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EDITORIAL ANALYSIS

Healing the System — Why India's Public Health Gaps Are a Governance Crisis



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Healing the System — Why India's Public Health Gaps Are a Governance Crisis

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INTERVIEW ANGLE

"India spends only 1.8% of GDP on public health vs the NHP target of 2.5%. Is the problem about spending more or spending better?"

Healing the System — Why India's Public Health Gaps Are a Governance Crisis

A Business Standard editorial on March 26, 2026 highlighted that India's public health spending remains stuck at ~1.8% of GDP — well below the National Health Policy 2017 target of 2.5%. The editorial followed a CAG performance audit of Delhi's health infrastructure (covering 2016-17 to 2021-22, tabled in the Delhi Legislative Assembly in February 2025) that exposed a 21% staff shortage, unspent NHM funds worth over Rs 510 crore, and overcrowded hospitals with missing beds. Despite the Union Budget 2026-27 crossing the Rs 1 lakh crore mark for health for the first time, systemic governance failures — not just funding gaps — remain the core challenge.

The Trigger — Delhi Budget and CAG Audit

The immediate trigger for this editorial is twofold. First, the Delhi government allocated Rs 12,893 crore for health in its 2025-26 budget — roughly 12-15% of its total budget, significantly higher than most states that allocate only 5-6%. Second, the CAG performance audit report on Delhi's health services (covering 2016-17 to 2021-22) laid bare the gap between budget allocations and actual outcomes on the ground.

Delhi's case is instructive because it is a high-spending state on health yet still suffers from overcrowded hospitals, drug shortages, and vacant posts. If a well-funded system fails to deliver, the problem is clearly one of governance and execution — not just money.

CAG Findings on Delhi Health — Key Data

The CAG audit of Delhi's Health and Family Welfare Department revealed systemic failures across staffing, infrastructure, and fund utilization:

| PARAMETER | CAG FINDING |
|---|--|
| Overall staff shortage | 21% across the Health and Family Welfare Department |
| Teaching specialists shortage | 30% positions vacant |
| Non-teaching specialists shortage | 28% positions vacant |
| Medical officers shortage | 9% positions vacant |
| Paramedical staff shortage | 38% positions vacant |
| Drugs Control Department staff shortage | 52% – led to insufficient inspection of drug units and blood banks |
| NHM fund utilization (by December 2025) | Only 46.46% of allocated funds utilized |
| Unspent NHM funds | Over Rs 510 crore remained unspent |

The audit further noted delays in commissioning new hospital infrastructure, non-functional medical equipment in government hospitals, and shortage of essential drugs at primary health centres.

The Public Accounts Committee (PAC) directed that these deficiencies be addressed in a time-bound manner, with progress to be reviewed as of June 30, 2026.

The National Picture — Health Spending Data

Delhi is a microcosm of a national problem. India’s public health spending trajectory shows persistent under-investment relative to stated policy goals:

| METRIC | DATA |
|--|---|
| NHP 2017 target for public health spending | 2.5% of GDP by 2025 |
| Actual public health spending (FY 2022-23) | ~1.9% of GDP (combined Centre + States) |
| Government health expenditure share of total health expenditure (FY 2021-22) | 48% (up from 29% in FY 2014-15) |
| Total Health Expenditure, FY 2021-22 | Rs 9,04,461 crore (3.8% of GDP) |
| Per capita health expenditure (FY 2021-22) | Rs 6,602 (~\$80) |
| Union Budget 2026-27 — Health Ministry allocation | Rs 1,06,530 crore (~10% increase over RE of FY 2025-26) |
| National Health Mission allocation (2026-27) | Rs 39,390 crore (6.17% increase over previous year) |
| PMJAY allocation (2026-27) | Rs 9,500 crore |

While total health expenditure rose from Rs 3.2 lakh crore in FY 2020-21 to Rs 6.1 lakh crore in FY 2024-25 (18% CAGR), public spending as a share of GDP has barely moved. The NHP 2017 target of 2.5% of GDP by 2025 has been decisively missed.

