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State comparative analysis of health expenditure of India

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Abstract

Health financing plays a vital role in social development, especially in developing countries like India, where Household Health Spending (HHS) significantly impacts healthcare funding and has financial risks to households. The study used secondary data from NHA and examines trends in population (POP), State Income (SI), National Health Expenditure (NHE), Per Head Healthcare Cost (PHHC), Government Health Spending (GHS), and Household Health Spending (HHS) and used econometric techniques such as trend analysis and panel data model, including Pooled OLS, Random and Fixed Effects models, supported by Lagrange Multiplier (Breusch-Pagan) Test and Hausman tests to implement the most appropriate specification.

The results reveal that although all states experienced income growth and an increase in Per Head Healthcare Cost, Government Health Spending, and a decrease in HHS health expenditure, HHS remains high, particularly in Punjab and West Bengal. The Fixed Effects model indicates that SI reduces HHS burden, while population growth increases it. The study concludes that reducing HHS demands higher public funding, enhanced efficiency, and improved health infrastructure to achieve Universal Health Coverage.

Keywords: Human capital formation, health spending, government policy, SDP, population

Introduction

Health is a crucial determinant for society as a whole. A healthy society contributes directly to productivity, human capital formation, and long-term economic growth. In India, health expenditure is important in determining access to universal health coverage, quality healthcare services, and financial protection for households.

A critical aspect of India's health expenditure is significant, with inter-state variation in health financing. The paper highlights the disparities in public healthcare infrastructure, government contribution, and the prevalence of private providers, among the Indian states. This study focuses on five developed states of India selected in terms of NSDP - net state domestic product, which include West Bengal, Punjab, Gujarat, Maharashtra, and Tamil Nadu. Despite the states having high income, the ratio of Private Spending is higher than Government Spending in the health sector.

Hence, the government of India has concerns about the persistently high share of Household Health Spending out of National Health Expenditure (NHE). Therefore, recently the government took policy initiatives such as Ayushman Bharat, National Health Mission, and increased government health spending, which have aimed to improve financial protection, although Household Health Spending (HHS) is still a burden on household of many states.

In this context, understanding the trends of health expenditure at the state level is essential for designing effective health financing policies. This study was conducted on an analysis of health expenditure in five major Indian states- West Bengal, Punjab, Gujarat, Maharashtra, and Tamil Nadu for

the period from 2014-15 to 2021-22. These states represent diverse economic, demographic, and institutional contexts across different regions of India. It examines trends in population, State Income ^[1] (SI), National Health Expenditure ^[2] (NHE), Per Head Healthcare Cost ^[3] (PHHC), Government Health Spending (GHS), and Household Health Spending ^[4] (HHS), and investigates how economic and demographic factors influence HHS payments.

Objectives

- To examine trends and to do a comparative study of the health expenditure across five Indian States, Zone-wise (West Bengal, Punjab, Gujarat, Maharashtra, and Tamil Nadu).
- To identify determinants of Household Health Spending (HHS) using panel data analysis.

Literature review

The study reviewed more than 15 papers regarding the State Comparative Analysis of Health Expenditure of India. Most of the studies have included the objectives on the government contribution to the health sector, and examined the health outcomes by using various methodologies such as the panel unit root test, the Arellano-Bond Generalized Method of Moments, correlation matrix, and causality test.

On that basis, the relevant studies are enumerated below: Duggal *et al.* (1995) ^[1, 2] conducted a study on Health Expenditure, highlighting the necessity of social investment for equitable access to health. They observed that the

inefficient utilization of public health infrastructure and the unequal distribution of resources. For analysis, they used secondary data, descriptive and comparative statistical methods from the Central Statistical Organization and NSSO. The study revealed that private expenditure on health (80 percent) is relatively high compared to public expenditure (20 percent). They found that health spending has been declining since 1970 and revealed significant regional disparities (rural and urban areas) in healthcare access. Hence, the study concluded that public investment is insufficient, with persistent disparities and a dominant private sector presence. Recommendations included increased public investment and improved regulatory mechanisms for health sector development.

