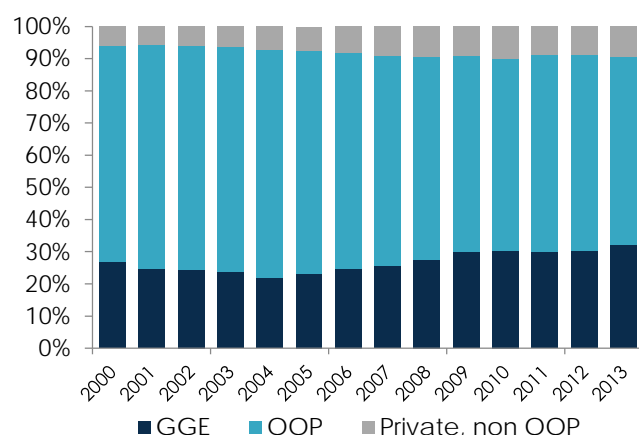




Key Indicators	
Population (2015)	1.25 billion
GDP per capita (USD, 2014, Atlas method)	\$1,570
Income classification	Lower-middle
Health Financing (2013)	
THE per capita (USD)	\$61
THE as % of GDP	4%
GHE as % of THE	32%
GHE as % of GGE	4.5%
OOP as % of THE	58%
DAH as % of THE	2.1%
Pooled private as % of THE	10%
HIV Financing (2013)	
HIV/AIDS prevalence adults 15+ (2015)	0.17%
DAH for HIV as % of TAE	28%
TAE per PLHIV (USD)	\$107
GAE as % of GGE	0.025%
GAE as % of TAE	72%

Source: World Bank, 2016; WHO, 2015; UNAIDS, 2016.  
 THE = total health expenditure, GDP = gross domestic product, GHE = government health expenditure, GGE = general government expenditure, OOP = out-of-pocket, DAH = development assistance for health, TAE = total AIDS expenditure, PLHIV = people living with HIV, GAE = government AIDS expenditure

Figure 1: Share of Total Health Expenditure



Source: WHO, 2015.

## Overview

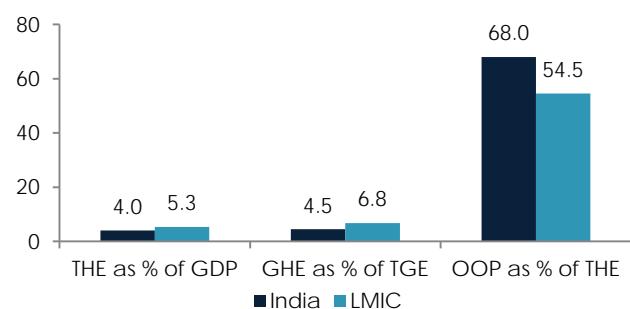
India's total health expenditure (THE) as a percentage of gross domestic product (GDP) has decreased within the last 10 years, since it became a lower middle-income country (LMIC). THE per capita for India is lower than the LMIC average, and the country receives relatively low amounts of external funding for health—2.1% of THE. In 2013, government health expenditure (GHE) was a smaller share of THE than that of its South Asian neighbors or other LMICs (Figure 2). GHE as a share of general government expenditure (GGE) is smaller than the recommended 15% of the government budget. GHE in 2013 was around 1.3% of GDP, and the government has not yet implemented its plans to increase this to 2.5% by 2017.

Out-of-pocket (OOP) expenditure makes up about 58% of THE (Figure 1); this has decreased slightly as the corresponding value for prepaid expenditure has increased. The percentage of population insured was about 17% in 2014, of which about 12% was through government, 3% through employment, and 2% individually financed (Mehra, 2014). In 2015, the new government elected in 2014 released a National Health Policy (NHP), focusing on improving insurance, but it has not been implemented yet. Meeting the goals of universal health coverage will require increased funding; however, such increases will not occur until budget deficits are reduced.

The private sector provides 80% of outpatient and 60% of inpatient care (Reddy, 2015). Many of these services are not oriented toward primary healthcare. With a weak regulatory system, there is a lack of enforcement of quality and cost standards in the private sector. Although public sector expenditure as a proportion of THE has not changed greatly, a high economic growth rate and government policy have contributed to a rise in public sector involvement within the health sector since 2000:

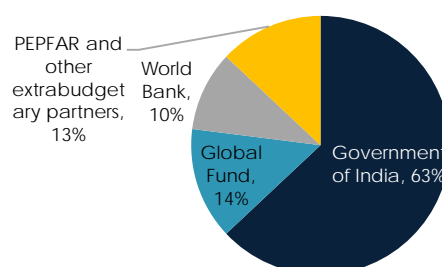
- The National Rural Health Mission, launched in 2005 to strengthen healthcare infrastructure and improve health indicators in the rural areas of 18 states, focused strongly on maternal and child health to reach Millennium Development Goal targets. A system is in place in which payment is offered to those choosing institutional delivery; this system has increased such deliveries. Due to the program's success, India created a National Urban Health Mission under an overarching National Health Mission (NHM) in 2013.
- Several government-funded health insurance programs have been launched since 2007; one of the largest is Rashtriya Swasthya Bima Yojana (RSBY). Established in 2008 to cover those below the poverty line, RSBY covers inpatient care with a lower-cost secondary care focus.

