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## Political Determinants of Health Inequalities in India

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### Abstract

This article undertakes a theoretical and analytical examination of the political determinants that underpin and perpetuate health inequalities in India. Drawing upon the social determinants of health framework, the study locates political economy, governance structures, policy design, electoral incentives, and inter-governmental fiscal arrangements as constitutive forces shaping differential health outcomes across the population. The analysis reveals that health disparities in India are not merely a product of resource scarcity or cultural heterogeneity but are systematically produced and reproduced through political processes, including the selective allocation of public expenditure, the fragmentation of health governance between the Centre and the States, the clientelist logic of welfare provisioning, and the marginalisation of subaltern voices in health policymaking. Employing qualitative secondary analysis of published scholarship, government documents, and longitudinal health survey data, the article argues that any durable remediation of health inequalities in India necessitates structural political reform alongside technocratic health system strengthening. The findings contribute to a growing body of comparative political economy of health literature by foregrounding the Indian case within a broader theoretical conversation about the politics of redistribution and social protection.

### Keywords

Health inequalities, India, Governance, Political determinants of health, Public expenditure, Social determinants.

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## Introduction

Health inequalities constitute one of the most enduring and morally significant dimensions of social stratification in contemporary India. The country has witnessed considerable aggregate improvements in health indicators over the past three decades life expectancy rose from approximately 58 years in 1990 to nearly 70 years by 2019, and child mortality declined substantially, yet these gains have been distributed with striking unevenness across geographic, social, and economic lines (Prabhakaran et al., 2018: 1455). The persistence of such inequalities invites critical scrutiny not merely of the technical dimensions of health system performance but of the deeper political architecture within which the health sector is embedded.

The dominant analytical tradition within public health has historically privileged proximate and biological determinants of ill-health nutritional status, sanitation coverage, immunisation rates; often treating these as largely technical problems amenable to targeted programmatic intervention. However, a growing body of scholarship within social epidemiology and political science has persuasively argued that health outcomes are profoundly shaped by what Marmot (2005: 1099) termed the 'causes of the causes'- the social, economic, and political conditions that determine the distribution of risk and resource within societies. Building on this tradition, Navarro and Muntaner (2004: 3) contend that political forces, including the nature of the state, the balance of class power, and the ideological commitments of governing coalitions, are among the most potent drivers of health inequality across national contexts.

In the Indian setting, political determinants operate through several interrelated mechanisms. The federal structure distributes health authority and fiscal resources in ways that generate inter-state divergence. Electoral competition shapes the logic of welfare provisioning, frequently privileging visible transfers over public goods investment. The entrenched social hierarchies of caste and gender interact with political representation to produce systematically unequal voice in health policymaking. And the trajectory of economic liberalisation since 1991 has restructured the political economy of health in ways that have exacerbated the commodification of care. Taken together, these dynamics suggest that health inequalities in India are, in a fundamental sense, politically constituted.

This article seeks to elaborate this argument through a theoretically informed, evidence-based analysis. It does not aspire to offer a comprehensive empirical survey of every dimension of Indian health inequality but rather to construct a coherent analytical narrative that illuminates the political mechanisms through which inequalities are produced and sustained. The article engages with the existing scholarship critically, drawing upon it to build an argument that is both contextually grounded and theoretically generative.

## Objectives and Methodology

The study pursues three principal objectives. First, it seeks to map the principal dimensions of health inequality in contemporary India, establishing the empirical contours of a problem that is often discussed in aggregate terms but whose specificity demands careful

delineation. Second, it aims to identify and theorise the political mechanisms through which these inequalities are produced, reproduced, and occasionally mitigated. Third, it endeavours to draw out the implications of this analysis for both scholarship and policy, contributing to a more politically literate understanding of the challenge of equitable health governance in India.

