Demand for Grants 2024-25 Analysis
Health and Family Welfare

Introduction

In India, states are responsible for public health and sanitation. This includes public hospitals and clinics. The Ministry of Health and Family welfare formulates a broader policy on public health, such as the National Health Mission. The Ministry of two departments: (i) Health and Family Welfare and (ii) Health Research. The Department of Health and Family Welfare funds the National Health Mission. Under the scheme, states are funded to meet targets on health outcomes, such as maternal health and infant mortality. The Department also regulates medical education, and funds certain medical colleges, such as AIIMS. It also implements initiatives to improve human resources in health. The Department of Health Research funds initiatives in medical research.

In 2019-20, government spending on health constituted 41% of total health expenditure in the country.[1] In 2013-14, this was 29%. Total health expenditure includes spending on medicines, insurance, hospitalisation, consultation and health infrastructure.

This note examines the allocation to the Ministry in 2024-25 and its expenditure patterns over the years. It also highlights issues in the health sector.

Overview of finances

In 2024-25, the Ministry has been allocated Rs 90,659 crore.[2] This is a 13% rise over the revised estimates of 2023-24. In 2024-25, the **Department of Health and Family Welfare** has been allocated 97% of the Ministry's allocation. The Department's allocation is 13% higher than its estimated expenditure in 2023-24.

The **Department of Health Research** has been allocated Rs 3,002 crore, which is a 4% rise on its estimated expenditure in 2023-24.

Table 1: Expenditure of the Ministry of Health and Family Welfare (in Rs crore)

	2022-23	2023-24 (RE)	2024-25 (BE)	% Change from RE to BE
Health and Family Welfare	73,308	77,625	87,657	13%
Health Research	2,423	2,893	3,002	4%
Total	**75,731**	**80,518**	**90,659**	**13%**

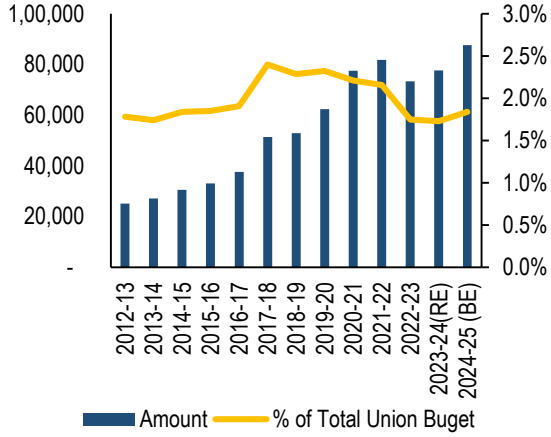
Note: BE is Budgeted Estimates and RE is Revised Estimates.
Sources: Demand No. 46 and 47, Expenditure Budget 2024-24; PRS.

Announcements in Budget Speech 2024-25

Digital Public Infrastructure: Digital public health infrastructure will be built to improve productivity and encourage innovation.

Between 2012-13 to 2022-23, expenditure towards the Department of Health and Family Welfare increased by an average 11% annually. In this period, the Department's spending constituted less than 2.5% of the overall spending of the union government. The Department's share in the union budget rose from 1.8% in 2014-15 to 2.4% 2017-18. However, it has dwindled since then.

Figure 1: Expenditure of the Department of Health and Family Welfare (in Rs crore) and its share in Union spending (in %)



Sources: Union Budgets 2012-13 to 2024-25; PRS.

Allocation towards the National Health Mission constituted 40% of the Ministry's budget in 2024-25. This mainly involves transfers to states to meet the Mission's targets. The allocation in 2024-25 is Rs 36,000 crore, 14% higher than the revised estimates in 2023-24.

Transfers to certain centrally run medical institutions, such as AIIMS (Delhi) and establishment expenditure for new AIIMS constituted 20% of the Ministry's allocation in 2024-25. This is 4% higher than the estimated spending in 2023-24.

Allocation towards the PM – Ayushman Bharat Health Infrastructure Mission is 63% higher in 2024-25 compared to revised estimates in 2023-24. The scheme focuses on strengthening primary healthcare infrastructure and disease surveillance.[3]

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

Heads	2022-23	2023-24 (RE)	2024-25 (BE)	% Change from RE to BE	Share in Ministry's Budget
National Health Mission	31,279	31,551	36,000	14.1%	40%
Autonomous Bodies	10,073	17,251	18,014	4.4%	20%
Pradhan Mantri Jan Aarogya Yojana	6,186	6,800	7,300	7.4%	8%
Human Resources for Health and medical education	1,975	1,520	1,275	-16.1%	1%
Central Government Health Scheme	4,631	4,296	5,384	25.3%	6%
PM ABHIM	1,542	2,300	3,757	63.3%	4%
AIDS and STD Control	2,143	2,421	3,049	26%	3%
Indian Council of Medical Research	2,047	2,295	2,879	19%	3%
Pradhan Mantri Swasthya Suraksha Yojana	7,518	1,900	2,200	15.8%	3%
Others	8,338	3,449	4,148	20.3%	5%
Total	**75,731**	**80,518**	**90,659**	**13%**	