Duggal *et al.* (1995) ^[1, 2] examined regional disparities in health expenditure across Indian states, noting health as primarily a state responsibility. Their study used secondary data and longitudinal statistical analysis to compare various expenditure variables. The analysis revealed that despite an increase in family welfare programs since 1975, but still been a decline in total government spending since the mid-1980s, indicating inefficiency in resource allocation. Therefore, the study concluded that it found regional disparities, in which developed states spend more per capita on health, while poorer states remain underfunded.

Bhat and Jain (2004) ^[3] studied state-level public health spending in India; they analysed that the government allocated around 0.5 percent of GSDP on health, excluding central initiatives like family welfare. Using secondary and panel data from 14 large states (1990-2002), they estimate an income elasticity of 0.68, highlighting diminishing PHCE as a percentage of GSDP amid economic challenges and showing that per capita health spending rises more slowly than income. This highlighted the difficulties in raising public spending to the suggested 2-3 percent of GDP, which is consistent with an increased quantity of studies on income-driven yet inelastic health expenditures in emerging nations. Bokhari *et al.* (2006) ^[4] studied the relationship between government expenditures on health and health outcomes to examine whether an increase in health spending can improve mortality rates the UN Millennium Development Goals. They used an advanced econometric approach on cross-country data from 127 nations for the year 2000, and found that health spending has reduced child and maternal mortality rates. Their analysis revealed that a 1percent increase in government expenditure on health correlates with a 0.33 percent decrease in under-five mortality and a 0.50 percent decrease in maternal mortality. The study concluded that increased government health budgets are effective in improving health outcomes.

Hooda (2016) ^[5] studied the determinants of public health expenditure in India using an empirical panel model. The study used the data on 16 selected major states of India for the time period 1987 to 2012. They used various methodologies, including Fixed Effects Panel and the Arellano-Bond Method, to explore the impact of factors such as income, political participation, and fiscal capacity on health expenditure per capita. The outcome shows a significant positive correlation between political participation and health spending, highlighting that states generating higher revenue can better fund healthcare. The

conclusion emphasized that health is a fundamental need, and many Indian states are inadequately prioritized in their health expenditure.

Balani *et al.* (2023) ^[6] analysed the correlation between public expenditure on health and income across Indian states. For state-wise analysis, the study used an advanced Granger causality test on data from 1981 to 2017, classified into two categories: the special states and non-special states based on demographic and economic factors. They found a short-run non-linear bi-directional relationship influenced by regime changes and institutional factors. special states (EAG) exhibited higher income elasticity in health spending compared to non-special states (non-EAG), although their expenditure levels were less consistent. The study revealed that the link between health expenditure and income is influenced by government factors, and recommended to use fund in an efficient manner that is output-based, based on budget implications, especially in developing EAG states.

Sofi and Yasmin (2024) ^[7] studied the effect of OOP health expenditure on the economic growth of Indian states. They emphasised how OOPHE affects the households. They used secondary data from the NHA and panel analysis of 19 states for the time period 2013-2014 to 2019-2020. They found that population growth and government health expenditure had no significant effect, and on the other hand, GSDP significantly reduces OOPHE. They concluded that reducing OOP health expenditure is essential for economic growth and recommended improving public health investment efficiency through health insurance coverage and strengthening primary healthcare infrastructure.

Conclusion

In short, the study indicates that reducing Household Health Spending, improving public health spending, and enhancing the effectiveness and targeting of universal health coverage will contribute to growth in India. Key policies that have been highlighted are strengthening primary healthcare, increasing insurance coverage, and improving state-level development. Therefore, all of the analysed research provides credibility to the idea that long-term economic growth and social development depend on fair access to healthcare and sustainable health financing.

Research gap

The study examines trends and conducts a comparative analysis of health expenditure in five Indian States (Punjab, Gujarat, Maharashtra, West Bengal, and Tamil Nadu), zone-wise, using panel data and Household Health Spending determinants.