Figure 2: Comparative Health Expenditure (2014)



Source : World Bank, 2016.

Figure 3: HIV Financing Sources 2012–17 (US\$2.24 billion)



Source: PEPFAR, 2015.

## Health Financing Functions

### Revenue contribution and collection

India has an administratively decentralized structure but little revenue-raising power resides at the state level. The new government has indicated that it would transfer a 10% larger share of revenue to the states. While overall public expenditure on health increased by an estimated 18% from fiscal year (FY) 2011/12 to FY 2013/14, at least six states decreased spending on health in the same timeframe. The NHM mandates that the majority of its funds are spent at lower levels; only 30% of funds should be spent at the district level and above.

### Pooling

Healthcare provisioning is the responsibility of the states, but their implementation of the government-funded insurance program, RSBY, and other schemes is uneven, with some of them supplementing the system through their own means. There are at least 16 government-supported or sponsored schemes in India. RSBY replaced many community-based health insurance schemes. RSBY and other schemes now cover 185 million people. These schemes are fully government funded (75% centrally and 25% through states) but implemented mostly through private providers. The payment system is operated through a third-party payer. It does not cover outpatient costs, although outpatient costs for key diseases are expected to be free under NHM, and has a yearly cap on total spending per household. RSBY has not reduced OOP expenditure; 70% of OOP covers outpatient care and drugs (Reddy, 2015). The plan is for NHP to increase coverage to link secondary and tertiary care to primary care. Mandatory insurance exists in the formal sector for armed forces and most central government employees.

### Purchasing

Government funding is split across service delivery (70%), pharmaceuticals (20%), and medical technologies and other components (10%). The Ministry of Health routinely under-spends and returns part of its budget allocation to the treasury. The high and rising level of private health expenditure is linked to a large number of private providers, particularly for hospital and diagnostic services. Existing private providers are accessible under RSBY insurance through a contracting process.

## HIV Funding

There are approximately 2.1 million people living with HIV (PLHIV) in India, of which 36% were on antiretroviral treatment in 2014. The Indian government spends about US\$102 per PLHIV. In 2013, it spent US\$215 million on HIV care, with 28% of this funding coming from external sources. The share coming from external sources is much lower than for many other LMICs receiving funding for HIV. Government spending on HIV is a very small portion of overall public expenditure—less than 0.035% of GGE, or 0.88% of GHE. HIV accounts for 0.77% of all deaths in India; the HIV and AIDS budget must improve to keep pace with disease burden. In recent years, India has seen a decline in new HIV cases, however. From 2012 to 2017, India's HIV response was estimated to cost US\$2.24 billion, with the government projected to fund 63% (Figure 3).

## References and Works Consulted

- Dutta, A. and C. Hongoro. 2013. *Scaling up National Health Insurance in Nigeria: Learning from Case Studies of India, Colombia, and Thailand*. Washington, DC: Futures Group, Health Policy Project.
- Institute for Health Metrics and Evaluation (IHME). 2015. *Financing Global Health 2014: Shifts in Funding as the MDG Era Closes*. Seattle, WA: IHME.
- Joint United Nations Programme on HIV/AIDS (UNAIDS). 2016. "HIV and AIDS Data Hub for Asia-Pacific: Evidence to Action." Available at: <http://www.aidsdatahub.org/>.
- Mehra, P. "Only 17% have health insurance cover." *The Hindu*. December 22, 2014.
- PEPFAR. 2015. *FY 2015 India Country Operational Plan (COP)*. Washington, DC: U.S. Department of State.
- Reddy, K.S. 2015. "India's Aspirations for Universal Health Coverage." *New England Journal of Medicine* 373: 1–5.
- WHO. 2015. "Global Health Observatory (GHO) Data." Available at: [http://www.who.int/gho/health\\_financing/government\\_expenditure/en/](http://www.who.int/gho/health_financing/government_expenditure/en/).
- World Bank. 2016. "Data Health." Available at: [data.worldbank.org/indicator/](http://data.worldbank.org/indicator/).

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