Staff Shortages and Infrastructure Gaps

The human resource crisis in public health is not limited to Delhi. Nationally, the picture is grim:

- **PHCs:** 30% shortage of Primary Health Centres against Indian Public Health Standards (IPHS) norms
- **Doctors at CHCs:** 57% shortfall of specialists at Community Health Centres (Rural Health Statistics 2021)
- **Doctor-population ratio:** India has approximately 1.34 doctors per 1,000 people; the WHO benchmark is 1.5 per 1,000. However, this national average masks a severe rural-urban skew — 80% of doctors practise in urban areas serving 35% of the population
- **Hospital beds:** India has only 0.79 government hospital beds per 1,000 population against the NHP 2017 target of 2 beds per 1,000 and the WHO benchmark of 3.5 beds per 1,000
- **PHC compliance:** Only 13% of PHCs (3,278 out of 24,918) adhere to basic IPHS standards
- **Nursing staff:** 24% vacancies in rural PHCs for sanctioned medical officer positions

The NITI Aayog State Health Index (5th edition, 2020-21) revealed significant inter-state disparities — Kerala, Tamil Nadu, and Telangana topped among larger states, while Uttar Pradesh, Bihar, and Madhya Pradesh ranked at the bottom, illustrating that governance quality determines health outcomes more than per-capita spending alone.

The Fund Utilization Problem

A persistent **paradox** defines Indian public health: money is allocated but not spent. This is not a resource problem — it is an administrative and governance failure.

- **NHM fund utilization:** Several states consistently fail to utilize their National Health Mission allocations. Delhi itself utilized only 46.46% of NHM funds by December 2025
- **PM Ayushman Bharat Health Infrastructure Mission (PM-ABHIM):** Allocated Rs 4,770 crore in 2026-27, but earlier phases saw significant delays in operationalizing District Public Health Laboratories and Block Public Health Units
- **State-level absorption capacity:** Poorer states with the worst health indicators — Bihar, Jharkhand, Uttar Pradesh — often have the lowest fund utilization rates, creating a vicious cycle where the most need meets the least execution capability

The NHP 2017 had recommended that two-thirds or more of public health resources be directed toward primary care. In practice, tertiary hospitals absorb a **disproportionate** share of budgets while PHCs and sub-centres remain understaffed and under-equipped.

Ayushman Bharat — Progress and Gaps

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), launched in September 2018, is the world's largest publicly funded health assurance scheme — covering Rs 5 lakh per family per year for secondary and tertiary hospitalization for 55 crore beneficiaries across 12.34 crore families.

Progress:

- Approximately 17 crore families (68%) now covered under PMJAY and other government health schemes
- Senior citizen expansion (2024): Coverage extended to all citizens aged 70+ irrespective of income — benefiting ~4.5 crore families with 6 crore senior citizens
- 1,81,873 Ayushman Arogya Mandirs (AAMs) operationalized as of November 2025, providing 12 expanded services including teleconsultation
- Screening milestones: 39.50 crore hypertension screenings, 36.70 crore diabetes screenings, 32.40 crore oral cancer screenings

Gaps:

- **The “Missing Middle”:** PMJAY covers the poorest 40%; the non-poor non-rich segment (~30% of the population) lacks adequate financial protection for health
- **OPD exclusion:** PMJAY covers only hospitalization (secondary and tertiary care), not outpatient consultations — which account for the bulk of healthcare spending by households
- **Quality of empanelled hospitals:** Reports of fraudulent claims, denial of services, and variable quality standards persist
- **Out-of-pocket expenditure:** Despite declining from 64.2% of total health expenditure (FY 2013-14) to 39.4% (FY 2021-22), OOP spending remains among the highest globally. About 49% of households seeking hospitalization experience catastrophic health expenditure, and 3-7% of households fall below the poverty line annually due to medical costs

