in 2022-23 (see Figure 9). There is also decrease in the allocation since then.

**Figure 9: 68% of funds were utilised under PMSSY for 2025-26**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

As of August 2025, 39% faculty positions and 37% non-faculty positions are vacant across 19 functional AIIMS.[53] The vacancies of faculty are the highest in AIIMS in following cities: (i) Rajkot (58%), (ii) Mangalagiri (51%), (iii) Jodhpur (46%), and (iv) Gorakhpur (46%).[53]

***Imbalance in availability of seats across states***

As of March 2023, there were 1.5 lakh seats for medical courses in the country.[5] This included one lakh MBBS seats, 42,100 MD/MS seats, and 4,166 Doctorate of Medicine and Masters of Surgery seats. The Standing Committee on Health (2024) noted that there is a regional imbalance in availability of seats.[54] For instance, Bihar (3,578) and Maharashtra (5,816), and Tamil Nadu (5,861) and Rajasthan (7,910) have very different availability of medical seats, despite having similar population.[54]

In September 2025, the government approved the addition of more than 10,023 medical seats in government colleges.[55]

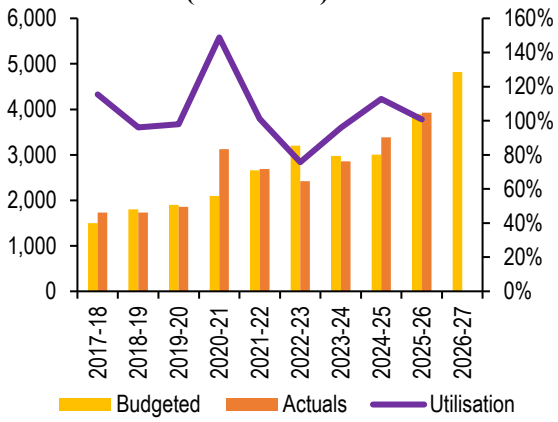
***Increase in cost of medical education***

The Standing Committee on Health (2024) observed that the cost of medical education in India had doubled between 2008 and 2018.[54] It can range between Rs 60 lakh to one crore rupees.[54] It recommended that the government come up with need-based scholarships, and offer incentives such as tax benefits for providing education to deserving candidates.[54] To reduce functioning costs, the Committee recommended collaborations between private medical colleges and district hospitals.[54] It also recommended subsidising laboratory equipment or machines in private colleges.[54]

## Health Research

The Department of Health Research has been allocated Rs 4,821 crore for 2026-27.[1] This is 23% higher than the revised estimates of 2025-26. The utilisation of the funds has increased between 2022-23 and 2024-25. The expenditure of the department is more than the allocation in 2025-26 (see Figure 10). As of March 2025, 165 viral diagnostic laboratories, 113 multidisciplinary research units, and 35 model rural health research units were established in medical colleges and research institutes.[56]

**Figure 10: Utilisation of funds by department of health research (in Rs crore)**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

***Lack of investment in health research***

According to the Standing Committee on Health (2023), India spent 0.02% of its GDP on health research in 2021-22.[57] This is lower than other countries spending on health research as share of their GDP. These countries include Denmark (0.93%) as of 2019, Singapore (0.43%) as of 2020, and Greece (0.34%) as of 2022.[58] The Standing Committee on Health (2023) noted that the existing expenditure was insufficient, and recommended enhancing spending to 0.1% of GDP.[57] In 2022, it also recommended allocating 5% of the Ministry's budget to the Department of Health Research.[57] In 2026-27, around 4.5% of the Ministry's budget is allocated to the Department of health research.

***Performance of ICMR***

The Indian Council of -Medical Research (ICMR) , is responsible for conducting and supporting medical research in India.[59] In 2026-27, the

Department has allocated 83% of its budget to ICMR (Rs 4,000 crore).[1] This is 27% higher than the revised estimates of 2025-26.