Methodologically, the study is situated within a tradition of qualitative secondary analysis and theoretical elaboration. It does not generate new primary data but instead undertakes a systematic and critical engagement with existing scholarship; including peer-reviewed journal articles, monographs, government reports, and longitudinal survey data from instruments such as the National Family Health Survey (NFHS) and the Sample Registration System (SRS). The analytical approach draws on the social determinants of health framework as elaborated by the WHO Commission on Social Determinants of Health (CSDH, 2008), as well as on comparative political economy frameworks that centre the role of the state, class, and power relations in shaping social policy outcomes.

The theoretical framework employed in this study treats political determinants not as a residual category but as a constitutive domain of health inequality explanation. Following Bambra et al. (2005: 187), the analysis proceeds from the premise that 'the welfare state is a key determinant of health and health inequalities' and that variation in welfare state design; which is itself a product of political struggle, institutional path dependence, and ideological

contestation is therefore a proximate cause of differential health outcomes. In India's case, the welfare state is partial, fragmented, and unevenly developed, making the political determinants of its configuration all the more analytically significant.

### **Conceptual Framework: Politics and the Social Determinants of Health**

The social determinants of health (SDH) framework, as synthesised by the World Health Organisation's Commission on Social Determinants of Health, establishes that health outcomes are fundamentally shaped by the conditions in which people are born, grow, live, work, and age, and that these conditions are in turn shaped by the distribution of money, power, and resources at global, national, and local levels (CSDH, 2008: 1). The Commission explicitly identified political factors; including the governance of welfare states and the political empowerment of marginalised communities as key upstream determinants of health equity. However, the political science literature on health inequalities has arguably gone further in theorising the specific mechanisms through which political forces shape health outcomes.

Schrecker and Bambra (2015: 4) argue that the politics of health inequalities must be understood within the context of neoliberal globalisation, which has restructured states' capacities and political incentives in ways that are frequently inimical to health equity. In their framework, fiscal austerity, labour market flexibilisation, and welfare retrenchment; all of which are politically driven processes generate the material deprivations and insecurities that translate into poor health. Whilst their primary focus is

on the Global North, the applicability of this framework to India a country that embraced market liberalisation in the early 1990s under significant external pressure and internal political consensus is analytically productive.

Navarro et al. (2006: 2037) offer another key theoretical resource, demonstrating through comparative analysis of OECD nations that the political traditions of governing parties specifically, the extent to which parties of the left and labour have been electorally dominant over extended periods are significantly associated with population health outcomes and health equity. Their findings underscore the importance of political ideology and the balance of class forces in shaping welfare state generosity and redistributive health policy. In India, the ideological heterogeneity of the party system and the absence of a durable social democratic tradition have created a distinctive political context for health governance.

Gramsci's concept of hegemony, as elaborated by later scholars, also offers theoretical purchase in understanding why politically produced health inequalities persist without generating sustained popular mobilisation for reform. When the ideology of meritocracy, individual responsibility for health, and the naturalisation of caste-based difference becomes hegemonic, the political determinants of ill-health are rendered invisible, and the burden of ill-health is attributed to individual behaviour or cultural practice rather than political structure (Farmer, 1999: 79). This ideological dimension is particularly salient in the Indian context, where caste discrimination continues to

produce systematic health disadvantage even as it is officially proscribed.

### **The Landscape of Health Inequality in India**

Before examining the political mechanisms that drive health inequalities, it is necessary to briefly delineate their empirical dimensions. India's health inequality landscape is multidimensional, spanning inter-state, intra-state, class, caste, gender, and rural-urban axes, and these dimensions interact in complex and cumulative ways. The National Family Health Survey data across its successive rounds provide the most comprehensive longitudinal picture of these patterns.

Inter-state disparities in health outcomes are perhaps the most geographically dramatic dimension of Indian health inequality. The Empowered Action Group (EAG) states - Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Odisha, Rajasthan, Uttar Pradesh, and Uttarakhand consistently record significantly higher maternal mortality rates, infant mortality rates, and under-five mortality rates compared to the southern and western states. The maternal mortality ratio in Assam in 2018-20 stood at 205 per 100,000 live births, compared to just 19 in Kerala- a tenfold difference within the same nation-state (Office of the Registrar General, 2022: 6). These disparities are not random but reflect the cumulative effects of historical underdevelopment, colonial extraction, differential investment in education and infrastructure, and crucially political choices about the prioritisation and design of health systems.