International Comparison

| COUNTRY | PUBLIC HEALTH SPENDING (% OF GDP) | PER CAPITA HEALTH SPENDING (USD, 2022) | HOSPITAL BEDS PER 1,000 | DOCTOR-PATIENT RATIO |
|----------------|-----------------------------------|--|---------------------------|------------------------|
| India | ~1.8-1.9% | ~\$80 | 0.79 (govt) / 1.3 (total) | 1:745 (1.34 per 1,000) |
| China | ~3.0% | ~\$500 | 4.3 | 2.4 per 1,000 |
| Brazil | ~4.0% | ~\$850 | 2.1 | 2.3 per 1,000 |
| Thailand | ~4.5% | ~\$370 | 2.1 | 0.9 per 1,000 |
| Sri Lanka | ~1.6% | ~\$157 | 3.6 | 1.2 per 1,000 |
| United Kingdom | ~10.4% | ~\$5,100 | 2.4 | 3.2 per 1,000 |
| Global Average | ~6.5% | ~\$1,325 | 2.7 | 1.7 per 1,000 |

Key takeaway: India spends less per capita on health than Sri Lanka (despite a much larger GDP), and has fewer government hospital beds per 1,000 people than almost every comparable economy. Thailand, with a similar per capita income trajectory, has achieved near-universal health coverage by spending 4.5% of GDP publicly — more than double India’s level.

Way Forward

The Business Standard editorial and the broader evidence base point to a multi-pronged reform agenda:

- 1 **Meet the 2.5% GDP target credibly:** The NHP 2017 deadline of 2025 has been missed. A revised roadmap with annual milestones and state-level accountability is needed. A new target of 3% of GDP by 2030 would bring India closer to peer-country levels
- 2 **Fix fund utilization before increasing allocations:** States with low absorption capacity need dedicated health administration cadres, simplified procurement processes, and outcome-linked fund releases. Unspent NHM allocations represent a governance failure, not a fiscal constraint
- 3 **Prioritize primary healthcare:** Following NHP 2017’s own recommendation, at least two-thirds of health spending should flow to primary care — PHCs, sub-centres, and Ayushman Arogya Mandirs. Currently, tertiary care absorbs a disproportionate share
- 4 **Address the human resource crisis:** Fast-track recruitment of specialists at CHCs (57% shortfall), [mandate](#) rural service bonds for medical graduates, establish a dedicated public health cadre at the state level (as recommended by multiple expert committees)

- 5 **Close the “Missing Middle” gap:** Extend some form of publicly funded health coverage to the estimated 30% of the population that is neither poor enough for PMJAY nor rich enough for private insurance
- 6 **Strengthen Ayushman Arogya Mandirs:** The 1.82 lakh AAMs must move beyond screening numbers to genuine comprehensive primary care — with adequate staffing, essential drug availability, and diagnostic capacity
- 7 **Governance reforms:** Independent health regulatory authorities at the state level, mandatory district-level health audits (like the CAG model), and real-time public dashboards for fund utilization and vacancy tracking

UPSC Angle

This editorial is significant for understanding the governance dimension of India’s health crisis — the gap between policy intent (NHP 2017) and execution reality.

- **Prelims:** NHP 2017 targets (2.5% GDP, two-thirds to primary care), PMJAY coverage (Rs 5 lakh, 55 crore beneficiaries), Ayushman Arogya Mandirs (1.82 lakh operational), WHO benchmarks (doctor-patient ratio 1:1000, hospital beds 3.5 per 1,000), IPHS norms
- **Mains GS-2:** Role of government in health — governance failures vs funding failures; Centre-State coordination under NHM; significance of CAG audits in ensuring accountability; PMJAY implementation challenges; right to health as a fundamental right debate
- **Essay:** “India does not have a health funding crisis — it has a health governance crisis”
- **Interview:** Why does India consistently miss its own health policy targets? Is the NHP 2017 target of 2.5% GDP still relevant or should India aim higher?

UPSC RELEVANCE

NHP 2017 targets, PMJAY coverage and eligibility, Ayushman Arogya Mandirs, NITI Aayog Health Index, WHO doctor-patient ratio benchmark, IPHS norms.

MAINS GS-2:

Government health policy and governance failures; federal health architecture; NHM fund utilization; role of CAG in social sector accountability; Ayushman Bharat — design vs implementation gaps.