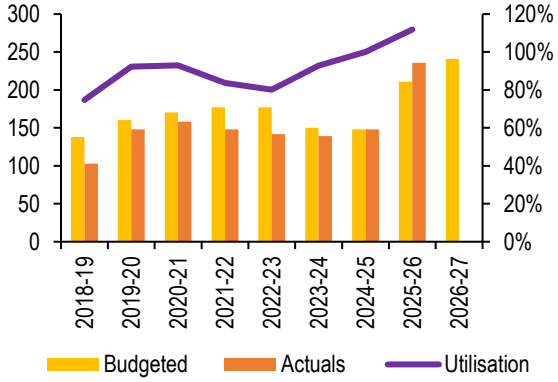
The Standing Committee on Health (2017) had observed that: (i) ICMR's research outputs were low, and (ii) strength of ICMR was too small to produce effective research.[60] As of 2023, ICMR has sanctioned 876 posts of scientists.[61] However, 16% of these posts were lying vacant.[61] The Standing Committee on Health (2023) recommended that an annual grant should be given to top faculties of medical colleges to produce more research output.[62] More funds should be allocated to promote cancer research.[62]

***Health research infrastructure***

The Department spends on following areas of research infrastructure: (i) laboratories to manage epidemics and calamities, (ii) tools to prevent outbreaks of epidemics, and (iii) infrastructure to promote health research.

Allocation on research infrastructure increased between 2018-19 to 2022-23 (see Figure 11). It decreased in 2023-24 and 2024-25. The expenditure increased in between 2023-24 and 2024-25. In 2026-27, Rs 241 crore has been allocated towards health research infrastructure.[1] This is 2% higher than the revised estimates of 2025-26. Between 2018-19 and 2024-25, the CAGR of the Department's expenditure is 6%.

**Figure 11: Utilisation of funds for health research infrastructure (in Rs crore)**




Note: Revised estimates of 2025-26 are taken as actuals.
Sources: Union Budget documents of various years; PRS.

