



## Article

# Glorifying Virchow: Current Debate on Neoliberal Policies and Health Inequalities in India

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**Abstract:** This paper explores the theoretical and empirical links between neoliberal policies and health inequalities in the Indian context. The pathways through which inequality generates population health outcomes remain a major source of dispute within social epidemiology and health economics. Virchow's philosophy, which undoubtedly galvanized thinking across the disciplines, emphasizes how political-economic ideologies and income inequality shape the distribution of health and social problems. In this paper, we argue that the focus on health inequality, while important, understates the role of neoliberal discourses and practices in making sense of contemporary debates on health inequality. Many quantitative studies have demonstrated that more neoliberal countries have poorer health than do fewer neoliberal countries, but we rarely find comprehensive documentation of evidence in the Indian context. Considering the fast-changing political and social environment and policy priorities post-1990s in general and post-2014, this paper examines the impact of a rising share of private healthcare delivery on health inequalities. Using inequality in the under-five mortality rate (U5MR) as a health outcome and per capita NSDP, per capita public health expenditure, the share of private health care spending and the poverty ratio as indicators of neoliberal policies, through robust econometric assessment, we find that economic growth without poverty reduction and public health care spending increase health inequalities. The fixed effects model plots depicting the interaction effects of PCPHE and time on health inequality suggest that public health spending consistently has a negative association with health inequality. However, the period impact of PCPHE on reducing health inequality has declined over time. Random effects model plots that show the interaction effects of the share of private health care utilisation and time consistently show a positive association with health inequality. Our findings also suggest that a positive association exists between the poverty ratio and health inequality. We conclude that integrating understandings of neoliberalism into theorising about health inequality enriches the political economic and political demographic perspective of health. India must implement "post-neoliberal" social and political economic policies to counter neoliberal models that emerged in the 1990s and rising social and health inequalities. Reducing poverty and ending austerity in public health spending are two key steps for reducing health inequalities.

**Keywords:** health inequalities; neoliberalism; political determinants of health

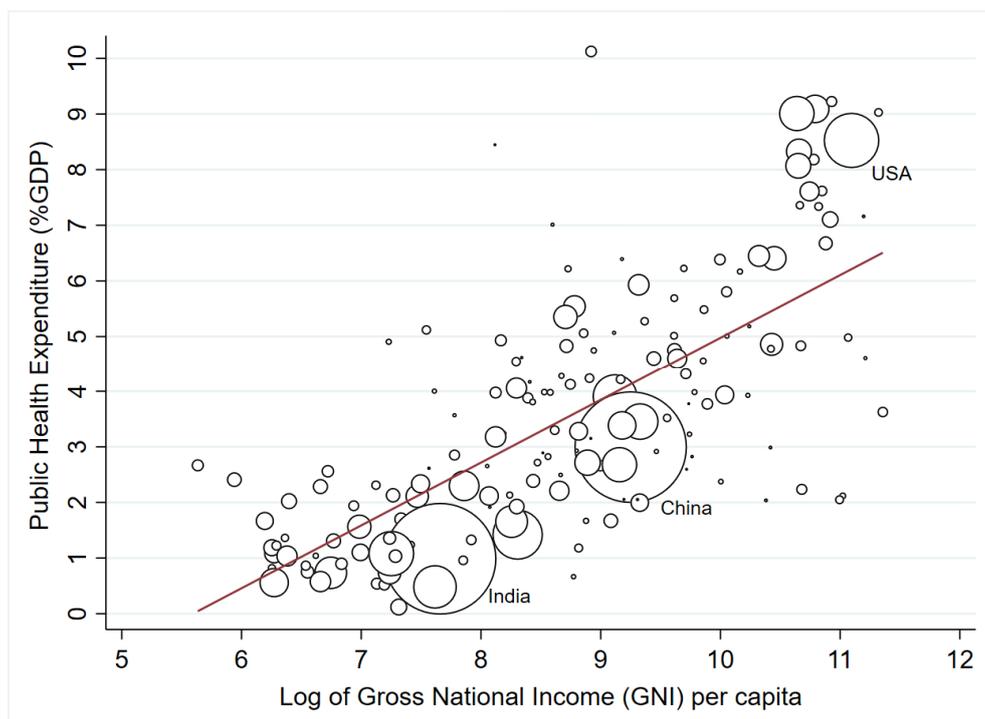
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## 1. Introduction

*“Medicine is a social science, and politics is nothing else but medicine on a large scale” [1]*

In the aftermath of a rapid economic transition, the 21st century heralded an era of new threats and challenges. The principal among these is the unbridled pace of rising healthcare costs and inequalities. The cost of health care is increasing swiftly in both developed and developing countries worldwide. Even those living in the richest countries of the world are worried about their ability to pay for critical health care [2–4]. However, it is difficult to guess what level of economic growth or gross domestic product (GDP) is required for an effective sponsoring of health for all [5]. Clarification of these crises is complex. Does the blame fall on greedy doctors, on the commodification of health care, on the willingness to pay from the people’s side or, conversely, on the failure of governments to provide adequate resources to pay for a proper health care system [6]? Several countries do not spend according to their economic size (Figure 1). These are simplistic understandings of complex problems that are profoundly ingrained in neoliberalism as an economic and social system. A critical analysis of the social determinants of health using a political–economic framework is thus essential.



**Figure 1.** Gross National Income and Public health expenditure (%GDP) in 2019. Source: Authors.

Current economic scholarship is rife with discussions and debates surrounding the determinants of health outcomes and inequalities. In particular, the mechanisms through which a political ideology generates population health outcomes and associated inequalities remain a major debate within health economics, social epidemiology, and medical sociology. In this paper, we argue that the focus on socioeconomic inequality and related political ideology, while important, understates the role of neoliberal discourses and practices in making sense of contemporary socioeconomic inequality and its health-related consequences.

Globally, many quantitative studies have demonstrated that more neoliberal countries have poorer health than do less neoliberal countries [7–9], but only a modicum of studies in India has explored how neoliberal discourses shape health outcomes empirically [5]. Some of them are also theoretical in nature [10].

However, neoliberalism has long been relegated to the peripheries of health economic discourses despite it having vast consequences for the state of health outcomes and inequalities for individuals of a political economy. Peacock, Bissell, and Owen (2014) argue that incorporating the understanding of neoliberalism into theorising about inequality enhances perspectives on social determinants of health [7].

The acknowledgement of the political nature of health and a contemplation of the political determinants of health are unequivocally important to facilitate a better understanding of health inequality. There is a pressing need to build on the body of work that helps us understand and illustrate the importance of political activity and public policy as determinants of health. It can help us explain the diverse ways in which political power and ideology

influence health equity. This not only contributes to more realistic and effective research on the political determinants of health equity but also underscores the need to embrace research programmes and political agendas that can design and implement policies that provide feasible and attractive alternatives to the prevailing convention of neoliberal ideas. In this paper, we devote a substantial portion of the paper to theory, albeit interspersed with empirical evidence.

## 2. Background

### 2.1. *Glorifying Virchow: Political Determinants of Health*

Rudolf L. C. Virchow, the father of modern pathology and the founder of social medicine, coined a well-known precept: “Medicine is a social science, and politics is nothing else but medicine on a large scale” [1]. Virchow’s philosophy indisputably galvanised thinking across disciplines, with his emphasis on how social inequality shapes the distribution of health and disease prevalence. His philosophy advocates “social inequality as the cause of diseases that require political actions” [11]. Many contemporary scholars have used philosophy in the interpretation of modern-day social and economic inequalities in health status in diverse populations. As Kickbusch (2015) writes, “health is a political choice”. Although the political determinants of health are less acknowledged within the framework of social determinants of health, the role played by political choices in a nation’s health is less surprising [12].

Health inequalities are central to current health policy internationally and in many nations. Neoliberal reforms in less developed or developing economies have led to considerable changes in healthcare systems around the world because of their emphasis on the free market rather than the right to health [13]. Under these economic policies, government spending and regulation were both reduced, and taxes were cut for corporations. The policies had massive effects, allowing for the rise of the high-tech revolution years later but widening the gap between the rich and the poor [9,14].

In India, within the framework of social and political determinants of health, specifically, the governance of health care has received less attention. Considering the fast-changing political and social environment and policy priorities post-1990s in general and post-2014, this paper examines the impact of the increasing share of private healthcare delivery on health inequalities.

This study begins by describing the historical political roots of neoliberalism in health care before moving on to consider several ways in which ideas associated with neoliberalism have been implemented globally across different contexts of health care delivery. The second section draws on ideas related to how and why neoliberalism is implicated in the rise in, and persistence of, health inequalities before key debates surrounding the pathways linking neoliberal policies and practices with poor health outcomes are reviewed. Section three presents empirical evidence from India on the extent to which neoliberal policies have led to an increase in health inequalities. The last section discusses the findings with a critical assessment of public health failure to address the links between neoliberal policies and health inequalities, arguing that this has led to an unjustified focus on frameworks that have little prospect of explaining, or catalysing, action to reduce health inequalities.