Socioeconomic and caste-based health inequalities compound these geographic

patterns. Dalits and Adivasis groups that face structural discrimination embedded in the caste system consistently experience worse health outcomes than upper-caste populations, even after controlling for income levels. NFHS-5 data (2019-21) reveal that the under-five mortality rate among children from Scheduled Caste households was 47 per 1,000 live births, compared to 35 among children from households classified in the general category (International Institute for Population Sciences, 2021: 56). These differentials reflect not only material deprivation but also the denial of access to health services rooted in social discrimination that has historically been tolerated and sometimes actively sustained by the political class.

Gender represents another fundamental axis of health inequality in India. The practice of sex-selective abortion, although illegal since 1994, has produced skewed sex ratios that reflect and perpetuate the systematic devaluation of female life. Son preference, rooted in patriarchal social norms that are reinforced by economic structures including dowry and inheritance patterns, translates into differential nutritional investment, healthcare-seeking behaviour, and ultimately life chances for girls and women. India's sex ratio at birth was 934 females per 1,000 males according to NFHS-5, with considerable regional variation - Haryana recorded only 914 (IIPS, 2021: 23). These patterns cannot be explained by biology and must be situated within a political economy of gender that the state has been insufficiently willing to confront.

### **Political Mechanisms of Health Inequality Production**

The political mechanisms through which these inequalities are produced operate at multiple levels and through several distinct channels, each of which merits sustained analytical attention. The following discussion examines in turn the role of public expenditure politics, federalism and inter-governmental dynamics, electoral logic and welfare provisioning, political representation and voice, and the ideological construction of health policy.

India's chronically low public expenditure on health is perhaps the most direct political determinant of health inequality. Public health spending as a share of GDP has historically hovered around 1 to 1.5 per cent; one of the lowest among comparable middle-income countries (World Bank, 2019: 34). This is not a consequence of fiscal impossibility but of political choice: the Indian state devotes substantial public resources to subsidies for industry, interest payments on public debt, and defence, while underinvesting in the social sector. Bajpai and Sachs (1999: 11) documented that even within the health budget, the allocation between preventive and curative care, and between primary and tertiary levels, reflected political calculations about visibility and electoral reward rather than epidemiological priority. The National Health Mission (NHM), launched in 2005, represented an attempt to address this chronic underinvestment, but the gap between aspirational allocation and actual expenditure remained substantial throughout the 2000s and 2010s.

The consequences of low public expenditure are severe and politically structured. India has

one of the highest rates of out-of-pocket health expenditure globally, with private spending accounting for approximately 62 per cent of total health expenditure in 2018 (WHO, 2021: 47). This forces households disproportionately poor, rural, and low-caste ones to either forgo needed care or incur catastrophic health expenditure that pushes many into or deeper into poverty. Ghosh (2011: 44) estimates that around 39 million people are pushed into poverty each year in India due to out-of-pocket health expenditure. The political decision to permit the commercialisation of healthcare without commensurate public sector expansion or effective regulatory oversight has thus been a principal driver of health-related impoverishment.

Indian federalism creates a second set of powerful political determinants of health inequality. Health is a State subject under the Seventh Schedule of the Indian Constitution, meaning that state governments bear primary responsibility for health system design and delivery. This constitutional arrangement, combined with wide variation in state fiscal capacity, political commitment, and administrative capability, has produced an extraordinarily fragmented national health system. Financially stronger states with greater state domestic product per capita; Maharashtra, Tamil Nadu, Karnataka, Gujarat - have been able to invest more substantially in health infrastructure, resulting in significantly better outcomes. Weaker states, including most of the EAG states, are caught in a fiscal-political trap in which limited revenues constrain health investment, which in turn contributes to poor human capital formation, limiting economic growth and future revenue generation (Rao et al., 2011: 771).