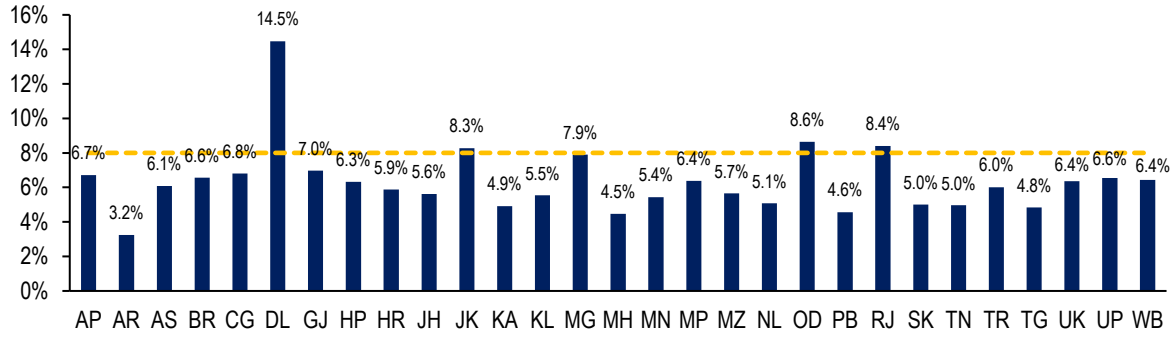
## Annexure

**Table 12: Government Health Expenditure as a share of overall health expenditure in certain states (in %)**

| States | Government Health Expenditure (as % of Total Health Expenditure) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 2014-15 | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 | 2020-21* | 2021-22* |
| Assam | 29 | 38 | 39 | 57 | 55 | 58 | 58 | 64 |
| Andhra Pradesh | 15 | 22 | 25 | 30 | 32 | 33 | 35 | 42 |
| Bihar | 17 | 19 | 21 | 40 | 45 | 44 | 47 | 55 |
| Chhattisgarh | 28 | 32 | 34 | 50 | 47 | 52 | 55 | 60 |
| Gujarat | 34 | 37 | 39 | 43 | 44 | 45 | 43 | 50 |
| Haryana | 24 | 28 | 30 | 33 | 36 | 41 | 41 | 46 |
| Himachal Pradesh | 44 | 47 | 51 | 49 | 52 | 52 | 52 | 58 |
| Jammu and Kashmir | 35 | 40 | 39 | 54 | 51 | 50 | 65 | 71 |
| Jharkhand | 24 | 30 | 31 | 29 | 34 | 33 | 34 | 49 |
| Karnataka | 22 | 26 | 27 | 33 | 34 | 31 | 36 | 43 |
| Kerala | 18 | 23 | 27 | 25 | 25 | 24 | 26 | 33 |
| Madhya Pradesh | 26 | 28 | 29 | 41 | 41 | 44 | 42 | 52 |
| Maharashtra | 17 | 24 | 23 | 26 | 27 | 27 | 31 | 34 |
| Odisha | 22 | 20 | 27 | 39 | 41 | 42 | 44 | 53 |
| Punjab | 17 | 20 | 20 | 26 | 29 | 30 | 31 | 36 |
| Rajasthan | 31 | 33 | 33 | 40 | 44 | 42 | 42 | 50 |
| Tamil Nadu | 25 | 28 | 27 | 41 | 47 | 44 | 50 | 52 |
| Telangana | 22 | 38 | - | 40 | 41 | 44 | 46 | 46 |
| Uttar Pradesh | 19 | 21 | 22 | 24 | 25 | 26 | 25 | 32 |
| Uttarakhand | 36 | 37 | 36 | 55 | 61 | 62 | 61 | 68 |
| West Bengal | - | - | 21 | 24 | 26 | 26 | 29 | 36 |
| **All-India** | **29** | **31** | **32** | **41** | **41** | **41** | **43** | **48** |

Note: Data for West Bengal is not available for 2014-15 and 2015-15. Data for Telangana is not available for 2016-17. Government Health Expenditure includes expenditure by the Union and state governments. *These years had the covid-19 pandemic.
Sources: National Health Accounts 2014-15 to 2021-22; PRS.

**Figure 12: Three states estimated to meet the National Health Policy target of 8% of budget on health**




Source: State Budget Documents; PRS.

**Table 13: Share of hospitalisation cases (excluding childbirth) in 2017-18 (in %)**

| States/UTs | Government | Private | States/UTs | Government | Private |
|---|---|---|---|---|---|
| Andhra Pradesh | 28% | 69% | Kerala | 38% | 58% |
| Arunachal Pradesh | 92% | 7% | Madhya Pradesh | 48% | 49% |
| Assam | 71% | 27% | Maharashtra | 22% | 74% |
| Bihar | 38% | 60% | Manipur | 80% | 20% |
| Chandigarh | 67% | 33% | Meghalaya | 85% | 15% |
| Chhattisgarh | 54% | 42% | Mizoram | 80% | 16% |
| Delhi | 62% | 37% | Nagaland | 73% | 27% |
| Goa | 66% | 34% | Odisha | 72% | 27% |
| Gujarat | 31% | 62% | Puducherry | 69% | 31% |
| Haryana | 31% | 67% | Punjab | 29% | 66% |
| Himachal Pradesh | 77% | 21% | Rajasthan | 51% | 48% |
| Jammu and Kashmir | 91% | 8% | Sikkim | 80% | 20% |
| Jharkhand | 41% | 54% | Tamil Nadu | 50% | 48% |
| Karnataka | 27% | 71% | **All-India** | **42%** | **55%** |

Sources: Key Indicators of Social Consumption in India: Health - July 2017 to June 2018, NSS; PRS.