Research methodology

This research used secondary panel data of five Indian States (Punjab, Gujarat, Maharashtra, West Bengal, and Tamil Nadu) for the period 2014-15 to 2021-22. The data source is the National Health Accounts.s

- The variables used in the study are population (in crores), State Income (in crores), per head healthcare cost, and Household Health Spending.
- The study uses panel data, which allows it to capture state-wise differences while also examining changes over time.

- While using EViews, the techniques used are trend analysis and panel regression.

$$HHS\%NHE_{it} = C + \beta_1(SI)_{it} + \beta_2(PHHC)_{it} + \beta_3(POP)_{it} + e_{it}$$

Where various steps are followed:

- Pooled OLS:** Panel least squares is a regression technique used for analysing panel data (multiple entities observed over time) by minimising the sum of squared residuals.
- Breusch-Pagan LM test:** used to test for period effects, confirming the suitability of panel estimation over pooled OLS.
- Random Effects:** A period random effects model was estimated to capture unobserved time-specific factors such as policy changes, macroeconomic shocks, and structural reforms affecting public health expenditure.
- Hausman test:** It determines whether the model with Fixed or Random Effects by testing if unobserved individual effects correlate with regressors.
- Fixed Effect:** The Fixed Effects model estimates unobserved bias in Household Health Spending (HHS).

State Comparative Analysis of Health Expenditure of India

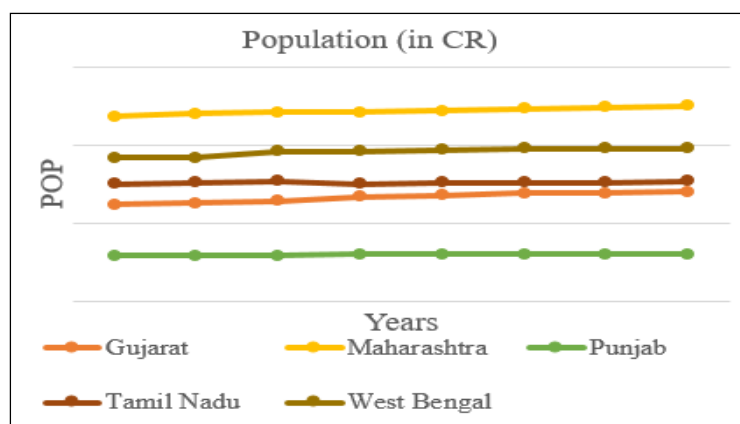
The objectives of the study are divided into two parts:

- Trends and Comparative Analysis of Health Expenditure.
- Determinants of Household Health Spending using Panel Data Analysis.

A. To examine trends and to do a comparative study of the health expenditure across five Indian States (West Bengal, Punjab, Gujarat, Maharashtra, and Tamil Nadu).

To simplify the analysis, the study has used one state from each zone (Gujarat - western zone, Maharashtra- western zone, Punjab- North Zone, Tamil Nadu- South Zone, West Bengal- East Zone) (dcmsme.gov.in) in terms of comparing with income and population status.

The purpose of this section is to examine interstate variations and temporal trends in key indicators such as population, State Income (SI), National Health Expenditure (NHE), Per Head Healthcare Cost (PHHC), Government Health Spending (GHS), and Household Health Spending (HHS).

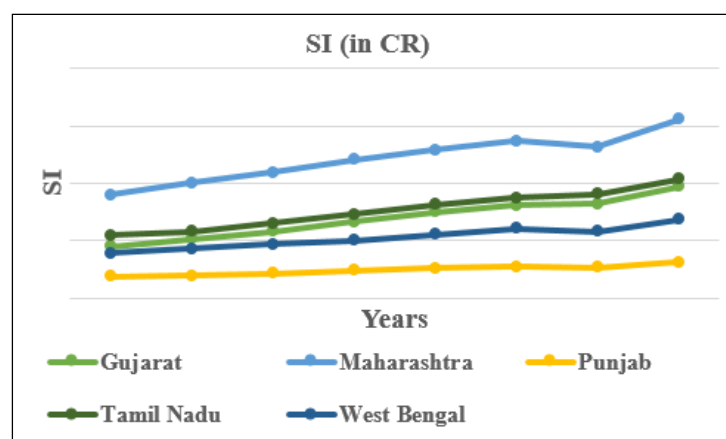


Source: Computed by Author

Fig 1: Total Population (in Crores) of Specific Indian States for the year 2014-15 to 2021-22