### 2.2. *Historical Political Roots of Neoliberalism in Healthcare*

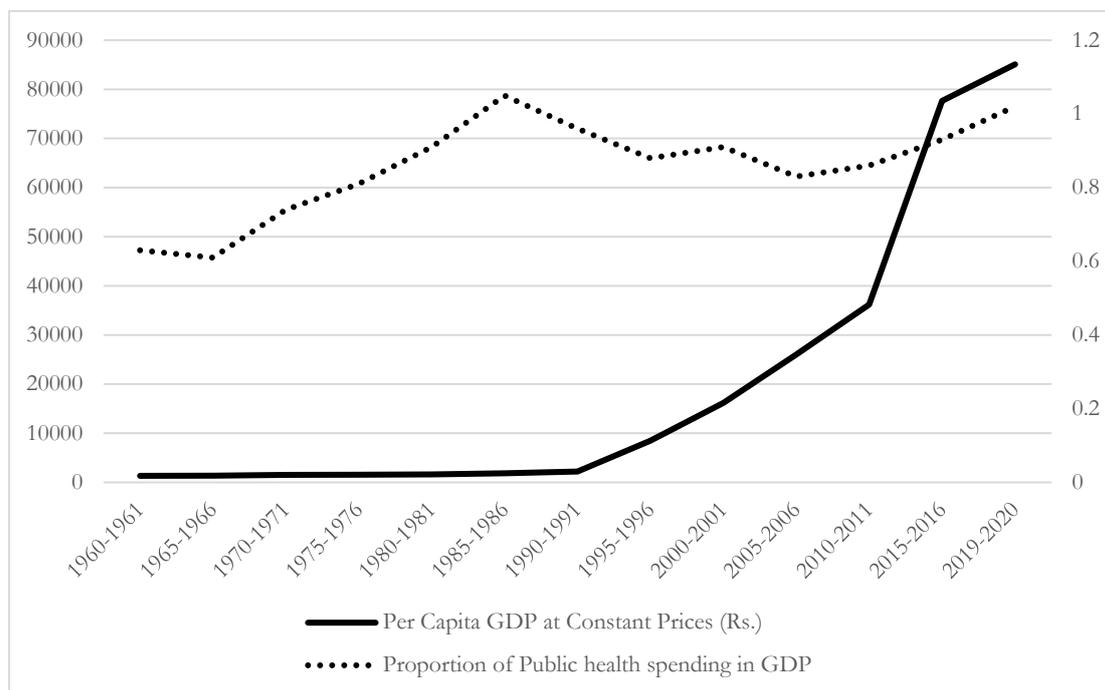
If one were to chart the historical trajectory of political and economic systems alongside patterns of health inequality, it becomes clear that the distribution of health outcomes has been closely linked to broader social organization. Anthropological evidence suggests that many hunter–gatherer societies were characterized by relatively egalitarian social relations and norms of resource sharing. As noted by Angus Deaton in *The Great Escape*, such systems limited the extent of socioeconomic differentiation within groups. Consequently, although mortality levels were high by modern standards, health outcomes tended to be relatively uniform across individuals [15].

With the emergence of more complex economic systems and stratified societies, however, inequalities in income, education, and access to resources increasingly translated into differences in health outcomes. In contemporary societies, these disparities are often reinforced through unequal access to healthcare services and medical innovations. For example, the U.S. healthcare system is accustomed to rapid bouts of innovation, both effective and dubious values. Regardless of their efficiency, a burgeoning trend in inequality among the education and income groups has been observed with the introduction of innovation. Rich, educated and often healthier individuals are quicker able to adopt new innovations [15].

This suggests that the politics of health are immersed in an ideological battle. In fact, the key contention in the politics of public health is the debate between primacies of economic profits over the greater good. The primacy accorded is always in tandem with the ideological leanings of a political economy [12]. India serves as an example of this realisation. The post liberalisation, privatisation and globalisation era in India has been characterised by

persistently low levels of public expenditure on health, which hovered approximately 1% of GDP since the Liberalisation, Privatisation and Globalisation reforms. Furthermore, although the National Common Minimum Programme aimed to increase public health expenditures to 2–3% of the country's GDP, India's public health expenditures decreased to 0.8% of GDP in 2005 (Figure 2). The subsequent rise in public health expenditures was attributed to salary increases in the public sector and not to direct political interventions in the health sector. A related symptom of the tendency to relegate public health spending to the peripheries of the political agenda is the low share of public health expenditure in the total health expenditure of India. As a result, India is plagued by an inefficient public health sector coupled with an unregulated private sector, which has served to increase health inequalities in the country [5]. Thus, health inequalities in India are a visible manifestation of the ideological lacunae embedded within the political system of our country [16].

Although neoliberal policies were adopted by India in 1991, its implementation and intensity vary across states. Differences in leadership, prior commitments, political regime, fiscal priorities and other factors led to variations in public healthcare expenditure, expansion of the private healthcare sector. So, this study does not assume that only in certain states the neoliberal policies were introduced but examines variations in a policy framework consistent with market-oriented governance.



**Figure 2.** Trends in Per Capita GDP versus Public Health Expenditure (in % of GDP).

### 2.3. Contemporary Debates Linking Neoliberalism and Health Inequalities

The fact that the politics of health is the major determinant of health status and inequality in a political economy is a notion that enjoys broad consensus in the current literature [12,17]. Makenbach (2014) noted that an increase in public health efficiency can be achieved with a greater understanding of the consequences of politics for population health [18]. However, the author inversely cautions against fostering illusions regarding the efficacy of political action. The subtle effects of the political agenda are less likely to be observed in the short run. This inability arises from the issues associated with observational and experimental studies, both of which are plagued by their biases. For example, social democratic governments are associated with better population health. However, studies that have observed this relationship have been unable to account for potentially confounding variables such as people's voting patterns and health-seeking behaviour [18].

However, recent literature on the political economy of health has substantially advanced understanding of how neoliberal policy regimes shape population health and health inequalities. Schrecker and Bambra (2015), for instance, argue that neoliberal governance restructured states through austerity policies especially in the wake of 2008 recession, thereby weakening social protection systems and increasing mortality, morbidity and health inequalities [19]. Similarly, Sparke (2018) highlights how contemporary global health governance increasingly relies on market-oriented mechanisms, public–private partnerships, and philanthropic capital, which often shift responsibility for health from public institutions to individuals and market actors [20].

Contributions compiled in *The Routledge Handbook of the Political Economy of Health and Healthcare* further demonstrate that neoliberal restructuring of health systems alters the balance between public and private provision, reshaping access to care and the distribution of health resources [21]. A broader strand of literature also situates these developments within the wider political economy of welfare states and globalisation. Navarro (2007) argues that health inequalities are fundamentally shaped by political power structures and redistributive institutions embedded within capitalist economies [22]. Labonté and Stuckler (2016) similarly show how neoliberal reforms including trade liberalisation, fiscal austerity, and labour market deregulation transform the social determinants of health across both developed and developing contexts [23].

Schrecker (2016) proposed that health effects are a response variable to a multitude of neoliberal epidemics. He defines neoliberalism through principal elements: markets are the natural and preferable alternative to organising human interactions; the function of the state is to ensure the smooth functioning of these markets, and justification for redistributive policies must trump the theoretical ideals of markets. In such a scenario, there are multiple channels of interaction between health outcomes and neoliberalism. The conventional typology divides these channels into two primary streams: material well-being and psychosocial dynamics. Material well-being is one of the most pronounced channels connecting health inequality and neoliberalism, as evidenced by low food security in the U.S. Official surveys estimated that close to 6.9 million US households experienced extremely low levels of food security [14].

In terms of psychosocial dynamics, Wilkinson's and Pickett's (2010) work, 'The Spirit Level', demonstrates that neoliberal policies shape agency and resistance to the increased inequalities and stress of everyday life [24]. The psychosocial ideal accounts for an individual's self-worth as driven by social inequalities and subsequent effects on health-seeking behaviour. Inequality in income extends beyond its monetary façade. Greater inequality also perpetuates the evaluation of people's worth in terms of their monetary and social standing, thereby imbuing a sense of anxiety tied to lower social standing [7]. It is instrumental in understanding the veiled epistemological character of the health sector in a neoliberal setting.

The most conspicuous manifestation of the linkages between health outcomes and neoliberal politics is the changing landscape of trade relations. The axiomatic preferences of neoliberalism are corroborated by its affinity for free trade and patent rights (for example, the TRIPS agreement). The most obvious outcome of this aspect of neoliberalism has been decreased access to medicines among lower-income countries. Studies have also shown that the increased volume of international trade has contributed to increasing obesity levels among low- and lower-middle-income countries [14].

Another aspect of the health sector in a neoliberal setup is the burgeoning private health insurance sector. Private health insurance arises in the face of failures of market and state authorities [25]. However, in India's case, private health insurance companies have exacerbated inequalities in four principal ways exclusion, screening (to avoid moral hazards), and obstacles faced by the poor and an unsubsidised health sector [5].