**Table 14: Shortfall of health workers at PHCs and CHCs in rural areas (as of 2022-23)**

| States/UTs | Specialists at CHCs | Nursing staff at PHCs and CHCs | Pharmacists in PHCs and CHCs | States/UTs | Specialists at CHCs | Nursing staff at PHCs and CHCs | Pharmacists in PHCs and CHCs |
|---|---|---|---|---|---|---|---|
| Andhra Pradesh | 9% | - | - | Manipur | 69% | - | - |
| Arunachal Pradesh | 96% | - | 52% | Meghalaya | 96% | - | - |
| Assam | 81% | - | - | Mizoram | 100% | - | 47% |
| Bihar | 81% | - | 51% | Nagaland | 94% | - | 37% |
| Chhattisgarh | 88% | - | 12% | Odisha | 81% | 41% | - |
| Delhi | - | - | 40% | Puducherry | 92% | - | - |
| Goa | 50% | - | - | Punjab | 84% | - | - |
| Gujarat | 88% | - | 9% | Rajasthan | 80% | - | 54% |
| Haryana | 94% | - | 33% | Sikkim | 100% | - | 15% |
| Himachal Pradesh | 97% | 70% | 11% | Tamil Nadu | 85% | - | 19% |
| Jammu & Kashmir | 42% | 33% | 9% | Telangana | 68% | - | 16% |
| Jharkhand | 72% | 7% | 54% | Tripura | 94% | - | - |
| Karnataka | 63% | - | 35% | Uttarakhand | 77% | 42% | 9% |
| Kerala | 93% | - | - | Uttar Pradesh | 74% | 27% | - |
| Madhya Pradesh | 95% | - | - | West Bengal | 95% | - | - |
| Maharashtra | 68% | 9% | 6% | **All-India** | **80%** | **10%** | **16%** |

Note: - refers to adequate or surplus of staff. Specialists include doctors such as surgeons, paediatricians, and OB & GY specialists.
Source: Health Dynamics of India, 2022-23, MoHFW; PRS.

**Table 15: State-wise shortfall in health facilities in rural areas (as of 2022-23)**

| States/UTs | SCs | | | PHCs | | | CHCs | | |
|---|---|---|---|---|---|---|---|---|---|
| | Required | Available | Shortfall (in %) | Required | Available | Shortfall (in %) | Required | Available | Shortfall (in %) |
| Andhra Pradesh | 7,036 | 11,070 | * | 1,160 | 1,145 | 1 | 290 | 138 | 52 |
| Arunachal Pradesh | 347 | 390 | * | 53 | 127 | * | 13 | 56 | * |
| Assam | 6,598 | 4,692 | 29 | 1,076 | 920 | 14 | 269 | 176 | 35 |
| Bihar | 22,543 | 9,654 | 57 | 3,748 | 1,519 | 59 | 937 | 274 | 71 |
| Chhattisgarh | 5,493 | 5,138 | 6 | 870 | 773 | 11 | 217 | 166 | 24 |
| Delhi | 17 | 8 | 53 | 2 | 5 | * | 0 | 0 | 0 |
| Goa | 83 | 202 | * | 13 | 21 | * | 3 | 1 | 67 |
| Gujarat | 8,469 | 9,149 | * | 1,364 | 1,483 | * | 341 | 350 | * |
| Haryana | 3,500 | 2,521 | 28 | 583 | 384 | 34 | 145 | 100 | 31 |
| Himachal Pradesh | 1,395 | 2,102 | * | 230 | 549 | * | 57 | 98 | * |
| Jammu & Kashmir | 2,064 | 2,434 | * | 336 | 890 | * | 84 | 52 | 38 |
| Jharkhand | 7,071 | 3,863 | 45 | 1,127 | 308 | 73 | 281 | 188 | 33 |
| Karnataka | 7,978 | 8,762 | * | 1,310 | 2,132 | * | 327 | 182 | 44 |
| Kerala | 1,746 | 4,930 | * | 289 | 780 | * | 72 | 211 | * |
| Madhya Pradesh | 14,572 | 10,258 | 30 | 2,335 | 1,440 | 38 | 583 | 332 | 43 |
| Maharashtra | 14,290 | 10,740 | 25 | 2,328 | 1,906 | 18 | 582 | 261 | 55 |
| Manipur | 549 | 392 | 29 | 86 | 74 | 14 | 21 | 8 | 62 |
| Meghalaya | 852 | 463 | 46 | 128 | 122 | 5 | 32 | 28 | 13 |
| Mizoram | 183 | 308 | * | 27 | 57 | * | 6 | 9 | * |
| Nagaland | 388 | 443 | * | 58 | 128 | * | 14 | 8 | 43 |
| Odisha | 8,812 | 6,598 | 25 | 1,415 | 1,277 | 10 | 353 | 330 | 7 |
| Punjab | 3,575 | 2,857 | 20 | 595 | 397 | 33 | 148 | 84 | 43 |
| Rajasthan | 13,269 | 14,042 | * | 2,155 | 2,179 | * | 538 | 650 | * |
| Sikkim | 86 | 148 | * | 13 | 24 | * | 3 | 2 | 33 |
| Tamil Nadu | 7,188 | 8,713 | * | 1,194 | 1,419 | * | 298 | 385 | * |
| Telangana | 4,339 | 4,228 | 3 | 708 | 594 | 16 | 177 | 29 | 84 |
| Tripura | 639 | 956 | * | 100 | 110 | * | 25 | 18 | 28 |
| Uttarakhand | 1,530 | 1,779 | * | 253 | 532 | * | 63 | 49 | 22 |
| Uttar Pradesh | 36,069 | 25,723 | 29 | 6,004 | 3,055 | 49 | 1,501 | 939 | 37 |
| West Bengal | 13,170 | 12,506 | 5 | 2,167 | 910 | 58 | 541 | 347 | 36 |
| **All-India** | **1,94,133** | **1,65,639** | **22** | **31,770** | **25,354** | **30** | **7,930** | **5,491** | **36** |