Figure 1 represents the growth patterns. Gujarat exhibits the strongest growth (6.2 crores to 7 crores), while Maharashtra and West Bengal show moderate growth. Punjab and Tamil

Nadu show stability in population growth rate. Further, it also reveals that Maharashtra and West Bengal have larger populations compared to other States.

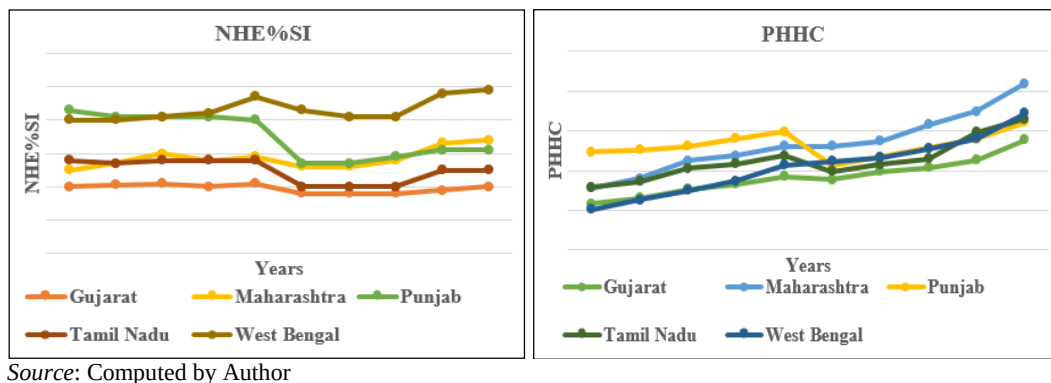


Source: Computed by Author

Fig 2: State Income (SI) (in Crores) of Specific Indian States for the year 2014-15 to 2021-22

Figure 2 represents the pattern of State Income (in Crores). From 2014-15 to 2021-22, the growth rate of Gujarat has approx. 116 percent, Tamil Nadu has 90 percent. Moderate growth is observed in West Bengal, with 76 percent, and

Maharashtra, with 73 percent. The lowest growth is observed in Punjab with 67 percent. Hence, it reflects that each state depends upon different sectors.

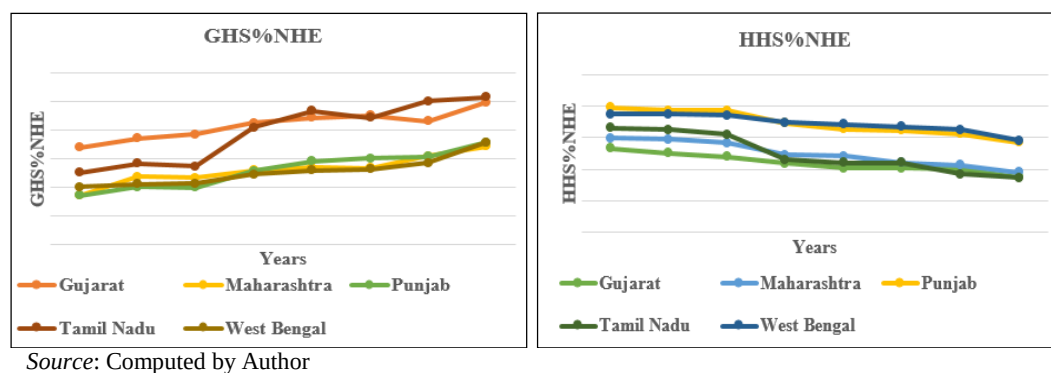


Source: Computed by Author

Fig 3 (a) and (b): National Health Expenditure proportion of State Income (in Percent) and Per Head Healthcare Cost (in Rupees) of Specific Indian States for the year 2014-15 to 2021-22