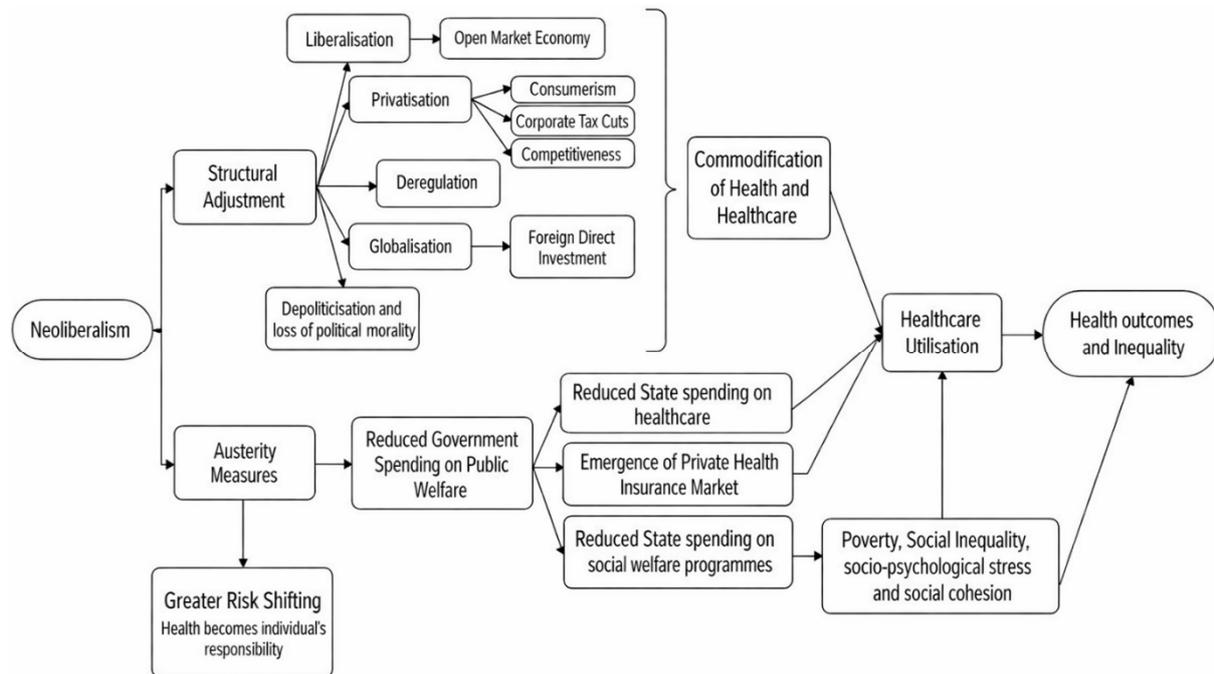
Taken together, this section of literature highlights that health inequalities cannot be understood solely through proximate socioeconomic determinants but must also be analysed within broader political-economic structures that govern welfare provision, market expansion, and state capacity. While much of this scholarship has focused on high-income countries or global comparative analyses, empirical evidence from large and heterogeneous middle-income countries remains limited.

We take the case of India to empirically demonstrate how neoliberal policies helped increase the average income and health status of the country and its states but also raised inequalities in even basic health indicators such as child survival. In this paper, neoliberalism is conceptualised as a political-economic ideology that prioritises market-based organisation of the economy, reduced state intervention in welfare provision, and an expanded role for private actors in the delivery of public goods and services. Neoliberal governance promotes policy frameworks centered on economic liberalisation, fiscal austerity, privatisation, and the restructuring of welfare systems. These policy orientations are often justified through the belief that market mechanisms allocate resources more efficiently than state-led systems. However, a growing body of scholarship has highlighted how neoliberal reforms may also reshape the distribution of social protection and public services, with important implications for inequality and population health outcomes. In this study, we therefore focus not on ideology per se, but on the policy regimes associated with neoliberal reform and their potential implications for health inequalities.

#### *2.4. Theoretical Framework: Mechanism of Neoliberal Policies' Influence on Health*

The term neoliberalism has been used in several ways to analyse its influence on health systems, healthcare, and health outcomes. For a more meaningful analysis, we need to conceptualise neoliberalism in broader terms. It is essential to go beyond the economic aspects and encompass its effects on political, cultural, and social processes.

Figure 3 presents a theoretical framework outlining the influence of neoliberalism on these aspects. From an operational point of view, neoliberalism operates primarily through structural adjustment programmes and austerity measures. Both fronts are a response to financial crises, which have come to be a part of the neoliberal setup with adverse effects on health outcomes. The structural adjustment programme, which became the hallmark of the IMF and World Bank towards the end of the 20th century, is characterised by the principles of liberalisation, privatisation, and globalisation.



**Figure 3.** Linkage between Neoliberalism and Health Inequality.

Liberalisation forms the basis of an open market economy that functions in an unfettered environment with unbridled prices. Accompanied by privatisation, the general atmosphere of soaring price levels is fuelled by consumerism and the alleged competitiveness of an open market economy. Further fillip is provided to the private sector by imposing corporate tax cuts. With respect to globalisation, foreign aid is directly tied to the enabling environment for greater penetration of the private sector. Additional aspects related to deregulation and de-politicisation are also involved, which advance an underlying loss of political morality that is intended to relegate welfare to the peripheries. These factors lead to the commodification of health and healthcare. Health, as an intangible aspiration and state of being, is markedly different from the regular goods and services traded in a market economy. However, the presence of an open market economy coupled with a strong private sector leads health to become a tradeable commodity that is available for those who can afford it. Morals dictate that good health should be a right for all, as it has a significant bearing on the functioning and capability of individuals. However, the implementation of a structural adjustment program strips the health of its essential character and markets it as a commodity based on price instead of a service governed by need.

Austerity measures concomitantly work towards reducing government spending on public welfare. The espousal of austerity measures during times of crisis presents yet other paradoxes of the neoliberal setup. Crises are known to accentuate inequalities through their disproportionate effects on the poor. Receding government spending during this event exacerbated the widening gap, leaving the poor even further behind. Austerity measures in the aftermath of the Great Recession had a devastating impact on health and health inequalities, particularly in the UK [26]. As a policy response in times of crisis, austerity measures reveal the tendency of governments to shift the risk of healthcare towards the individual. Health thus becomes an individual's responsibility. The individualisation of health relays the true extent of moral perversion that grips a neoliberal politico-economic setup. When health is relegated as an individual's responsibility, the implicit assumption underlying the risk shift is that a citizen possesses adequate means to ensure quality healthcare for oneself. However, the assumption withers away in the face of the poverty trap created by neoliberalism.

This poverty trap is created by the decline in government spending on public welfare, which affects health outcomes through reduced social welfare funding and healthcare funding. With a receding government presence

in social welfare, citizens do not possess a social security net to fall back upon in times of crisis. Austerity measures, against this backdrop, worsen their condition. Furthermore, an unfettered market economy, functioning primarily through supply and demand dynamics, fails to account for the deprived, especially in terms of healthcare.

Additionally, reduced social welfare funding falters in terms of addressing poverty and social inequalities and lessens social cohesion, which aggravates the psychosocial stress associated with the inability to secure routine functioning and capability during times of crisis.

### 2.5. Coburn Argued that Neoliberalism

*produces both higher income inequality and lower social cohesion and.... either lowered health status or a health status which is not as high as it might otherwise have been [7]*

When society is divided into markedly different social groups, not only in terms of income and wealth but also in terms of available avenues and opportunities, health status produces a widely polarising spectrum with scales tipping in favour of the rich and wealthy. Reduced social cohesion resulting from such blaring gaps further hinders the larger community from working towards better health outcomes.

In this event, along with the commodification of health and reduced spending on healthcare, rising poverty and social inequalities significantly impact the health-seeking behaviour of an individual. Entrenched inequalities and poverty are also reflected in the health outcomes of a political economy. Similarly, healthcare utilisation indicates the extent of health inequalities present in a political economy.

## 3. Empirical Evidence from India

### 3.1. Data

For the empirical segment, the study used multiple data sources: health data were obtained from successive rounds of the National Family Health Surveys (NFHS) from 199–93 to 2019–21 [27–31]. Following Coburn (2000) and Dreze and Sen (2012), who used child survival as an illustrator to explain the impact of neoliberal policies, in this study, health outcomes are measured in terms of under-five mortality rates (U5MRs), which capture both mortality levels observed among infants and children aged 1–5 years [5,32] and it is the outcome of cumulative effect of sanitation, nutrition, healthcare access, socio-economic conditions. The increase in the per capita net state domestic product (NSDP) and private healthcare share are treated as proxy indicators of neoliberal healthcare policies. The share of private healthcare reflects a more straightforward relationship with neoliberal healthcare policies as it reflects the market expansion in healthcare services and treated as part of broader neoliberal policy framework in health care. The use of the NSDP is necessary to account for the structural growth of neoliberalism in the country. Supplementary Figure S1 shows that the growth of GDP per capita recorded a structural breakthrough in the aftermath of the 1991 liberalisation and privatisation reforms in the country. Supplementary Figure S2 also shows the correlation between GDP per capita and FDI per capita in a country, highlighting the positive association between the two variables. The association with FDI justifies the use of the NSDP per capita in two ways. First, the increased flow of foreign direct investment is a hallmark of the neoliberal agenda [33]. Second, the increased flow of FDI is indicative of the behavioural prescriptions imposed on the recipient countries, as proposed by Kentikelenis & Rochford (2019) in their power asymmetry framework [34].

NSDP, the share of public health expenditure in GDP and the workforce participation rate have been collected from successive rounds of the Central Statistical Organisation (CSO), Ministry of Statistics and Programme Implementation (MoSPI), Government of India [35–37]. Male and female literacy rates and levels of urbanisation were compiled from successive censuses of India [38–40].

We also use successive rounds of the National Sample Survey Organisation (NSSO) on social consumption data to estimate out-of-pocket expenditures on institutional deliveries [35–37]. Public health expenditure across the states was collected from reports of the Ministry of Health and Family Welfare (MoHFW), whereas public health spending across countries was collected from the World Health Organisations Global Health Expenditure database [41]. The descriptive statistics of all the study variables are presented in Table 1. A detailed description of the variables used is also provided in Supplementary Table S1.