Note: * refers to surplus of health facilities.
Sources: Health Dynamics of India 2022-23, Ministry of Health and Family Welfare; PRS.

**Table 16: Maternal Mortality Ratio (deaths per lakh live births) in selected states (as of 2021-23)**

| States | MMR | States | MMR | States | MMR |
|---|---|---|---|---|---|
| Andhra Pradesh | 30 | Karnataka | 68 | Tamil Nadu | 35 |
| Assam | 110 | Kerala | 30 | Telangana | 59 |
| Bihar | 104 | Madhya Pradesh | 142 | Uttar Pradesh | 141 |
| Chhattisgarh | 146 | Maharashtra | 36 | Uttarakhand | 91 |
| Gujarat | 51 | Odisha | 153 | West Bengal | 104 |
| Haryana | 89 | Punjab | 90 | **All-India** | **88** |
| Jharkhand | 54 | Rajasthan | 86 | | |

Sources: Special Bulletin on MMR, 2021-23, Sample Registration System, September 2025; PRS.

**Table 17: Estimated Infant Mortality Rate (deaths per thousand live births) (as of 2023)**

| States/UTs | IMR | States/UTs | IMR | States/UTs | IMR |
|---|---|---|---|---|---|
| Andhra Pradesh | 19 | Jammu and Kashmir | 14 | Punjab | 17 |
| Arunachal Pradesh | 20 | Jharkhand | 29 | Rajasthan | 29 |
| Assam | 30 | Karnataka | 14 | Sikkim | 6 |
| Bihar | 23 | Kerala | 5 | Tamil Nadu | 12 |
| Chhattisgarh | 37 | Madhya Pradesh | 37 | Telangana | 18 |
| Delhi | 14 | Maharashtra | 14 | Tripura | 15 |
| Goa | 6 | Meghalaya | 34 | Uttar Pradesh | 37 |
| Gujarat | 20 | Mizoram | 13 | Uttarakhand | 20 |
| Haryana | 26 | Nagaland | 10 | West Bengal | 17 |
| Himachal Pradesh | 14 | Odisha | 30 | **All-India** | **25** |

Sources: Volume 58 No. 1, Sample Registration Survey Bulletin, September 2025; PRS.