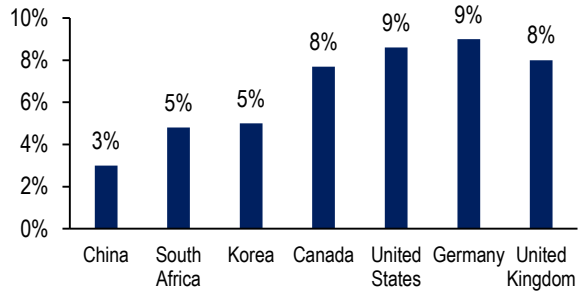
Note: Expenditure on Autonomous Bodies includes transfers to institutions such as AIIMS, Delhi and NIMHANS, Bangalore and expenditure on establishing new AIIMS.
Sources: Demand No. 46 and 47, Expenditure Budget 2024-25; PRS.

Issues to consider

Allocations fall short of policy targets

The National Health Policy, 2017 recommends government health expenditure (state and centre combined) to be 2.5% of GDP.[4] In 2019-20, government health expenditure was estimated to be 1.4% of GDP.[1] This was significantly lesser than that of certain countries (see Figure 2).[5] In 2022-23, government health expenditure in India is expected to be 2% of GDP.[6]

Figure 2: Government health expenditure in certain countries (in%) (2019)



Sources: General government health expenditure % of GDP, World Bank; PRS.

The National Health Policy also recommends states to spend over 8% of their budgets on health.[4] In 2023-24, states, on an average, allocated 6.2% of their budget on health. States with lowest allocations include: (i) Punjab (4.2%), Maharashtra (4.6%), Karnataka (4.9%), and Telangana (5%).

In 2018-19, a 4% health and education cess on income was introduced.[7] In 2021-22 the Pradhan Mantri Swasthya Suraksha Nidhi (PMSSN) was formed to receive cess collections on health.[7] In 2020, the Ministry of Finance declared that 25% of cess collections would be utilised for health.[7] In 2023-24 and 2024-25, transfer to health is estimated to be lesser.

Table 3: Cess collection and transfers for health (in Rs crore)

	Cess Collection	Transfers to PMSSN	% Transferred
2021-22	52,732	-	0%
2022-23	61,809	18,339	30%
2023-24 (RE)	73,000	9,870*	14%
2024-25 (BE)	83,000	14,758	18%

Note: RE is revised estimates, BE is budgeted estimates.
Sources: Receipt Budget and Expenditure Budget 2023-24 and 2024-24; PRS.

Primary healthcare infrastructure is still deficient

The National Health Policy, 2017 recommends a bed capacity of two beds per 1,000 persons.[4] As of 2021, India has 0.6 beds per 1,000 persons.[8]

Primary healthcare in India is organised in a three-tiered system. This consists of: (i) Sub-Centres, (ii) Primary Health Centres (PHCs) and (iii) Community Healthcare Centres (CHCs).[9] Each unit fulfils a distinct function. For example, Sub centres seek to bring behavioural change in the community and provide services in areas such as maternal health, family welfare and immunisation. PHCs provide basic preventive and curative healthcare. CHCs provide specialist services.[9]

Indian Public Health Standards (IPHS) provide population coverage norms at each level of primary healthcare (Table 4). As of 2021-22, each level of primary healthcare covers a greater population than recommended.[9] Coverage of PHCs has worsened since 2019-20.

Table 4: Population coverage of primary healthcare

	Norm	2019-20	2020-21	2021-22
Sub Centre	300-5,000	5,729	5,734	5,691
PHC	20,000-30,000	35,730	35,602	36,049
CHC	80,000-1,20,000	1,71,779	1,63,298	1,64,027

Sources: Rural Healthcare Statistics; PRS.

IPHS also provides the norms for staff and infrastructure for each unit of the primary healthcare system. We discuss the status below.

PHC: Each PHC is required to have four to six beds. As of 2021-22, 74% of PHCs had a minimum of four beds.[9] However, PHCs in certain states fell significantly short of the mark. These include: Odisha (10% PHCs having at least four beds), Assam (37%), Bihar (41%). In 2005, the Ministry aimed to have 50% of PHCs open 24 hours by 2010.[9] As of 2021-22, only 45% PHCs were open 24 hours. Himachal Pradesh (5% of all PHCs open 24 hours), Maharashtra (13%), Uttarakhand (11%) and West Bengal (25%) fell significantly short of the target.[9]

CHCs: Each CHC is required to have four kinds of specialists on-board.[9] These are: (i) Surgeon, (ii) Physician, (iii) Obstetrician and (iv) Paediatrician. As of 2021-22, only 10% of all CHCs had all four specialists on-board.[9] According to NITI Aayog (2021), 72% of all hospital beds were located in urban areas. [10]