The total literacy rate, female literacy rate, male literacy rate, workforce participation rate and level of urbanisation were employed as control variables to distinguish the individual effects of neoliberalism on health inequalities. Additionally, robustness checks were conducted to corroborate the findings of our main model. The poverty ratio, per capita public health expenditure, utilisation of private health care services and governance index were subsequently used as alternate variables.

**Table 1.** Descriptive statistics of the study variables.

Variable	Observations	Mean	Std. Dev.	Min	Max
Year	75	2005.80	10.18	1992	2021
Concentration index of U5MR	75	-0.15	0.06	-0.29	0.03
U5MR	75	65.33	34.13	5.19	142.20
Total literacy rate	75	70.20	10.99	42.25	95.00
Female literacy rate	75	61.17	14.02	27.56	93.60
Male literacy rate	75	79.18	8.56	55.53	96.70
log of NSDP pc	75	10.30	0.98	8.41	12.09
Poverty ratio	75	21.63	11.44	0.79	51.91
Share of private health care	75	52.98	20.22	11.00	84.80
Log PCPHE	75	10.74	0.56	9.47	11.77
Work force participation rate	75	39.66	5.23	22.23	48.77
Level of urbanization	75	30.07	10.85	11.99	58.57
Governance Index	75	0.50	0.08	0.37	0.67

### 3.2. Econometric Approach

#### 3.2.1. Health Inequality Measurement

Health inequality is measured via two measures: the poor-rich ratio and Wagstaff's concentration index (CI) [42]. The concentration index is twice the area between the concentration curve and the 45°-line curve, indicating that there is no relationship between the two variables. The mathematical proof of Wagstaff's corrected concentration index is as follows:

$$C = \frac{2cov(h_i, R_i)}{h} \quad (1)$$

where  $h_i$  is the health variable. Specifically, we measured health inequality in the U5MR.

$R_i$  is the rank variable. We used the wealth quintile as a rank (socioeconomic gradient) variable.

$C$  ranges from  $(1 - n)/n$ , maximal pro-poor inequality (that is, all health is concentrated on the poorest individual), to  $(n - 1)$ , maximal pro-rich inequality.

Although the CI for our health variable (U5MR) is negative and pro-poor, for plotting purposes, we have used the absolute value of the CI, i.e., ABS (CI).

#### 3.2.2. Partial Correlations

We plotted partial correlations between per capita NSDP and CI in U5MR adjusting to averages of U5MR. The partial correlation per capita NSDP ( $a$ ), CI in U5MR ( $b$ ) and average U5MR ( $c$ ) can be written as:

$$r^{abc} = \frac{r^{ab} - r^{ac} r^{bc}}{\sqrt{(1 - r_{ac}^2)(1 - r_{bc}^2)}} \quad (2)$$

#### 3.2.3. Panel Data Regression

By constructing a panel of 15 states over five time points ( $n = 75$ ), the study employed fixed and random effects regression models to assess the impact of the rise in per capita NSDP and private health care share on health inequalities. We used multiple robustness checks where we employed alternative predictors (e.g., poverty rates) and alternative models (linear regression estimates for different time points) to observe the consistency of the evidence that emerged from the main analysis.

Fixed effects regression model:

$$Y_{it} = \alpha_i + \beta_1 X_{it} + \delta_i + \mu_{it} + e_{it} \quad (3)$$

$$I = 1 \dots n; t = 1 \dots T$$

where  $Y_{it}$  is the concentration index of U5MR and where  $\alpha_i$  is the unknown intercept for each entity.  $\beta_1 X_{it}$  is the coefficient of the explanatory variable log of the NSDP per capita and time dummy;  $\beta_k$  is the coefficient of each of the explanatory variables, viz., female and male literacy rates, work force participation rates and levels of urbanisation;  $\delta_i$  is the state dummy;  $i$  is the unit of observation;  $t$  is the period of time.;  $\mu_{it}$  is within the entity error term; and  $e_{it}$  is the overall error term.

Random effects regression model:

$$Y_{it} = \alpha_{it} + \beta_1 X_{it} + \delta_i + e_{it} \quad (4)$$

$$I = 1 \dots n; t = 1 \dots T$$

where  $Y_{it}$  is the concentration index of U5MR;  $\alpha_{it}$  is the unknown intercept for each entity;  $\beta_1 X_{it}$  is the coefficient of the explanatory variable, which is the interaction term of the log of NSDP per capita and the time dummy;  $\beta_k$  is the coefficient of each explanatory variable, i.e., the female and male literacy rate, work force participation rate and level of urbanisation; and  $\delta_i$  is the state dummy. where  $i$  is the unit of observation,  $t$  is the period, and  $e_{it}$  represents the overall error term.

## 4. Results

### 4.1. Trends in Economic Growth versus Health Inequalities

The nonlinearity argument for income and health outcomes is common among all the literature in economics, demography, and public health [43]. Preston argued that income is only a part of mortality reduction and health outcome success [44]. In Figure 4, we plot trends in per capita GDP (an indicator of economic growth) and the poorest-richest ratio in the U5MR (an indicator of health inequality). Trends in per capita GDP from 1992–2021 reveal that it was growing at a slower rate until the mid-2000s, thereafter experiencing an accelerated rise. In general, when economic growth is distributed uniformly across the population, a country is likely to experience a decline in health inequalities. However, India presented a typical case where we did not observe a consistent declining trend in health inequalities (measured through both the poorest-richest ratio and CI in the U5MR) with an increase in per capita GDP. While health inequalities experienced an increasing trend from 1992–93 to 1998–99, followed by a decline between 1998–99 and 2005–06, a steady rise can be observed in the years thereafter. In particular, this worsening of health inequalities was accentuated after 2015, which coincides with a new political regime that espoused aggressive new liberal policies of health care delivery where the role of publicly sponsored insurance-based private sector health care occupied a central stage instead of building public health infrastructure [45].

The failure of growth in per capita income to translate into reduced inequalities in health is a symptom of uneven distribution of income, a hallmark of the neoliberal setup. In fact, Wilkinson (1999) points towards smaller status differences, which play a vital role in the impressive health performance of many centrally planned economies in the initial years [46]. Similarly, in India, the rise in health inequality can be directly attributed to the widening status difference.