**Table 18: Cases of communicable and non-communicable diseases in selected states and UTs**

| States/UTs | Communicable disease | Non-communicable disease (as of 2022) | | | |
|---|---|---|---|---|---|
| | Tuberculosis (Nov, 2024) | Diabetes | Hypertension | Cardiovascular disease | Common cancers |
| Andhra Pradesh | 69,371 | 4,24,884 | 3,73,322 | 11,397 | 703 |
| Arunachal Pradesh | 2,430 | 11,718 | 17,895 | 295 | 894 |
| Assam | 42,202 | 32,833 | 49,936 | 913 | 131 |
| Bihar | 1,67,193 | 7,81,534 | 6,12,054 | 11,125 | 69,387 |
| Chandigarh | 5,885 | 7,447 | 8,176 | 45 | 1 |
| Chhattisgarh | 32,526 | 3,95,822 | 3,68,505 | 9,972 | 1,28,238 |
| Delhi | 88,868 | 34,541 | 37,518 | 872 | 106 |
| Goa | 1,710 | 9,205 | 9,348 | 2,077 | 92 |
| Gujarat | 1,13,431 | 1,03,631 | 1,28,740 | 7,081 | 3,617 |
| Haryana | 73,703 | 97,628 | 1,09,876 | 2,990 | 1,649 |
| Himachal Pradesh | 13,429 | 21,913 | 37,050 | 426 | 3,800 |
| Jammu & Kashmir | 10,442 | 45,512 | 69,699 | 2,900 | 329 |
| Jharkhand | 53,213 | 1,12,357 | 1,04,492 | 2,492 | 1,733 |
| Karnataka | 65,186 | 85,089 | 1,06,566 | 7,656 | 7,009 |
| Kerala | 17,267 | 85,227 | 1,65,443 | 8,123 | 10,773 |
| Madhya Pradesh | 1,49,093 | 1,60,618 | 1,83,955 | 17,469 | 8,903 |
| Maharashtra | 1,86,706 | 1,86,802 | 2,47,755 | 13,591 | 8,972 |
| Manipur | 2,067 | 5,048 | 4,838 | 120 | 20 |
| Meghalaya | 3,890 | 4,412 | 12,045 | 72 | 1,379 |
| Mizoram | 1,985 | 4,390 | 7,207 | 7 | 239 |
| Nagaland | 3,419 | 3,584 | 8,257 | 688 | 578 |
| Orissa | 48,917 | 4,28,610 | 4,61,632 | 8,938 | 6,509 |
| Punjab | 49,739 | 1,96,389 | 2,34,219 | 8,859 | 7,034 |
| Rajasthan | 1,45,405 | 7,28,737 | 12,35,777 | 30,191 | 1,402 |
| Sikkim | 1,122 | 1,071 | 3,796 | 54 | 15 |
| Tamil Nadu | 77,820 | 3,94,522 | 6,37,770 | 11,152 | 3,748 |
| Telangana | 62,722 | 1,97,408 | 5,81,644 | 169 | 1,200 |
| Tripura | 2,760 | 15,762 | 39,068 | 657 | 146 |
| Uttar Pradesh | 5,63,573 | 6,32,712 | 4,91,114 | 21,825 | 4,481 |
| Uttarakhand | 24,984 | 24,653 | 30,475 | 729 | 95 |
| West Bengal | 83,962 | 8,20,606 | 10,95,502 | 33,491 | 9,639 |
| **All-India** | **21,65,020** | **60,60,133** | **74,79,846** | **2,25,361** | **2,83,656** |

Sources: *Unstarred Question No. 1736, MoHFW, Rajya Sabha, December 10, 2024;
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