Ayushman Bharat Health and Wellness Centres

In 2015, the Task Force on Comprehensive Primary Healthcare Rollout observed that PHCs provided a narrow range of services that were restricted to pregnancy, child health and some disease programmes.[11] In 2018, the Ayushman Bharat – Health and Wellness Centres (HWCs) were launched to provide comprehensive primary healthcare. Each HWC would cover a population of 3,000-5,000 people and provide services including: (i) care in pregnancy and child-birth, (ii) childhood and adolescent healthcare services, and (iii) screening and basic management of mental ailments and emergency medical services.[12]

As of June, 2024, 1.6 lakh SHCs and PHCs have been upgraded to HWCs (renamed as Ayushman Aarogya Mandir).[12] As of December 2023, HWCs have screened for illnesses such as: (i) hypertension (56 crore screenings), (ii) diabetes (48 crore), (iii) oral cancer (33 crore), and (iv) cervical cancer (10 crore).[13]

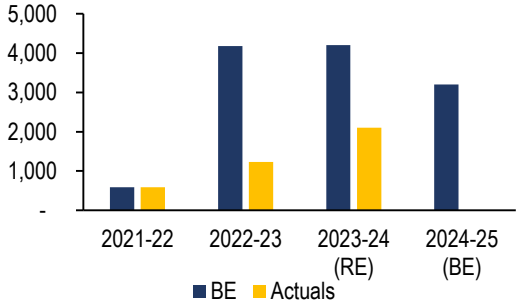
Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM ABHIM)

PM ABHIM was launched in October 2021 (renaming the Prime Minister Atmanirbhar Swasth Bharat Yojana that was announced in Budget 2021).[14] It is a Centrally Sponsored Scheme (with some Central Sector components) spread over five years from 2021-22 to 2025-26.[14] The Mission focuses on developing capacities of health systems across primary, secondary and tertiary healthcare levels, to prepare health systems in responding effectively to the current and future pandemics.

Under the Centrally Sponsored component, PM-ABHIM seeks to create 17,788 HWCs in 10 states and 11,024 HWCs in urban areas across all states[15] This component also supports creation of: (i) 602 critical care hospital blocks in districts with over five lakh people, (ii) Block level public health units in 3,000 blocks and integrated public health laboratories in 730 districts.

The Mission has been allocated Rs 3,757 crore in 2024-25, which is 63%% higher than the revised estimates of 2023-24. Utilisation of funds under the Centrally Sponsored component has been low (Figure 3).

Figure 3: Allocation and Utilisation towards PM-ABHIM - CSS Component (in Rs crore)



Sources: Demand No. 46, Expenditure Budget 2024-25, Union Budget; PRS

Certain targets in health outcomes are not met

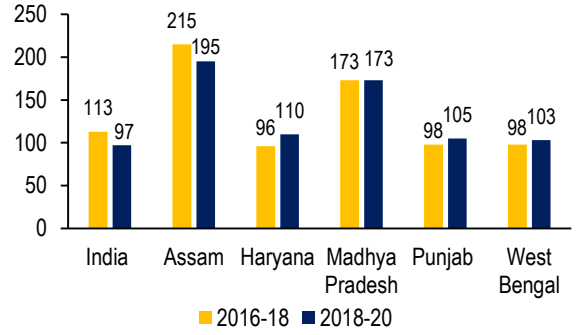
The National Health Policy and National Health Mission have set targets in health outcomes to be achieved by 2019-2025.[4,16] These include, reducing maternal, infant and neo-natal mortality, blindness, communicable and non-communicable diseases. Certain targets have not been completely met. These are discussed below:

Maternal mortality

Maternal mortality ratio (MMR) measures death of pregnant mothers due to pregnancy or childbirth complications as a share of 1,00,000 births. The National Health Policy, 2017 targeted reducing maternal mortality to 100 by 2020.[4]

MMR in India reduced to 97 in 2018-20.[17] In Haryana, Punjab and West Bengal, MMR has increased since 2016-18. Assam (195) and Madhya Pradesh (173) have a significantly higher MMR than the national average.

Figure 4: Maternal Mortality Ratio in India (per 1,00,000 births)*[*]

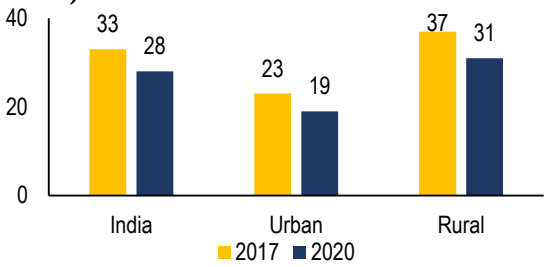


Sources: National Health Profile 2022, Central Bureau of Health Intelligence; PRS.

Infant mortality

Infant mortality ratio (IMR) measures deaths of children within a year of their birth as a share of 1,000 births. The National Health Mission targeted reducing IMR to 25 per 1,000 births.[16] As of 2020, IMR in India was 28. This was higher in rural areas (Figure 5).[17] States with a higher IMR than the national average include: (i) Chhattisgarh (38), (ii) Uttar Pradesh (38), (iii) Assam (36) and (iv) Odisha (36) (see Table 7 in Annexure). [17]

Figure 5: Infant Mortality Ratio (per 1000 births)



Sources: National Health Profile 2022, Central Bureau of Health Intelligence; PRS.