Figure 3 represents the National Health Expenditure in percent and the Per Head Healthcare Cost in rupees. From 2014-15 to 2021-22, National Health Expenditure is highest in Punjab and West Bengal, while Gujarat, Maharashtra, and

Tamil Nadu have a low rate. On the other hand, the Per Head Healthcare Cost has increased in each state. It reflects that due to an increase in State Income, increases Per Head Healthcare Cost.



Source: Computed by Author

Fig 4 (a) and (b): Government Health Spending and Household Health Spending (in Percent) of Specific Indian States for the year 2014-15 to 2021-22

Figure 4 represents Government Health Spending and Household Health Spending. It reveals that from 2014-15 to 2021-22, in Gujarat, GHS has increased from 34 percent to 49.8 percent, and a fall in PHE from 53.1 percent to 35 percent. The progress is observed in Maharashtra and Tamil Nadu, where GHS doubled over eight years, and HHS fell from 59.6 percent to 38 percent, and from 66.4 percent to 34.6 percent, respectively. On the other hand, Punjab and West Bengal reveal the gain in GHS from 17 to 35.8 percent and 20 to 35.7 percent, respectively, but HHS is falling from 79.3 to 57.2 percent and 75 to 58.3 percent, respectively, and remains the highest compared to other states.

B. To identify determinants of PHE expenditure using panel data analysis.

Section two examines the effectiveness of health financing policies of these five states. The study analyses the economic and demographic determinants of Household Health Spending. Using panel data analysis in specific Indian states, focusing on the role of State Income (SI), Per Head Healthcare Cost (PHHC), and Population (POP). The result will be empirical evidence for reducing HHS burden and

strengthening financial protection in India's health system.

This panel data Fixed Effects (FE) model was selected through a rigorous specification testing process to robustly estimate the HHS determinants across Indian states, accounting for unobserved state-specific heterogeneity. Panel data methods were employed due to the balanced dataset (5 states $\times$ 8 years = 40 observations), which captures both cross-sectional (inter-state) and time-series (temporal) variations in HHS drivers like SI, PHHC, and POP. This approach mitigates omitted variable bias common in cross-sectional analysis and controls for endogeneity better than time-series alone, aligning with prior health economics studies on Indian states (e.g., Hooda, 2016; Sofi & Yasmin, 2024) [5, 7].

For Panel Data Analysis

Panel least squares is a regression technique used for analysing panel data (multiple entities observed over time) by minimising the sum of squared residuals.

$$Y_{it} = \alpha + \beta X_{it} + e_{it}$$

$$HHS\%NHE_{it} = C + \beta_1(SI)_{it} + \beta_2(PHHC)_{it} + \beta_3(POP)_{it} + e_{it}$$

Where,

$HHS\%NHE_{it}$ = Household Health Spending as a percentage of National Health Expenditure in state i at time t .

C = Constant (intercept) term, representing HHS when all explanatory variables are zero.

Household Health Spending (HHS) - All direct payments made by households that include doctor fees, hospitalisation, etc.

$\beta_1, \beta_2, \beta_3$ = Coefficients measuring the marginal effect of SI, PHHC, and POP on Household Health Spending (HHS).

(SI) = State Income

(PHHC) = Per Head Healthcare Cost.

(POP) = Population

e_{it} = Error term.

$i = 5$ (Punjab, Gujarat, Maharashtra, West Bengal, and Tamil Nadu), $t = 8$ (2014-15 to 2021-22).