The Centre-State fiscal transfer architecture mediates but does not resolve these inequities. The Finance Commission, which recommends the horizontal distribution of central tax revenues among states, has historically used population and inverse income as criteria for horizontal devolution, which should in principle channel more resources to poorer states. However, the spending and absorptive capacity of poorer states is itself constrained by historical underinvestment in administrative infrastructure, creating a perverse dynamic in which states most in need of central transfers are least able to utilise them effectively (Mukherjee, 2012: 134). Centrally Sponsored Schemes such as the NHM require states to co-fund programmes, creating further disadvantages for fiscally constrained states. The political economy of Centre-State relations, including partisan dynamics between the ruling parties at the Centre and in the States, also shapes the flow of central assistance in ways that cannot be reduced to purely technical criteria.

The logic of electoral competition constitutes a third major political mechanism of health inequality production. India's democratic system creates powerful incentives for politicians to prioritise transfers that are individually visible and electorally attributable over public goods investments; like public health infrastructure whose benefits are diffuse and temporally delayed (Keefer and Khemani, 2005: 1). This theoretical insight, drawn from the political economy literature on public goods provision, helps explain why India's politicians have historically invested in food subsidy programmes, cash transfers, and loan waivers rather than in building robust primary health

systems. The poor; who constitute the numerically dominant electoral constituency are approached not as rights-bearing citizens entitled to quality public health services but as beneficiaries of targeted welfare schemes whose political loyalty must be periodically purchased.

Whilst this electoral logic is not unique to India, it takes a distinctive form given the role of caste and community identities in structuring political coalitions. Chandra (2004: 3) argues that in patronage democracies like India, the distribution of public goods tends to follow ethnic or caste lines, with political elites directing resources towards their own co-ethnics or caste kin. This produces systematic exclusion of marginalised groups - Dalits, Adivasis, Muslims - from the benefits of political patronage, compounding the health disadvantages these groups already experience from structural discrimination. The 'politics of presence'- the degree to which these groups are represented in elected bodies and the bureaucracy thus becomes a health issue, as representation shapes the distribution of public resources with direct health consequences.

The political marginalisation of those who bear the greatest burden of health inequality is therefore itself a determinant of the perpetuation of those inequalities. Heller (2000: 484) draws a pointed contrast between Kerala and other Indian states, attributing Kerala's exceptional health outcomes; high life expectancy, low infant mortality, near-universal literacy- in significant part to a long history of mass political mobilisation, left party organisation, and civic engagement that gave the poor a degree of political leverage

that compelled the state to invest in social provisioning. Conversely, in states where political mobilisation of the poor has been limited or where their political energies have been channelled into caste-based identity politics rather than demands for public goods, the state has faced weaker pressures to prioritise equitable health investment.

The relationship between political representation and health outcomes is further mediated by bureaucratic capacity and administrative accountability. Even where political will to invest in health exists as it demonstrably did in some states that expanded public health infrastructure in the 2000s the implementation of health programmes is contingent on a functional administrative machinery. In many poorer states, the public health bureaucracy is characterised by high rates of absenteeism among health workers, weak supply chain management for medicines and equipment, and limited local accountability mechanisms (Banerjee et al., 2008: 1341). These bureaucratic dysfunctions are not politically neutral but reflect the political economy of public employment, which in many Indian states has become a domain of patronage distribution rather than service delivery.

### **Economic Liberalisation, the State, and the Restructuring of Health Inequality**

The political economy of Indian health policy cannot be understood without reference to the transformative impact of economic liberalisation since 1991. The liberalisation consensus which emphasised fiscal consolidation, privatisation, and a reduced role for the state in economic management had profound implications for the health sector,

reshaping both the material conditions of population health and the political space for equitable health policy. Whilst the neoliberal reform agenda generated sustained economic growth and contributed to poverty reduction, its distributional consequences were far from egalitarian, and its effects on health equity were complex and in significant respects negative.