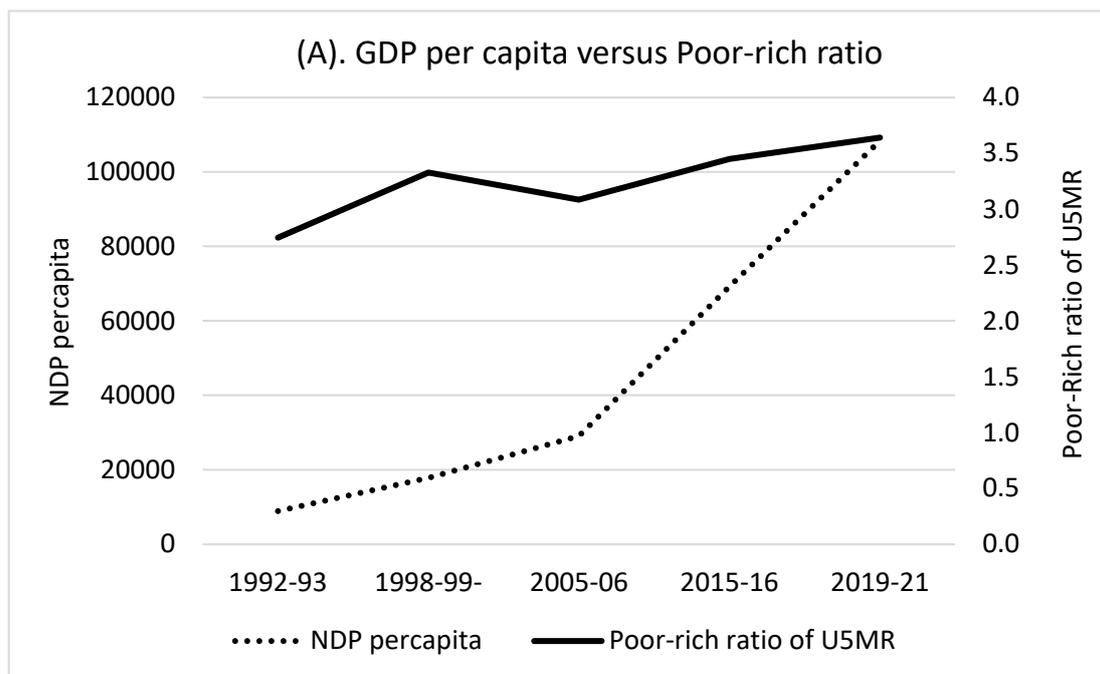
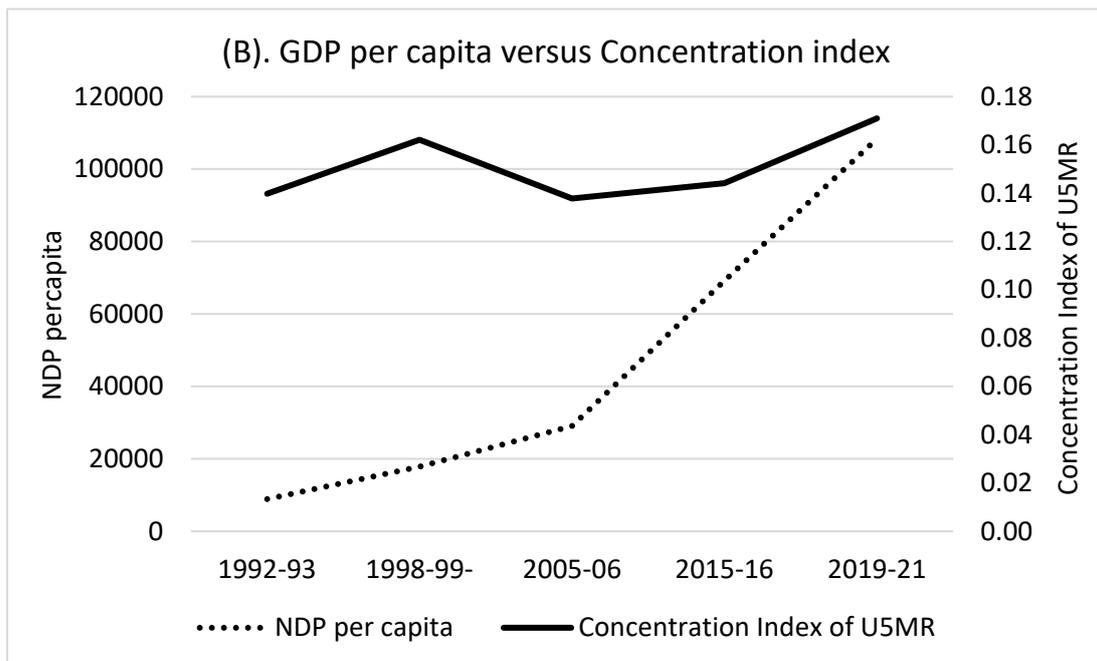
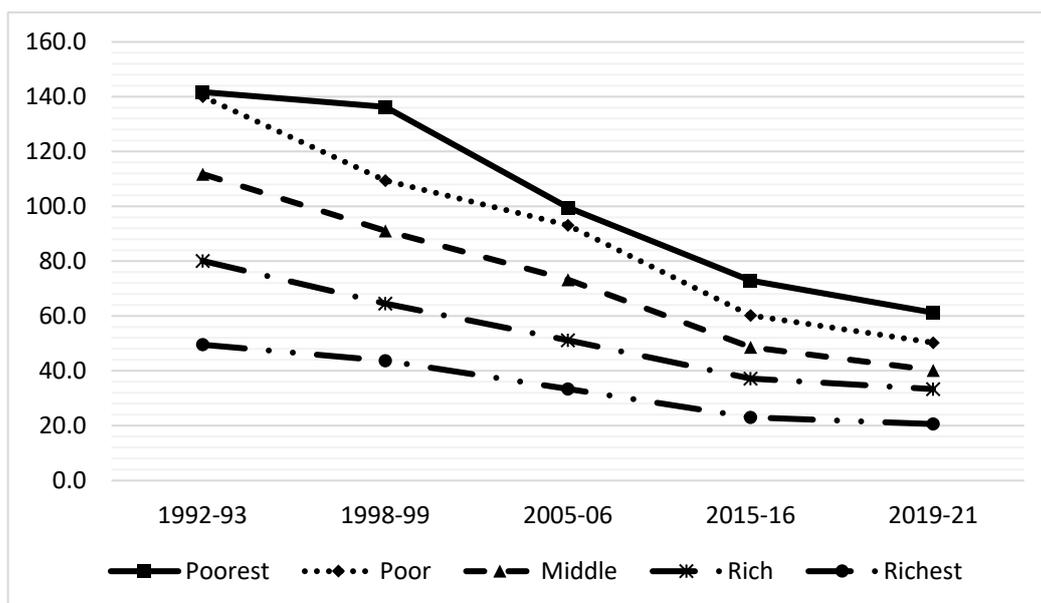


Figure 4. Cont.



**Figure 4.** Trends of GDP per capita and Health Inequality in U5MR from 1992 to 2021. Note: Concentration index value was in minus implying pro-poor in U5MR, however, for plotting purpose, we took absolute value: ABS(CI).

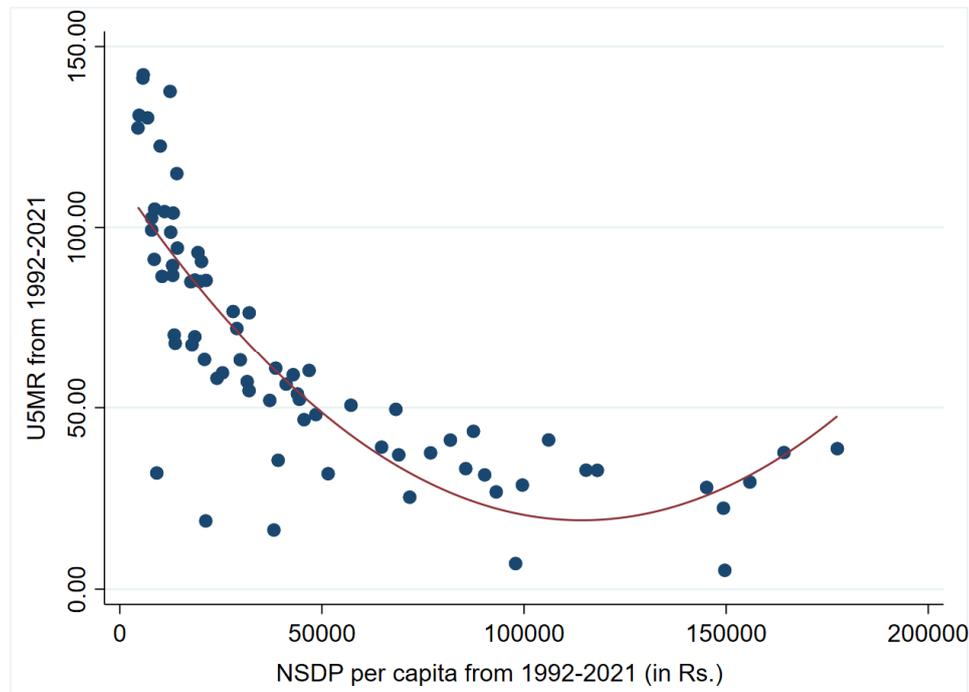
Figure 5 reveals another facet of the status of health inequalities in the country over time. Although the trends in the U5MR across the income quintiles appear to be converging, a closer look would reveal that this convergence is a result of a deceleration in the improvement of the U5MR among the higher-income groups instead of marked progress in the lower-income group. This insight can be further corroborated by examining the level of the U5MR in the richest income group in 1992–93, which hovered approximately 50 per thousand children aged 0–5 compared with approximately 20 per thousand children aged 0–5 in 2019–21. The slope of the U5MR trend among the richest income group stagnated from 2015–16 and from 2019–21. Convergence in health inequalities cannot be considered a reflection of improvement in health outcomes if it is driven by a retrogressing trend in the better-off groups.



**Figure 5.** Trends in U5MR by Economic status.

#### 4.2. Correlation and Partial Correlation

Figure 6 depicts the association between the U5MR and the Per Capita NSDP, suggesting a nonlinear relationship, implying that economic growth does not necessarily result in better and equitable health outcomes. This association belies the notion of trickle-down theory, which forms the pedestal of the neoliberal setup. Assumptions regarding the linear relationship between economic growth and better health outcomes, along with trickle-down theory, have prevented targeted actions towards addressing unequal health outcomes. For economic growth to translate into equalised health outcomes, concerted efforts toward bridging not only income wealth but also fissures within the healthcare provisions of an economy are needed.



**Figure 6.** Relationship between U5MR and Per Capita NSDP, 1992 to 2021.

The relationships between the Under-5 mortality rate and the NSDP per capita are plotted in Figure 6. Similarly, the partial correlation between the Per Capita NSDP and the CI was estimated by adjusting for the average U5MR and share of private health care (Figure 7). In both cases, we find a positive relationship between the per capita NSDP and the CI. This implies that an increase in economic growth has failed to reduce health inequalities and instead accentuated them. This increase in health inequalities is occurring despite the increase in health averages. A similar finding was reported by Goli and Arokiasamy in 2014 [47]. They reported that since the late 1990s, convergence in the decline of health inequalities has been replaced by emerging divergence. The coinciding divergent trends in health inequality after economic reforms signal the impact of neoliberal policies.

#### 4.3. The Effect of Economic Growth on Health Inequality

The random effects model estimates in Table 2 suggest that throughout the period considered for the study, the per capita NSDP consistently has a positive association with health inequality, net of other control variables. An increase of almost twelve times in the per capita NSDP did not translate into reduced health inequality and instead exacerbated it further. The results of Model 5, which controls for male and female literacy, the workforce participation rate, the level of urbanization and the state of residence, suggest that hardly any decline was registered in the level of positive association between the per capita NSDP and health inequality. In 1992–93, a unit change in per capita NSDP increased health inequality by 0.12 times, which remained at 0.10 for 2019–21. This not only points to a continued positive relationship between the NSDP and health inequality but also reveals that this positive relationship has not weakened over time. These findings are in line with Deaton’s (2003) observations in the context of both developed and developing countries [43].