Table 1: Panel Least Squares (Pooled OLS) results

Response Variable: HHS (Y)		Time period = 8, States = 5		
		Total observations: 40		
Variable	Coeff.	Std Err.	t-Stat	Prob.
C	50.23543	4.957614	10.1329	0
SI (X1)	-2.98E-05	2.52E-06	-11.8608	0
PHHC (X2)	0.003356	0.000959	3.50076	0.0013
POP (X3)	3.933218	0.524864	7.49378	0

Source: Author's Estimation

R-square = 0.81, F-statistic = 54.11, Prob = 0, Durbin-Watson stat = 0.39

- Table 1 reports the result of pooled panel regression with Household Health Spending as the dependent variable and State Income (SI), Per Head Healthcare Cost (PHHC), and Population (POP) as independent variables.
- It shows R-square is 0.818 (81.8 percent), indicating that all independent variables explain 81.8 percent of the variation in Household Health Spending. The F-statistic is highly significant ($P < 0.01$), confirming the overall goodness-of-fit.
- SI (X_1) has a highly significant and negative relation ($-2.98E-05, p < 0.01$). This implies that as a state's income level rises, Household Health Spending (HHS) declines, suggesting better financial protection and possibly stronger public health systems in richer states.
- PHHC (X_2) has a highly significant and positive relation ($0.003356, p < 0.01$). This implies that higher per-capita health spending is associated with higher HHS, possibly reflecting increased utilization of healthcare services or cost-sharing mechanisms.
- Population (X_3) has a statistically significant and positive relation ($3.93, p < 0.01$). Larger population sizes tend to increase Household Health Spending (HHS), reflecting pressure on public health systems and greater reliance on private healthcare.
- Overall, the pooled model suggests that economic growth reduces HHS burden, while population pressure and increased per-capita health spending raise it.
- It also explains that if the P-value is above 0.05, we accept the panel least squares pooled OLS result, if the P-value is below 0.05, indicating rejection of the null hypothesis, we run a fixed or random effects model.
- Hence, the P-value is below 0.05, we reject the null hypothesis, and further, we run a fixed or a random effects model.

Table 2: Lagrange Multiplier (Breusch-Pagan) Test

HO: No panel effects exist			
H1: At least one effect exists (cross-section, time, or both)			
Hypothesis Testing			
	Cross-section	Time	Both
Breusch-Pagan	13.37367	1.858259	15.2319
	-0.0003	-0.1728	-0.0001

Source: Author's Estimation

The table examines the presence of period effects instead of pooled OLS.

- Table 2 represents the Lagrange Multiplier (Breusch-Pagan) Test for random effects. The Cross-section Chi-square value = 13.37 ($P < 0.01$), and both effect values = 15.23 ($P < 0.01$).
- It reveals that it leads to rejecting the null hypothesis, and the OLS model is not sufficient, and either the Random or Fixed Effects model is more appropriate.

Table 3: Random Effects Model

Variable	C	S E	t-Stat	Prob.
C	5.02E+01	3.399097	14.77905	0

SI (X1)	-2.98E-05	1.73E-06	-17.29917	0
PHHC (X2)	0.003356	0.000657	5.105897	0
POP (X3)	3.933218	0.359863	10.92975	0

Source: Author's Estimation

R-square = 0.81, F-statistic = 54.11, Prob = 0, Durbin-Watson stat = 0.39

A period random effects model was estimated to capture unobserved time-specific factors such as policy changes, macroeconomic shocks, and structural reforms affecting public health expenditure.

- All three independent variables remain statistically

significant: SI - Negative and Significant, and PHHC and Population - Positive and Significant.

- The R-square remains the same to pooled model (0.818), and the F-statistic is also significant, indicating good model fit.
- The RE model assumes that state-specific effects are random and uncorrelated with regressors. It suggests that higher income reduces HHS, while population growth and Per Head Healthcare Cost increase the HHS burden.
- However, whether RE is appropriate must be confirmed using the Hausman test.

Table 4: Hausman Test Summary

Summary	χ^2	χ^2 d. f.	Prob.
Cross-section random	44.481426	3	0

Source: Author's Estimation

It determines whether the model has Fixed or Random Effects by testing if unobserved individual effects correlate with regressors.