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NATIONAL HEALTH POLICY 2017 — KEY TARGETS:

Public health expenditure target: 2.5% of GDP by 2025 (missed — actual ~1.8-1.9%)

Two-thirds of health resources to primary care (not achieved)

Reduce IMR to 28 per 1,000 live births, MMR to 100 per 1 lakh live births

Adopted by Cabinet: March 15, 2017

Replaced: NHP 2002

UNION BUDGET 2026-27 — HEALTH ALLOCATIONS:

Ministry of Health and Family Welfare: Rs 1,06,530.42 crore (~10% increase over FY 2025-26 RE)

National Health Mission: Rs 39,390 crore

PM-JAY (Ayushman Bharat insurance): Rs 9,500 crore

PM Ayushman Bharat Health Infrastructure Mission: Rs 4,770 crore

Department of Health Research: Rs 4,821.21 crore

First time health budget crossed Rs 1 lakh crore

CAG AUDIT OF DELHI HEALTH (2016-17 TO 2021-22):

Overall staff shortage: 21%

Teaching specialists: 30% vacant; Non-teaching specialists: 28% vacant

Paramedical staff: 38% vacant

Drugs Control Department: 52% staff shortage

NHM fund utilization (by Dec 2025): only 46.46%

Unspent NHM funds: over Rs 510 crore

PAC review deadline: June 30, 2026

AYUSHMAN BHARAT PM-JAY:

Launched: September 23, 2018 (Ranchi, Jharkhand)

Coverage: Rs 5 lakh per family per year for hospitalization

Beneficiaries: 55 crore individuals across 12.34 crore families

Senior citizen expansion (2024): All citizens aged 70+ covered irrespective of income (~6 crore seniors, ~4.5 crore families)

Does NOT cover: OPD, cosmetic surgery, fertility treatment, organ transplants, drug rehabilitation

AYUSHMAN AROGYA MANDIRS (AAMS):

Operational (as of November 2025): 1,81,873

Services: 12 expanded packages including teleconsultation

Screenings: 39.50 crore (hypertension), 36.70 crore (diabetes), 32.40 crore (oral cancer)

Wellness sessions conducted: 5.73 crore (as of June 2025)

INDIA HEALTH INFRASTRUCTURE – NATIONAL DATA:

Government hospital beds: 0.79 per 1,000 population (NHP target: 2; WHO benchmark: 3.5)

India short of ~2.4 million hospital beds

PHC compliance with IPHS: only 13% (3,278 of 24,918)

CHC specialist shortfall: 57%

Rural PHC medical officer vacancies: ~24%

Doctor-population ratio: 1.34 per 1,000 (WHO benchmark: 1.5 per 1,000)

OUT-OF-POCKET HEALTH EXPENDITURE:

OOP as share of total health expenditure: declined from 64.2% (FY 2013-14) to 39.4% (FY 2021-22)

Government share of total health expenditure: rose from 29% (FY 2014-15) to 48% (FY 2021-22)

Households experiencing catastrophic health expenditure: ~49%

Households pushed below poverty line by health costs: 3-7% annually

NITI AAYOG STATE HEALTH INDEX (5TH EDITION, 2020-21):

Top performers (larger states): Kerala, Tamil Nadu, Telangana

Bottom performers: Uttar Pradesh, Bihar, Madhya Pradesh

Based on 24 weighted indicators across health outcomes, governance, and inputs

OTHER RELEVANT FACTS:

India's total health expenditure (FY 2024-25): Rs 6.1 lakh crore (18% CAGR from FY 2020-21)

Per capita health spending: ~\$80 (2022) vs global average of ~\$1,325

Thailand spends ~4.5% of GDP publicly on health and achieved near-universal coverage

Sri Lanka spends ~\$157 per capita on health — nearly double India's level

National Health Accounts (latest): 2021-22 edition released by Union Health Ministry

Health budget increase since 2014-15: cumulative 194%

“Missing Middle” — ~30% of population neither covered by PMJAY nor able to afford private insurance

Sources: [Business Standard](#) , [PIB](#) , [PRS India](#) , [CAG India](#) , [Down to Earth](#) , [NITI Aayog](#)



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