Anaemia amongst women

The National Health Mission aims to reduce the prevalence of anaemia amongst women aged 15-49.[16] Between 2015-16 to 2019-21, the prevalence of anaemia amongst non-pregnant women increased from 53% to 57% and amongst pregnant women increased from 50% to 52%.[18]

Non-communicable diseases

The National Health Policy and the National Health Mission aim to reduce burden from non-communicable diseases.[4,16] These include: (i) cardiovascular diseases, (ii) stroke, (iii) hypertension and (iv) chronic respiratory diseases. In 2010, a National Action Plan was formulated, which targeted reducing mortality due such diseases by 25%, by 2025.[19]

Between 1990 and 2016, share of deaths due to non-communicable diseases in overall deaths increased from 38% to 62%.[20] In 2016, over 70% of deaths of persons aged 40 and above were due to non-communicable diseases.[20] Cardiovascular diseases were the leading cause of deaths within non-communicable diseases (28%).[20] Disease burden of non-communicable diseases also rose from 31% to 55% between 1990 and 2016.[20]

Ischaemic heart disease constituted the largest share of overall disease burden in 2016.[20] In 2016, there was a 104% rise in the number of healthy life years lost due to ischemic heart disease.[20]

Table 5: Share of certain non-communicable diseases in overall disease burden in 2016 (in %)

	1990	2016
Ischemic heart disease	3.7%	8.7%
Chronic Obstructive Pulmonary Disease	3.1%	4.8%
Diabetes	0.7%	2.2%

Source: India: Health of the Nation's States, Indian Council of Medical Research; PRS.

The National Health Mission stresses on strengthening primary care services to screen and address non-communicable diseases.[16]

National Health Mission

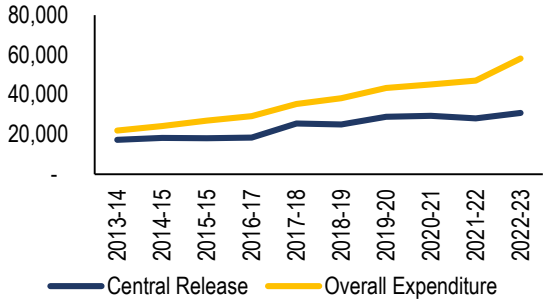
The National Health Mission supports states in strengthening primary healthcare and meeting certain health outcomes. These include reducing infant and maternal mortality rates, out-of-pocket expenditure, mortality from communicable and non-communicable diseases, and tuberculosis.[16] States have the flexibility to choose expenditure areas within scheme guidelines.

NHM consists of two sub-missions - the National Rural Health Mission (NRHM) and National Urban Health Mission (NUHM).[21] Expenditure under the scheme is made along the following components: (i) health systems strengthening, (ii) infrastructure maintenance, (iii) communicable and non-communicable diseases, and (iv) Reproductive, Maternal, New-born, Child Health and Adolescent (RMNCH+A) services.

Central releases under the Mission have stagnated since 2019-20 (Figure 6). Its share in overall expenditure under the scheme has also consistently reduced. In 2022-23, Rs 30,908 crore were released to States/UTs. In 2024-25, overall allocation under NHM is Rs 36,000 crore (this includes release to States/UTs). This is 14% higher than the revised spending in 2023-24.

[*] Corrected on August 1, 2024

Figure 6: Expenditure under the National Health Mission (in Rs crore)



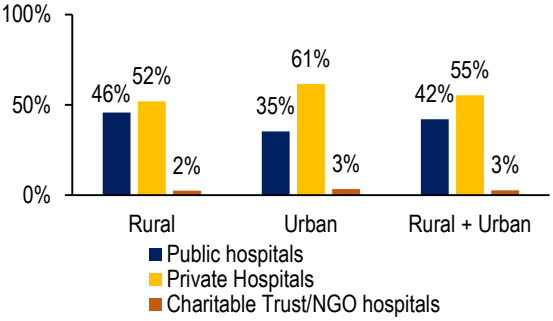
Note: Overall expenditure includes expenditure against central and state releases and unspent balances.
Sources: Unstarred Question No. 1086, Ministry of Health and Family Welfare, Lok Sabha, December 8, 2023; PRS.

The Standing Committee on Health and Family Welfare (2023) had noted that despite high utilisation under the scheme, budgetary allocations to NHM are insufficient to meet its aims.[51] According to the National Health Accounts, 2019-20, 56% of government health expenditure was directed towards primary healthcare.[1] The National Health Policy, 2017 suggests allocating up to two-thirds or more of the budget to primary care, followed by secondary and tertiary care.[4] The 15th Finance Commission also recommended that by 2022, two-thirds of the total health expenditure should be on primary healthcare.[22]

Significant reliance on private healthcare facilities which tend to be more expensive

As per the National Statistical Office (2017-18), private hospitals accounted for 55% of hospitalisation cases in India (excluding childbirth).[23] Government hospitals accounted for 42% of hospitalisations (Figure 7). Share of hospitalisations in government hospitals was lower in states such as: (i) Telangana (21%), (ii) Maharashtra (22%), (iii) Uttar Pradesh (27%), and (iv) Punjab (29%) (see Table 8 in Annexure).[23]

Figure 7: % share in hospitalisation cases (2017-18)



Sources: Key Indicators of social consumption in India: Health, NSS 75th Round, July 2017 - June 2018; PRS.