- Table 4 represents the Hausman test comparing fixed effects and random effects. It reveals that the chi-square statistic is 44.48, P-value is 0.000.
- Since the P-value is below 0.05, indicating the rejection of the null hypothesis, it means the Fixed Effects model is preferred, and the Random Effects model is not appropriate because the unobserved state-specific effects are correlated with the regressors.

Table 5: Fixed Effects Model

Variable	C	S E	t-Stat	Prob.
C	5.669169	40.234	0.140905	0.8888
SI (X1)	-3.13E-05	4.55E-06	-6.862747	0
PHHC (X2)	0.000119	0.001195	0.09927	0.9215
POP (X3)	11.94927	5.744985	2.079948	0.0456

Source: Author's Estimation

R-square = 0.92, F-statistic = 55.70, Prob = 0, Durbin-Watson stat = 0.914

The Fixed Effects model estimates bias in Household Health Spending (HHS).

- Table 5 represents the most reliable model, where R-square is 0.924 (92.4 percent of variation is explained), and the F-statistic is 55.7 ($P < 0.01$) indicates overall model is highly significant.
- Here, SI reveals negative and significant results that indicate higher state income reduces Household Health Spending (HHS), reflecting better public financing. On the other hand, PHHC reveals no significant result and explains that once state effects are controlled, Per Head Healthcare Cost does not significantly affect Household Health Spending (HHS). Also, Population (POP) has positive and significant values, indicating that population pressure increases HHS burden due to an increase in public demand.
- **Overall inferences**
 - SI is the strongest determinant → Richer states experience lower HHS.
 - Population significantly raises HHS burden, reflecting infrastructure stress.
 - Public financing efficiency matters more than spending.

- Fixed Effects model is statistically superior → State-specific characteristics (governance, institutions, health systems) critically shape HHS outcomes.

Conclusion

The study used trend analysis and shows that State Income (SI) and Per Head Healthcare Cost increased among the five states over the time period 2014-15 to 2021-22. While the ratio of National Health Expenditure to SI is still comparatively low in the majority of states. The analysis found that Gujarat, Maharashtra, and Tamil Nadu contribute relatively smaller portions of their revenue to health and medical services, while Punjab and West Bengal consistently reflect greater health expenditure levels.

In the state analysis, the composition of health finance found an increase in Government Health Spending (GHS) and shows a progressive decrease in Household Health Spending, but it is still relatively high in Punjab and West Bengal, which reflects household faced financial instability.

The panel data analysis found that income and population size have a major impact on Household Health Spending in Indian states. A higher SI reduces the financial burden on households, highlighting the significance of both public healthcare and economic development. On the other hand, it also reveals that population growth increases Household Health Spending due to rising demand. When state-specific variables are taken into consideration, the impact of Per Head Healthcare Cost initially seems important but then decreases. The Fixed Effects model confirms that HHS patterns are significantly influenced by economic and governance variations among states. Therefore, in addition to increased public spending, reducing out-of-pocket expenses needs to improve equitable allocation of resources, primary healthcare systems, targeted health funding, and increased quality and efficiency of health and medical facilities.

Hence, the government plays an important role through initiatives like Aayushman Bharat, National Health Mission, etc, that aimed to achieve Universal Health Coverage, effective public financing, population-responsive health infrastructure, and targeted interventions to reduce household dependence on Household Health Spending.

Limitations

Fixed Effects panel analysis is subject to standard econometric limitations:

Fixed Effect test struggles to identify time-invariant variables like geography; just 8 years (2014-15 to 2021-22, $N=5$ states, $T=8$) limit power for dynamic effects.³

It neglects the micro-level characteristics like private provider dominance and insurance adoption.

Also, The Fiscal decentralisation, health outcomes, and policy shocks (Ayushman Bharat after 2018) are not included.