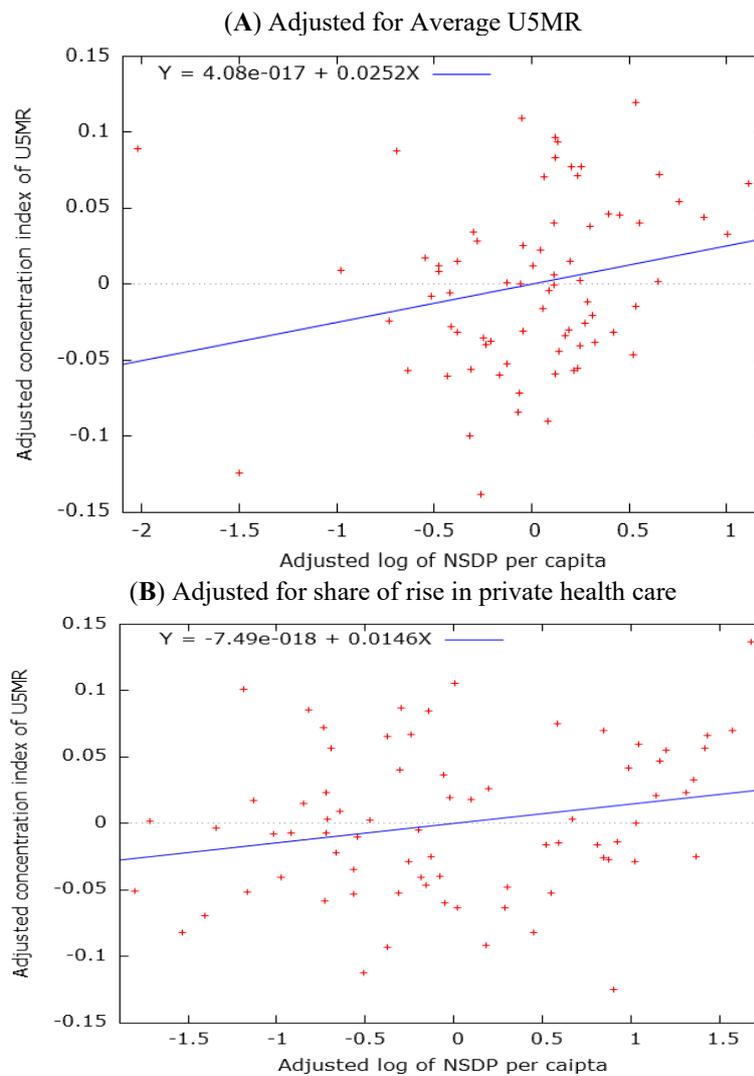


Figure 7. Partial correlation plot of NSDP per capita and Health inequality in U5MR.

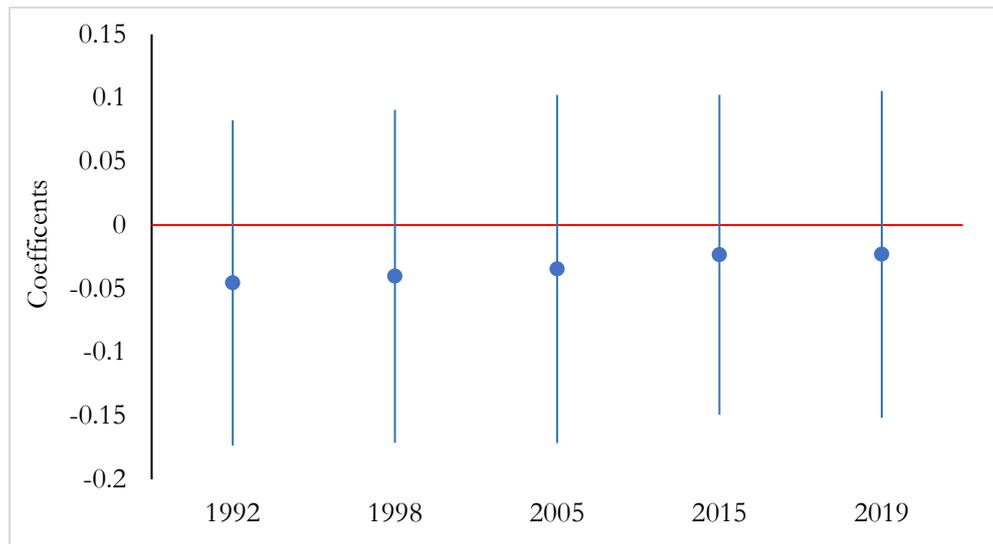
Table 2. Random effect estimates: Dependent variable-U5MR.

Variables	Model 1	Model 2	Model 3	Model 4	Model 5
Interaction of log of NSDP Per capita and time					
log of NSDP pc and 1992	0.0753 *** (0.0166)	0.117 * (0.0700)	0.130 * (0.0714)	0.124 * (0.0728)	0.125 * (0.0762)
log of NSDP pc and 1998	0.0721 *** (0.0154)	0.110 * (0.0648)	0.122 * (0.0660)	0.116 * (0.0674)	0.117 * (0.0709)
log of NSDP pc and 2005	0.0664 *** (0.0147)	0.102 * (0.0616)	0.115 * (0.0630)	0.109 * (0.0642)	0.110 (0.0682)
log of NSDP pc and 2015	0.0617 *** (0.0136)	0.0940 * (0.0567)	0.106 * (0.0581)	0.101 * (0.0591)	0.102 (0.0634)
log of NSDP pc and 2019	0.0619 *** (0.0131)	0.0925 * (0.0545)	0.105 * (0.0560)	0.101 * (0.0569)	0.102 * (0.0616)
Female literacy rate		✓	✓	✓	✓
Male literacy rate			✓	✓	✓
Work force participation rate				✓	✓
Level of urbanisation					✓
State dummy		✓	✓	✓	✓
Constant	-0.540 *** (0.150)	-0.972 * (0.652)	-1.376 * (0.773)	-1.367 * (0.778)	-1.370 * (0.789)
Observations	75	75	75	75	75
Wald chi2	26.54	35.82	36.73	36.56	35.86
Number of states	15	15	15	15	15

Note: Standard errors in parentheses; \*\*\*  $p < 0.01$ , \*  $p < 0.1$ ; the concentration index value was negative, indicating poor U5MR; however, for regression purposes, we took the absolute value ABS (CI).

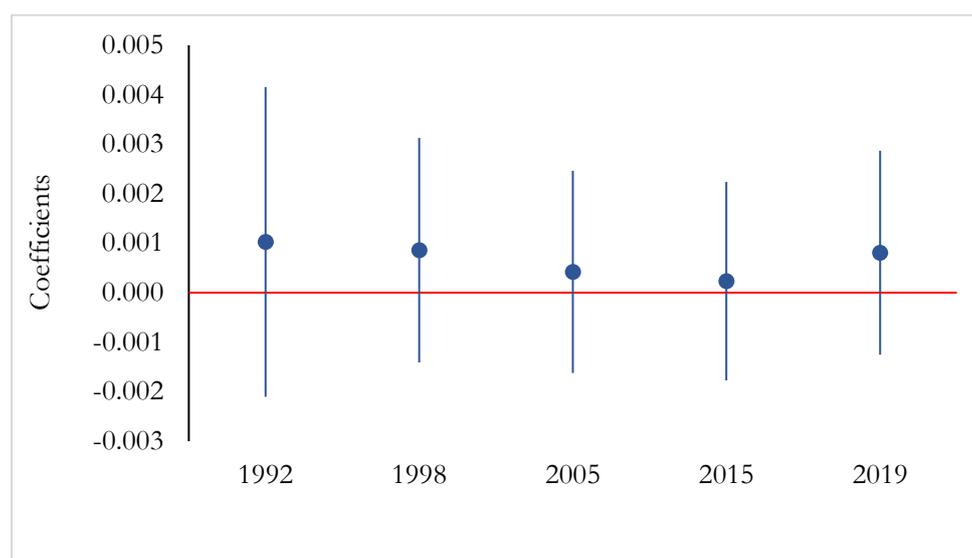
#### 4.4. Robustness Checks

To affirm the main findings of the study, we carried out multiple robustness checks. First, we used per capita public health expenditure (PCPHE) as an alternative indicator for neoliberal policies. The rationale behind the choice of this alternative stems from the fact that austerity in public health spending is considered a key political determinant of health and an indicator of neoliberal policies [26]. The fixed effects model plots depicting the interaction effects of PCPHE and time on health inequality suggest that public health spending consistently has a negative association with health inequality (Figure 8). However, the impact of the PCPHE on reducing health inequality is declining over time. This can be attributed to the stagnant trend in PCPHE, which has been unable to keep at par with the rising out-of-pocket health expenditure.



**Figure 8.** Fixed effects estimates: The effect of the interaction of PCPHE and time on health inequality.

Second, we used the share of private healthcare utilisation as an alternative indicator for neoliberal policies. Random effects model plots that show the interaction effects of the share of private health care utilisation and time on health inequality consistently revealed a positive association with health inequality (Figure 9). Although we observed a slight reduction in health inequalities after the introduction of the National Rural Health Mission in 2005, a reversal in the improvement trend was again witnessed from 2015–2021 with the emergence of a new political regime in 2014, which is pursuing a more aggressive neo-liberal health care policy.



**Figure 9.** Random effects estimates: The effect of interaction of share of private health care expenditure and time on health inequality. Note: Model is controlled for male-female literacy, workforce participation rate, level of urbanization, per capita NSDP and State dummies.