Share of private hospitals and clinics in cases of outpatient care was even higher. This refers to services such as consultation and treatment extended to a non-hospitalised individual.[24] Here, private hospitals and clinics accounted for 66% of all such cases.[23]

As per the NFHS-5 (2019-21), 50% respondents did not generally use a government health facility.[25] This was higher in states such as: (i) Bihar (80%), (ii) Uttar Pradesh (75%) and (iii Telangana (64%).[25] Major reasons include poor quality of care, long waiting times and lack of facilities available nearby (Table 6).

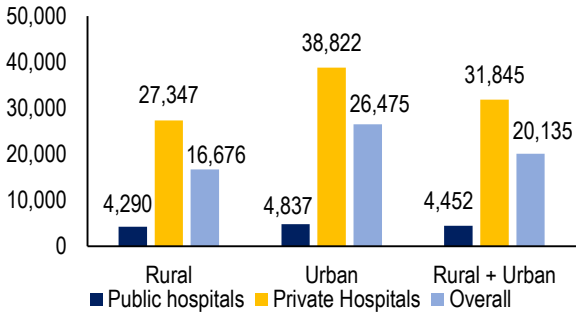
Table 6: Reasons for not availing government health facility (in %)

Reason	Responses (in %)
Poor Quality of care	48%
Long waiting time	46%
No nearby facility	40%
Facility timings inconvenient	25%
Health personnel absent	15%

Sources: National Family Health Survey-5 (2019-21); PRS.

Private healthcare tends to be more expensive. As of 2017-18, hospitalisation in a private facility was seven times more expensive than a public facility (Figure 8).

Figure 8: Cost of hospitalisation (in Rs) (2017-18)



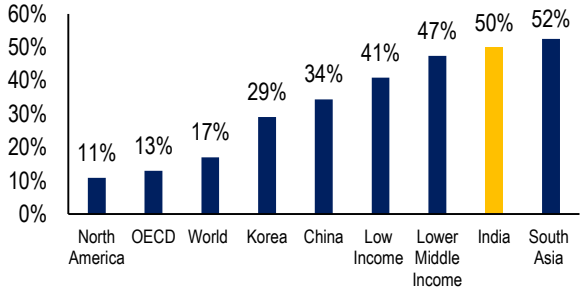
Sources: Key Indicators of social consumption in India: Health, NSS 75th Round, July 2017, June 2018-; PRS.

About half of all healthcare expenses are borne directly by households

Out of pocket health expenditure (OOPE) refers to direct health expenditure made by households at the point of receiving health care.[27] A high OOPE indicates low insurance coverage and a high use of private healthcare.

As a proportion of current health expenditure, OOPE in India was close to 50% in 2021.[26] It has reduced from 65% in 2010.[26] Current health expenditure includes health insurance, hospitalisation, medicines, consultation and other recurrent medical expenses.[27] However, OOPE in India is significantly higher than several other countries (Figure 9).

Figure 9: Out of Pocket Expenditure (as a % of Current Health Expenditure) (2021)



Note: OECD, low income and low middle income are country groupings.
Sources: Out of Pocket Health Expenditure (% of Current Health Expenditure); World Bank; PRS.

OOPE can be reduced by expanding insurance coverage or subsidised healthcare. In India, insurance coverage is low. As per NSO (2017-18), 86% of persons in rural areas and 81% in urban areas were not covered by insurance.[23] As per NFHS-5 (2019-21), 41% of households had a member covered under health insurance or financing scheme.[28] This was higher than 29% in 2015-16 (NFHS-4).

As of 2019-20, 14% of current healthcare expenditure (Rs 83,604 crore) was financed through insurance schemes.[27] Over half of these were private insurance. In 2017-18, 13% of rural and 9% of urban households financed hospitalisation cases through borrowings.[23]

As per NITI Aayog (2021), about 30% of the country's population is not eligible for government or many forms of private insurance.[29] The ineligible population mainly include self-employed farmers in rural areas and shop workers or craft workers in urban areas.

Insurance schemes in India are limited in their coverage. They largely do not cover out-patient care.[29] As per National Health Accounts (2019-20), outpatient care constituted 45% of current health expenditure.[27] According to NITI Aayog (2021), 80-85% of all catastrophically affected households were affected by expenses on outpatient care.[29] A household is catastrophically affected if its health expenses as a share of overall expenses exceed a predefined limit.