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Appendix

Table 1: Total Population (in Crores) of Specific Indian States for the year 2014-15 to 2021-22

Year	Gujarat	Maharashtra	Punjab	Tamil Nadu	West Bengal
2014-15	6.2	11.8	2.9	7.5	9.2
2015-16	6.3	12	2.9	7.6	9.2
2016-17	6.4	12.1	2.9	7.7	9.6
2017-18	6.7	12.1	3	7.5	9.6
2018-19	6.8	12.2	3	7.6	9.7
2019-20	6.9	12.3	3	7.6	9.8
2020-21	6.9	12.4	3	7.6	9.8
2021-22	7	12.5	3	7.7	9.8

Source: National Health Accounts

Table 2: State Income (SI) (in Crores) of Specific Indian States for the year 2014-15 to 2021-22

Year	Gujarat	Maharashtra	Punjab	Tamil Nadu	West Bengal
2014-15	8,95,927	17,92,122	3,68,011	10,92,564	7,74,778
2015-16	10,25,188	20,01,223	3,91,543	11,61,963	8,53,000
2016-17	11,53,327	21,88,532	4,26,988	13,02,639	9,31,222
2017-18	13,28,068	24,11,600	4,78,636	14,61,841	9,99,585
2018-19	14,92,156	25,79,628	5,12,511	16,30,209	11,02,283
2019-20	16,17,143	27,34,552	5,37,031	17,43,144	12,07,823
2020-21	16,36,781	26,27,542	5,30,340	18,08,239	11,55,821
2021-22	19,37,066	31,08,022	6,14,227	20,71,286	13,63,926

Source: National Health Accounts

Table 3: National Health Expenditure proportion of State Income (SI) (in Percent) and Per Head Healthcare Cost (PHHC) (in Rupees) of Specific Indian States for the year 2014-15 to 2021-22

Year	Gujarat (GJ)		Maharashtra (MH)		Punjab (PJ)		Tamil Nadu (TN)		West Bengal (WB)	
	NHE	PHHC	NHE	PHHC	NHE	PHHC	NHE	PHHC	NHE	PHHC
2014-15	2.1	3060	3	4502	4.1	5220	2.8	4101	4.1	2998
2015-16	2	3332	2.8	4734	4.1	5598	2.8	4339	4.2	3479
2016-17	2.1	3703	2.9	5210	4	5960	2.8	4734	4.7	4277
2017-18	1.8	3534	2.6	5236	2.7	4231	2	3955	4.3	4460
2018-19	1.8	3943	2.6	5467	2.7	4682	2	4311	4.1	4668
2019-20	1.8	4130	2.8	6301	2.9	5118	2	4605	4.1	5103
2020-21	1.9	4526	3.3	6957	3.1	5567	2.5	5936	4.8	5603
2021-22	2	5556	3.4	8361	3.1	6416	2.5	6595	4.9	6874

Source: National Health Accounts

Table 4: Government Health Spending and Household Health Spending (in Percent) of Specific Indian States for the year 2014-15 to 2021-22

Year	Gujarat (GJ)		Maharashtra (MH)		Punjab (PJ)		Tamil Nadu (TN)		West Bengal (WB)	
	GHS	HHS	GHS	HHS	GHS	HHS	GHS	HHS	GHS	HHS
2014-15	34	53.1	17	59.6	17	79.3	25	66.4	20*	75
2015-16	37.2	50.4	23.7	58.9	20	77.4	28.4	65.2	20*	75
2016-17	38.6	48.1	23.3	56.7	19.8	77.3	27.3	62.1	21.2	74.1
2017-18	42.5	43.9	25.9	49.1	25.7	69.4	41	45.9	24.4	69.8
2018-19	44.4	40.7	26.9	48.4	29.1	65.5	46.9	44.3	25.9	68.7
2019-20	45.1	40.8	26.6	44.1	30.1	64.7	44.3	44.3	26.4	67.1
2020-21	43.1	40	31	42.4	30.7	62.3	50.3	36.9	28.6	65.1

2021-22	49.8	35	34.3	38.1	35.8	57.2	51.7	34.6	35.7	58.3
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Source: National Health Accounts