In the third set of robustness checks, we used the poverty ratio as an alternative predictor variable. Neoliberal policies not only increase economic inequality but also slow progress toward a reduction in the poverty ratio. On the other hand, evidence suggests that a reduction in the poverty ratio is associated with a reduction in health inequality [15,42]. To evaluate this hypothesis in the Indian context, we ran a fixed effect regression model by taking the interaction of the poverty ratio and time as a predictor and inequality in the U5MR as the dependent variable (Table 3). Our findings suggest that a positive association exists between the poverty ratio and health inequality, meaning that a decline in the poverty ratio helps reduce health inequality. This suggests that if economic growth is accompanied by poverty reduction, it helps reduce health inequality.

**Table 3.** Fixed effect estimates: Dependent Variable-Inequality in U5MR.

Variables	B-Coefficient
Interaction of Poverty ratio and time	
log of poverty ratio and 1992–93	0.00310 * (0.00248)
log of poverty ratio and 1998–99	0.00360 * (0.00265)
log of poverty ratio and 2005–06	0.00604 ** (0.00267)
log of poverty ratio and 2015–16	0.00654 ** (0.00271)
log of poverty ratio and 2019–20	0.00640 ** (0.00250)
Female literacy rate	✓
Male literacy rate	✓
Work force participation rate	✓
Level of urbanisation	✓
Log of NSDP Per Capita	✓
Constant	0.0506 (0.514)
Observations	75
Number of States	15
R-squared	0.178

Note: Standard errors in parentheses; \*\*  $p < 0.05$ , \*  $p < 0.1$ .

To corroborate this finding, in the fourth set of robustness checks, we regressed the concentration index of under-5 mortality on the governance index for the year 2019, controlling for other socioeconomic variables (Table 4). The negative coefficient of the governance index aligns with the main findings of this paper. It indicates that with an improvement in governance, health inequality decreases. The rationale for including the governance index as an alternate predictor is based on the insight that poverty reduction is necessary for reducing health inequality. Effective governance plays a crucial role both in designing and implementing targeted poverty alleviation and social welfare programmes. Governance can influence health inequalities through several pathways. First, better governance improves the efficiency and transparency of public service delivery, ensuring that health programmes, subsidies, and social protection schemes reach the intended beneficiaries, particularly vulnerable and low-income populations. Second, effective governance strengthens institutional capacity and accountability, which can reduce leakages, corruption, and administrative inefficiencies in the delivery of health and welfare interventions. Third, governance also shapes broader socioeconomic conditions by facilitating investments in public health infrastructure, sanitation, nutrition, and maternal and child health services, which are critical determinants of population health outcomes. In contexts where governance is weak, limited institutional capacity and ineffective programme implementation may disproportionately disadvantage poorer households, thereby widening health disparities. Conversely, stronger governance can enhance the reach and effectiveness of public health and welfare programmes, improve access to essential healthcare services among disadvantaged groups, and ultimately contribute to reducing health inequalities.

**Table 4.** OLS Estimates: Effect of Governance Index on Health Inequality.

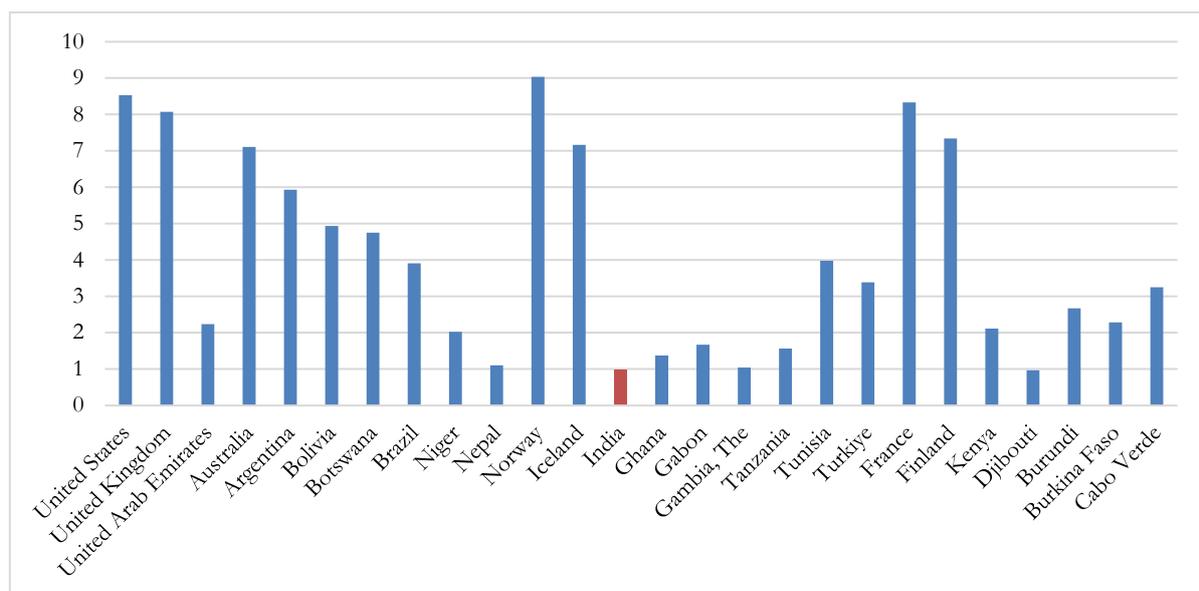
Variables	$\beta$ -Coefficient
Governance Index	-0.0692 * (0.269)
Under 5 Mortality	✓
Poverty Ratio	✓
Level of Urbanisation	✓
Workforce Participation Rate	✓
Literacy Rate	✓
Public Private Ratio	✓
Per Capita NSDP	✓
Constant	-0.714 (0.586)
Observations	15
R-squared	0.801

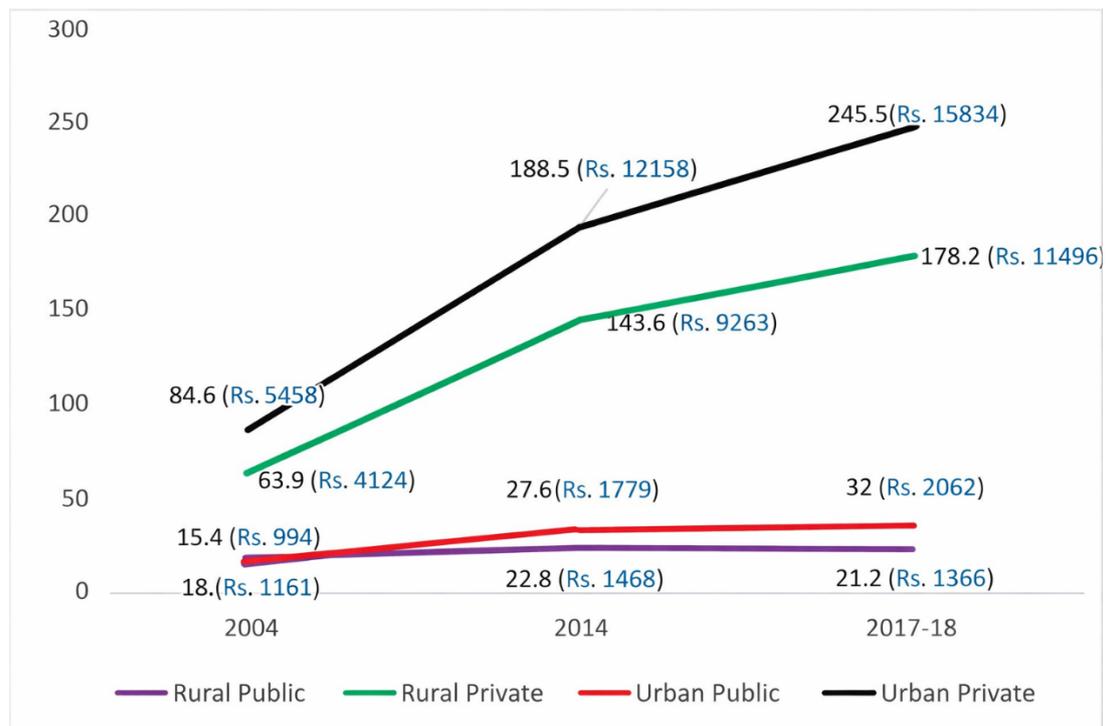
Note: Standard errors in parentheses; \*  $p < 0.1$ ; Since the governance index is not available for all time points, we conducted an OLS regression instead of panel data estimation.

#### 4.5. How can Health Inequalities in the U5MR be Reduced?

Following our empirical analysis, the effect of neoliberalism on increased health inequalities in the U5MR can be clearly distinguished. This causation can be traced through the multiple pathways outlined in the theoretical framework presented in this paper (Figure 3). Therefore, it becomes evident from the theory of the “political economy of health” that alongside economic growth, poverty reduction and public health spending are two critical components (implying austerity and social cohesion domains of neoliberal policies, respectively) for ensuring health for all in highly unequal societies such as India. The Indian healthcare delivery system is highly hierarchical and compartmentalized [5].

The hierarchical nature of the healthcare delivery system in India hinders the accessibility of healthcare, thereby significantly impacting health inequalities. In addition, public health spending has been one of the lowest in the world, even less than many of the poorer economies of Sub-Saharan African countries (Figure 10). Figure 11 reveals the perils of inadequate health expenditure and its effects on health outcomes. Several countries are not spending on public health according to their economic size, thereby experiencing greater levels of U5MR. India serves as an example of this aberration. In this context, any efforts to reduce health inequalities must focus more on poverty alleviation programs and increase health care expenditures.