Ayushman Bharat – PM Jan Aarogya Yojana

The scheme provides cashless treatment of up to five lakh rupees per family per year, for hospitalisation at any empanelled hospital.[30] Eligibility under the scheme is based on deprivation criteria in the Socio-Economic Caste Census, 2011 (SECC).[31] This includes deprivation in occupation, shelter and background.

Based on the criteria, 11 crore families (approximately 50 crore individuals) are eligible to be covered under the scheme.[32] As of June 2024, 34.6 crore Ayushman Bharat Cards have been issued.[33] About 50% of the cards have been issued to women.[33]

As of January 15, 2024, 6.2 crore hospitalisations worth Rs 79,174 crore have been authorised.[34] About 6.2 crore claims have been submitted, and of these 5.8 crore (93%) have been settled.[34]

Allocation: In 2024-25, Rs 7,300 crore has been allocated to the scheme. The Standing Committee on Health and Family Welfare (2023) observed that allocation of Rs 6,000-7,000 crore to the scheme is not sufficient for 33 States/UTs.[35] Between 2019-20 to 2022-23, 69% of allocated funds under the scheme were utilised. Utilisation has improved from 41% in 2020-21 to 86% in 2022-23.

Limited coverage: The Standing Committee on Health and Family Welfare (2023) noted that the scheme was limited in its coverage of treatments and beneficiaries.[35] It recommended including out-patient services within the scheme's ambit. The Committee also recommended expanding the scheme to include classes of uninsured people lying above the poverty line, including those in the informal sector.[35]

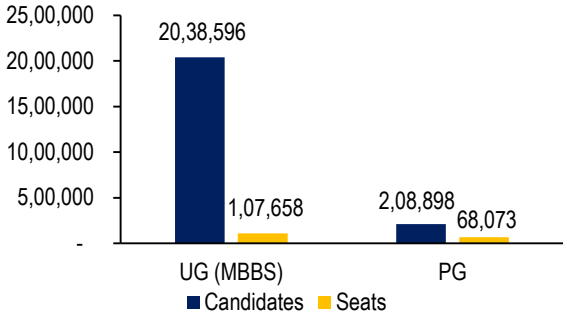
Limited Empanelment: As of July 2024, 30,174 hospitals have been empanelled out of which about 56% are public hospitals.[30] The average bed capacity of empanelled hospitals is 48.[36] The Standing Committee on Health and Family Welfare (2023) also observed that hospitals were largely concentrated in tier-2 and tier-3 cities, and were sparsely distributed across the country.[35] The Comptroller Auditor General (2023) noted deficiencies in quality of infrastructure at several empanelled healthcare providers.[36]

Healthcare system lacks adequate medical personnel

The World Health Organisation (WHO) recommends 44.5 physicians, nurses and midwives per 10,000 persons.[37] As of 2020, India has 32.3 of these personnel per 10,000 persons.[38] Lack of medical personnel disproportionately affects healthcare in rural areas. Between 2005 and 2022, shortfall of specialists such as surgeons in rural areas increased from 46% to 79%.[9]

The demand for seats in medical courses in India exceeds the availability (Figure 10). As of 2023, candidates applying for the National Eligibility Cum Entrance Test - UG (NEET-UG) were 19 times more than the available MBBS seats.[39] Candidates who cleared the exam were 11 times greater than the available seats. Similar differences were observed in PG medical courses.

Figure 10: Medical aspirants far exceed available seats (in 2023)



Sources: Report No. 157, Standing Committee on Health and Family Welfare; PRS.

Seats are also unevenly distributed across states. As of 2020, Rajasthan had half of Tamil Nadu's medical seats despite similar population levels. Similarly, Bihar had 30% of Maharashtra's medical seats.[39] As of August 2023, five states contributed to 48% of all MBBS seats and 47% of PG seats in the country.[39] These were: (i) Karnataka, (ii) Tamil Nadu, (iii) Maharashtra, (iv) Uttar Pradesh and (v) Telangana (see Table 9 in annexure)[40]

To address the shortage in medical seats, the Standing Committee (2024) recommended: (i) increasing the maximum intake in medical courses, and (ii) relaxing the minimum criteria on bed capacity and occupancy, for teaching hospitals.[39] Currently, annual intake capacity for new medical colleges is limited to 50-150 seats. The Committee recommended increasing it to 250 seats, depending on faculty and infrastructure. Currently, teaching hospitals must have a minimum bed capacity of 220-900, depending on intake.[41] They must also maintain an occupancy rate of 80%. The Committee recommended adjusting these criteria for geographical specificities.

The Committee also recommended increasing medical seats keeping in mind India's healthcare needs in the next 20-25 years.[39] This would entail identifying the kind of specialists India would need in the future.