The fiscal consolidation imperatives associated with liberalisation constrained public expenditure on health during the 1990s and into the 2000s, a period characterised in health policy circles as one of 'reform fatigue' in the social sector (Berman and Ahuja, 2008: 59). The retreat of the state from direct health provisioning, combined with the rapid growth of the private health sector, produced a highly unequal two-tier system in which the quality of care received by an individual was increasingly determined by their ability to pay rather than by their need for treatment. Qadeer (2011: 23) argues that the growth of the private sector in Indian healthcare has not merely complemented but actively undermined the public system, drawing qualified health personnel from the public sector, raising the costs of care across the system, and intensifying the commodification of health.

The political logic of liberalisation also reshaped the ideological terrain of health policymaking, strengthening the position of market-oriented approaches to health system reform and marginalising advocates of universalist public provisioning. The discourse of 'insurance-based' health coverage embodied in schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) and later

Ayushman Bharat - reflects the ascendancy of this market-oriented logic, in which the state's role is conceived primarily as that of a financier of private sector service delivery rather than a direct provider (Sriram and Goli, 2020: 78). Critics have argued that this model does little to address the structural underfunding of primary healthcare, focuses narrowly on hospitalisation-based catastrophic expenditure whilst neglecting the continuum of preventive and promotive care, and channels public resources into a private sector that is weakly regulated and prone to moral hazard.

### **Caste, Gender, and the Politics of Health Voice**

Any account of the political determinants of health inequalities in India must engage seriously with the intersecting hierarchies of caste and gender, both because these hierarchies generate systematic health disadvantages and because they shape the political processes through which health policy is made and implemented. The analytical challenge is to move beyond a descriptive account of caste and gender health disparities to a theorisation of the political mechanisms through which these hierarchies are reproduced in and through health governance.

Caste discrimination in access to healthcare has been extensively documented in anthropological and sociological studies. Dalit patients report being subjected to discriminatory treatment by health workers, being denied access to health facilities, and being allocated physically inferior spaces within health institutions (Thorat and Lee, 2005: 42). These practices of discrimination,

rooted in the social values of caste purity and pollution, are reproduced within the public health system in part because the health workforce; including doctors, nurses, and auxiliary staff is not exempt from the caste prejudices of the wider society, and because the institutional accountability mechanisms that might deter discriminatory treatment are weak. Critically, the political unwillingness to actively enforce constitutional prohibitions against caste discrimination within the health sector and to implement affirmative action in health workforce composition in ways that might disrupt these practices reflects the continuing power of upper-caste interests within the political class.

Gender shapes the politics of health through multiple mechanisms. Women's health needs have historically been constructed narrowly within a maternal and child health framework that defines women primarily as reproductive vessels rather than as rights-bearing individuals with a full range of health needs. This framing reflects and reinforces patriarchal social norms but is also politically convenient, as it allows the state to claim commitment to women's health whilst confining its interventions to the domain of reproduction. The under-investment in women's health beyond the maternal and child domain; including mental health, non-communicable diseases, and reproductive coercion - is therefore a political choice with profound health consequences (Berer, 2012: 532).

The political representation of women in Indian legislative bodies, whilst improving following the introduction of reservations in Panchayati Raj institutions under the 73rd

Constitutional Amendment in 1992, remains limited at the state and national levels. Research by Beaman et al. (2012: 1497) demonstrates that female political leadership has positive effects on the provision of health-relevant public goods, including clean water and sanitation, in Indian village councils, suggesting that the political under-representation of women at higher levels of governance has real consequences for health-relevant policy. The resistance of national and state legislatures to women's reservation; the Women's Reservation Bill languished in legislative limbo for decades before a version was finally passed in 2023- is itself a reflection of the political power asymmetries that perpetuate gender-based health inequalities.