**Figure 10.** Public Health Expenditure as Percentage of GDP across the select countries, 2019.



**Figure 11.** Trends in mean OOPE (in US\$) by place of residence and the level of care from 2004 to 2017/18 in India. Source: [48]; Note: Data values outside the parenthesis are in US\$, while inside the parenthesis, they are in Indian rupees. OOPE stands for out-of-pocket expenditure.

In particular, if we reduce the U5MR and inequality in the U5MR in India, it is important to reduce the burden of maternity care expenditures on households. Our analyses of three successive rounds of NSSO data (2004, 2014 and 2017/18) suggest that, except at rural public facilities, the average OOPE for institutional delivery has increased significantly in both rural and urban areas even after adjusting to inflation in prices. Figure 11 shows that the increase is the greatest for urban private facilities (US\$ 84.6 in 2004 to US\$ 245.4 in 2017/18, increased by 66%). It also increased in urban public facilities (US\$ 58 in 2004 to US\$ 162 in 2017/18, raised by 64%) and in rural private facilities (US\$ 63.9 in 2004 to US\$ 178 in 2017/18, raised by 64%).

Our analyses assume importance in the context of prevailing political austerity towards funding for public health in general and maternal and child health care in particular in India. To improve equity in child survival, the country needs evidence on mechanisms determining health inequalities for designing policy inputs for schemes running under a recently launched Pradhan Mantri Matru Vandana Yojana (PMMVY), a maternity benefit programme run by the government of India introduced in 2016. The programme is deemed to be an enhanced conditional cash transfer (CCT) scheme for pregnant and lactating women 19 years of age or older for their first live birth. The country introduced the Maternity (Amendment) Bill 2017, an amendment to the Maternity Benefit Act, 1961, which was passed by the Indian parliament in 2017 [49].

Considering these new developments, it is important to report whether incentives provided under the schemes are enough to cover catastrophic payments incurred by the households on institutional deliveries and reduce inequalities in child survival chances in the country. Our study provides two key messages for contemplation under PMMVY to improve MCH care and reduce inequality in U5MR. First, considering the previous evidence on catastrophic expenditures for households due to institutional delivery [50] and the evidence of a decrease in real wages and consumption levels in the country [51], the increase in the OOPE on institutional delivery can become more catastrophic for households and increase inequality in the U5MR. Secondly, there is a need to bolster the central contribution to conditional cash transfers (CCTs) under the JSY programme in low-income states. Evidence suggests that better-performing states such as Tamil Nadu, Andhra Pradesh, Kerala, and Telangana provide CCT benefits that are equivalent to or exceed the average OOPE incurred by households, even in private facilities [48]. Adequate financial incentives can reduce the economic barriers to accessing institutional delivery and maternal health services, particularly for poorer households. By encouraging timely antenatal care, skilled birth attendance, and postnatal care, such support can contribute to improved maternal and neonatal health outcomes, which are critical determinants of child survival. Strengthening financial protection mechanisms in poorer states may therefore help reduce socioeconomic inequalities in access to maternal health services and ultimately contribute to lowering under-five mortality rates. India pledged \$100 billion to reduce maternal and under-five deaths by 2030,

and unfortunately, the budget outlays for health continue to be just more than 1% of the gross domestic product (GDP) [52].

## 5. Conclusions and Wider Implications

Many quantitative studies have demonstrated that more neoliberal countries have poorer health than do less neoliberal countries [53,54], but we find little comprehensive documentation of evidence in the Indian context. By analysing inequality in the Under-Five Mortality Rate (U5MR) as a health outcome and per capita NSPD, per capita public health expenditure, the share of private health care spending and the poverty ratio as indicators of neoliberal policies, using robust econometric assessment, we find that economic growth without poverty reduction and public health care spending increases health inequalities. At the macrolevel, income has a positive relationship with health inequalities. Interpreting the empirical findings of our study in the context of the literature [32,55] shows that income inequality, diminishing social cohesion and political morality and privatisation of health care are the proximate key mechanisms through which neo-liberal policies act on health outcomes and increase health inequalities.

Consequently, the issue of economic development and health outcomes in India must be seen in the larger context of the demands of democracy and social justice. During the last thirty years, the Indian economy has done very well in terms of GDP growth [5]. However, high growth has failed to translate into an equitable distribution of health outcomes. Globally, neoliberal regimes have been promoted widely because of their technical efficiency and wealth creation, whereas social consequences, such as disparate access to prosperity and power, have been widely overlooked [56]. These power asymmetries have had a profound impact on shaping health policies and outcomes at the international, national, and subnational levels [34,57]. The shift from public provision for healthcare to private alternatives in healthcare has created barriers to effective policy measures because of the rise of medical-individualist models of healthcare, strengthening the role of players with material interests over emphasising the achievement of health equity [58].

In India, these normative considerations demonstrate that ill health and social inequalities are not merely matters for public health specialists, demographers and economists to map and measure—they are also of central concern to political theorists to understand why there is an imperative to address them and establish how it would be justified to do so. Crucially, however, the state can also use its power and political action to adopt ideological and policy positions that promulgate ill health and health inequality. Finally, we conclude that integrating the understanding of neoliberalism into theorising about health inequality enriches the political economic and political demographic perspectives of health. Additionally, taking cues from the success of the Latin American Social Medicine Mode [59], India must implement “post neoliberal” social and political-economic policies to counter neoliberal models that emerged in the 1990s and rising health inequalities. Post neoliberal ideologies present alternative avenues for tackling issues related to equity and redistribution. These frameworks prioritise universal welfare programmes, greater public investment in health systems, and stronger regulatory oversight of private healthcare markets. By strengthening redistributive mechanisms and expanding social safety nets for economically and socially disadvantaged groups, post-neoliberal policy orientations may help mitigate structural inequalities that translate into disparities in health outcomes. Two key mechanisms through which such post-neoliberal policies could help reduce health inequalities in India are increased public investment in healthcare systems and the reaffirmation of community-based healthcare models. India’s public health framework envisions a tiered healthcare delivery structure beginning with Primary Health Centres (PHCs) and extending to higher levels of care. However, underinvestment and uneven implementation have limited the effectiveness of this system in many regions. Strengthening these foundational structures through greater public funding and institutional support could help rebuild a robust community-based health system. Ensuring adequate public health facilities at each geographic level supported by an expanded network of community health workers can improve awareness, accessibility, and utilisation of maternal and child health services among disadvantaged populations. Such measures would not only strengthen preventive and primary healthcare but also contribute to reducing inequalities in health outcomes, including disparities in child survival.

Politics and healthcare are intricately connected, although their linkages operate in a conspicuous manner. For many years, these linkages have been overlooked in favour of analysing health outcomes through the socioeconomic lens. However, the socioeconomic profile of a country is determined by its political leanings. These deterministic pathways are outlined in the theoretical framework presented in this paper. Fiscal prioritisation of healthcare can impact the situation in the healthcare system of a nation. As India would do, greater percolation of neoliberalism in the country’s political context has resulted in increased health inequalities for the country, which operate

through various mechanisms. A clear inclination towards austerity can be observed in the government's approach towards the health sector by observing the share of public and private health expenditures (Figures 10 and 11).

Exploring such linkages, this study attempts to explore nuances of India's shift towards neoliberalism and its consequences for the country's health outcomes and inequalities. Our analysis highlights the necessity of good health and healthcare to be viewed as a right for all and not an expensive choice that takes into consideration the income of an individual. When we shed the commodified nature of health, the responsibility for its provision rests on the shoulders of the political forces operating in a country. Political perspectives on health not only touch upon the provisioning of healthcare but also address normative aspects related to ethics, accountability, and political representation in terms of healthcare. More importantly, the political lens of healthcare highlights the notion of shared responsibility that forms the essence of a well-functioning political setup. This paper contributes to health policy and planning by identifying areas where India needs to work to achieve efficiency with equity in health status.

### Supplementary Materials

The additional data and information can be downloaded at: <https://media.sciltp.com/articles/others/2603191023344274/GSSD-26010085-SI.pdf>. Figure S1: Testing the hypothesis of 1991 as a Structural break in economic growth for India. Note: Wald test for a structural break: Known break date. Sample: 1960 thru 2023. Break date: 1991.  $H_0$ : No structural break. Number of observations: 64.  $\chi^2(1)$ : 8.2504. Prob >  $\chi^2$ : 0.0041. Figure S2. Correlation between per capita GDP and Per capita FDI in 2021 (in USD). Table S1: Definition of the variables.

### Author Contributions

S.G. developed the concept of the study. S.B. acquired and managed the data. S.G. and S.B. analyzed the data. S.G., S.S. and S.B. drafted the manuscript. S.G., S.S. and S.B. critically revised the manuscript. All authors have read and agreed to the published version of the manuscript.

### Institutional Review Board Statement

The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008. The study used a secondary source of data available in the public domain. Thus, it does not require obtaining separate written or verbal consent from all the subjects.

### Informed Consent Statement

Not applicable.

### Data Availability Statement

The data are publicly available at the DHS Program: <https://dhsprogram.com/Data/>.

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### Conflicts of Interest

The authors declare no conflict of interest.

### Use of AI and AI-Assisted Technologies

No AI tools were utilized for this paper.

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