National Eligibility Cum Entrance Test (NEET)

The National Eligibility-cum-Entrance Test (NEET) is a single common entrance examination for undergraduate (UG) and post graduate (PG) medical and dental courses in India. The exam is conducted by the National Testing Agency (NTA) in multiple languages. In 2024, about 23 lakh students appeared for NEET (UG).[42] In June 2024, the Ministry of Education launched a CBI inquiry into cases of alleged malpractices reported in the NEET (UG) 2024.[43] Citing malpractice, the NEET (PG) was also postponed.[44] In June 2024, a retest was conducted for 1,563 students, of whom 861 students appeared for the test.[45]

The Supreme Court was petitioned seeking a re-examination for NEET (UG).[46] In July 2024, the Supreme Court rejected the plea for re-examination.[47]

Human Resources for health and medical education

Under this head, spending is channelled towards: (i) establishing new medical colleges with district referral hospitals, and (ii) upgrading state medical colleges to increase MBBS and PG seats.[15] In 2024-25, Rs 1,275 crore has been allocated towards this head.[2] This is 16% lower than the revised estimates of 2023-24.

Funds under this head have been underutilised. In 2022-23, only 26% of allocation under this head was spent.[2] In 2023-24, utilisation is estimated to be 23%.[2]

Establishment of new medical colleges: Between 2014 and 2019, 157 new medical colleges were approved As of February 2024, 108 are functional.[48]

Increasing MBBS and PG seats: The government aims to add 10,000 MBBS seats and 8,058 PG seats.[15] As of February 2024, 4,977 MBBS seats have been approved.[48] As of March 2023, 7,916 PG seats were approved as well.[15]

Pradhan Mantri Swasthya Surksha Yojana (PMSSY)

The scheme has two components: (i) setting up new AIIMS and (ii) upgrading government medical colleges to build tertiary care facilities. [49]

PMSSY has been allocated Rs 2,200 crore. In 2024-25, Rs, 6,800 crore has been allocated for establishing new AIIMS. This amounts to Rs 9,000 crore, which is 4% higher than revised estimates of 2023-24.

Under the scheme, 22 new AIIMS have been approved. As of July 2023, six AIIMS are fully functional, while construction of three AIIMS has not begun.[49]

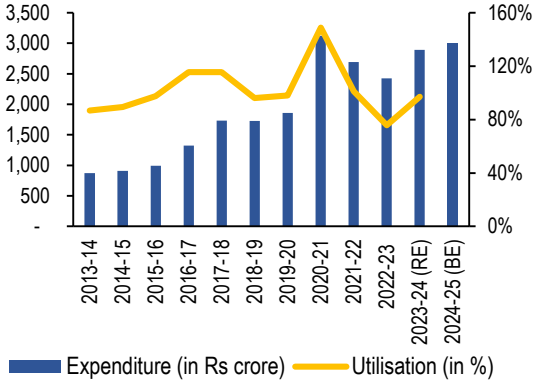
As of August 2023, 39% teaching and 42% non-teaching positions across AIIMS are vacant.[50] Teaching vacancies are higher in campuses such as: (i) Madurai (77%), (ii) Jammu (61%), and (iii) Rajkot (61%).

Lack of investment in health research

In 2024-25, the Department of Health Research has been allocated Rs 3,002 crore.[2] This is 4% of the Ministry's budgeted allocation for the year. Allocation towards the Department has increased by 4% against the revised estimates of 2023-24. Between 2013-14 to 2022-23, expenditure of the Department increased by 12% annually.

In this period, the Department utilised 102% of its allocated funds. Utilisation peaked in 2020-21, when 149% of allocated funds were utilised. However, in 2022-23, this dropped to 76%.

Figure 11: Expenditure and utilisation of funds by Department of Health Research



Note: Re is Revised Estimate and BE is Budgeted Estimate.
Sources: Union Budget documents of various years; PRS.

As a share of GDP, spending on health research in India is significantly lower than some other countries. The Standing Committee on Health and Family Welfare (2023) noted that in 2021-22, total spending on health research in India was 0.02% of GDP.[51] In 2017, the United States and United Kingdom spent 0.65% and 0.44% of their GDP on health research, respectively.[51] The Committee recommended increasing health research spending to 0.1% of GDP.[51]

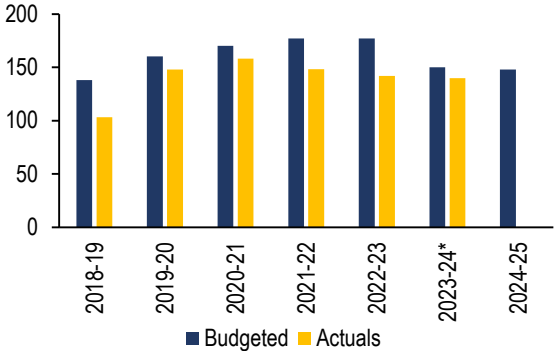
Spending towards the Indian Council of Medical Research (ICMR) constitutes the largest portion of the Department's spending. In 2024-25, ICMR has been allocated 73% of the Department's budget, that is, Rs 2,732 crore. However, in 2020-21, research spending by ICMR constituted only 3% of all research expenditure by the centre.[52] The Standing Committee (2023) noted that current research spending by the ICMR is not sufficient to address health concerns such as anaemia, cancer and hypertension.