### **Towards a Political Economy of Health Equity Reform**

The analytical framework developed in this article points towards a set of conclusions about the conditions for meaningful progress towards health equity in India. These conclusions are not optimistic in a simplistic sense but are grounded in a realistic appraisal of the political structures that would need to change, alongside the health system reforms that have been more extensively discussed in the public health literature.

The first and most fundamental conclusion is that durable health equity in India requires political reform, not merely programmatic health intervention. The expansion of public health infrastructure, the reduction of out-of-pocket expenditure, and the improvement of health service quality are all necessary conditions for health equity, but their achievement and sustainability are contingent on political changes; including the democratic

deepening of accountability structures, the political empowerment of marginalised communities, and a shift in the ideological climate of health policymaking away from market-led models towards universalist public provisioning. Maani and Galea (2020: 12) argue, in a global context, that addressing the political determinants of health requires 'a politics of equity' - a sustained political project oriented towards the reduction of structural inequality and there is no reason to suppose that India is exempt from this requirement.

The comparative evidence from within India is instructive in this regard. Kerala's health achievements, whilst partly attributable to historical cultural factors, are overwhelmingly a product of political history; specifically, of the sustained presence of a left political movement that organised the poor, demanded public goods investment, and created institutional mechanisms of popular accountability over the state (Sen, 1992: 210). Himachal Pradesh, Tamil Nadu, and to a degree Rajasthan represent more recent examples of states where sustained political will; variously generated by competitive party politics, civil society pressure, and bureaucratic entrepreneurship, has produced significant health equity improvements. These cases suggest that political change within the existing constitutional framework is possible and health-consequential, even if it falls short of the structural transformation that a more radical political economy analysis would suggest is necessary.

The inter-governmental architecture of Indian health governance is a domain in which political and institutional reform could yield significant health equity gains. The case for a

more robust system of equalisation transfers; one that goes beyond the existing Finance Commission framework to ensure that all states can offer a nationally defined package of health services- has been made on both equity and efficiency grounds (Rao et al., 2011: 774). The National Health Policy 2017 articulated the goal of raising public health expenditure to 2.5 per cent of GDP, a target that would require both a significant increase in central allocation and a strengthening of states' fiscal capacity. Whether this political commitment translates into budget reality will depend, as ever, on the relative power of health advocates and fiscal conservatives within the political arena.

## Conclusion

This article has argued that health inequalities in India are not merely a technical health system problem but are politically constituted produced and sustained through the operation of political mechanisms that include public expenditure choices, the federal distribution of health authority and resources, the electoral logic of welfare provisioning, the political marginalisation of those bearing the greatest burden of ill-health, and the ideological hegemony of market-oriented approaches to health governance. Drawing on the social determinants of health framework and the comparative political economy of health literature, the analysis has sought to render visible the political processes that are all too often bracketed in mainstream public health discourse.

The argument does not reduce health inequality to a simple function of political will or ideological orientation but traces the complex, multi-level political mechanisms

through which structural inequalities are inscribed in health outcomes. Caste, gender, class, and geographic location intersect with political processes in ways that compound disadvantage and make the achievement of health equity an inherently political project. The evidence from within India - from the comparative experience of Kerala, Tamil Nadu, and other states - suggests that political change within the existing constitutional framework can yield real health equity improvements, but also that the scale and persistence of India's health inequalities reflect structural political conditions that will require sustained and wide-ranging political reform to address.

The contribution of this analysis lies not in identifying a single political fix for India's health inequalities but in insisting that any serious account of those inequalities and any serious programme for their remediation must begin by taking politics seriously understanding the state not as a neutral administrative vehicle for health policy but as an arena of contested power whose configuration fundamentally shapes who lives and who dies, in what conditions, and with what access to care. Future research should further elaborate the mechanisms through which specific political changes in representation, fiscal architecture, regulatory capacity, and ideological framing translate into health equity outcomes, building the evidence base that advocates for a more just distribution of health in India will need to make their case effectively.

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