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.[2]

Allocation towards research infrastructure consistently increased between 2018-19 to 2022-23. It has dwindled since then (Figure 12). This is mainly on account of reduced allocation and expenditure towards epidemic management and prevention. In 2021, the Standing Committee on Health and Family Welfare highlighted the need for a full-proof surveillance system for timely identification of viruses and intervention for the same.[53]

Figure 12: Allocation and expenditure towards health research infrastructure



Note: Actuals data for 2023-24 is the revised estimate of expenditure.
Sources: Department of Health Research, Expenditure Budget 2024-25; PRS.

Annexure

Table 7: Infant Mortality Rate (per 1,000 live births) and Anaemia in Women aged 15-49 (in %)

State/UT	IMR (2020)	Anaemia (2019-21)
Andaman and Nicobar Islands	7	58%
Andhra Pradesh	24	59%
Arunachal Pradesh	21	40%
Assam	36	66%
Bihar	27	64%
Chandigarh	8	60%
Chhattisgarh	38	61%
Dadra and Nagar Haveli and Daman and Diu	16	63%
Delhi	12	50%
Goa	5	39%
Gujarat	23	65%
Haryana	28	60%
Himachal Pradesh	17	53%
Jammu and Kashmir	17	66%
Jharkhand	25	65%
Karnataka	19	48%
Kerala	6	36%
Ladakh	16	93%
Lakshadweep	9	26%
Madhya Pradesh	43	55%
Maharashtra	16	54%
Manipur	6	29%
Meghalaya	29	54%
Mizoram	3	35%
Nagaland	4	29%
Odisha	36	64%
Puducherry	6	55%
Punjab	18	59%
Rajasthan	32	54%
Sikkim	5	42%
Tamil Nadu	13	53%
Telangana	21	58%
Tripura	18	67%
Uttar Pradesh	38	50%
Uttarakhand	24	43%
West Bengal	19	71%
India	**28**	**57%**

Sources: National Health Profile 2022, NFHS-5 (2019-21); PRS.

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Table 8: Share of hospitalisation cases (excluding childbirth) by type of hospital (in %)

	Government	Private	Charitable Trust/NGO
India	**42%**	**55%**	**3%**
Andaman and N. Islands	83%	17%	0%
Andhra Pradesh	28%	69%	3%
Arunachal Pradesh	92%	7%	2%
Assam	71%	27%	2%
Bihar	38%	60%	2%
Chandigarh	67%	33%	1%
Chhattisgarh	54%	42%	4%
Dadra and Nagar Haveli	66%	34%	0%
Daman and Diu	19%	81%	0%
Delhi	62%	37%	1%
Goa	66%	34%	0%
Gujarat	31%	62%	7%
Haryana	31%	67%	2%
Himachal Pradesh	77%	21%	2%
Jammu and Kashmir	91%	8%	1%
Jharkhand	41%	54%	6%
Karnataka	27%	71%	2%
Kerala	38%	58%	4%
Lakshwadeep	70%	26%	4%
Madhya Pradesh	48%	49%	3%
Maharashtra	22%	74%	4%
Manipur	80%	20%	1%
Meghalaya	85%	15%	1%
Mizoram	80%	16%	5%
Nagaland	73%	27%	0%
Odisha	72%	27%	1%
Puducherry	69%	31%	0%
Punjab	29%	66%	5%
Rajasthan	51%	48%	1%
Sikkim	80%	20%	0%
Tamil Nadu	50%	48%	2%
Telangana	21%	78%	1%
Tripura	95%	4%	1%
Uttarakhand	36%	63%	1%
Uttar Pradesh	27%	70%	2%
West Bengal	69%	29%	2%

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

Table 9: Medical seats across States/UTs (as of August 2023)

State/UT	UG	PG	State/UT	UG	PG
Andaman Nicobar	114	1	Madhya Pradesh	4,650	2,352
Andhra Pradesh	6,435	3,523	Maharashtra	10,475	6,043
Assam	1,550	738	Manipur	525	255
Bihar	2,665	1,212	Meghalaya	50	37
Chandigarh	150	584	Mizoram	100	-
Chhattisgarh	2,005	579	Odisha	2,525	1,234
Dadra and Nagar Haveli	177	-	Puducherry	1,830	1,017
Delhi	1,497	2,950	Punjab	1,800	788
Goa	180	135	Rajasthan	5,575	1,867
Gujarat	6,900	2,875	Sikkim	150	34
Haryana	2,185	886	Tamil Nadu	11,600	5,082
Himachal Pradesh	920	356	Telangana	8,540	2,976
Jammu and Kashmir	1,347	656	Tripura	225	91
Jharkhand	980	270	Uttar Pradesh	9,703	4,169
Karnataka	11,695	6,402	Uttarakhand	1,150	1,827
Kerala	4,655	1,917	West Bengal	5,175	2,080
			Total	**1,07,528**	**52,936**

Sources: Unstarred Question No. 2605, Ministry of Health and Family Welfare, Lok Sabha, August 4, 2023; PRS.

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