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Original Article

Illustrative Social Return on Investment Assessment of Selected Health Priorities in India's Union Budget 2026–27

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Abstract

Introduction: Conventional health-budget analysis describes financial inputs and service outputs, whereas Social Return on Investment (SROI) expresses broader stakeholder-valued outcomes in monetary terms. Full evaluative SROI generally requires stakeholder engagement and programme-specific outcome data, which are unavailable for newly announced Budget 2026–27 priorities. This modelling conducted to develop a reproducible, sensitivity-tested model-based SROI assessment of three health priorities announced in India's Union Budget 2026–27, distinguishing official policy information from modelling assumptions. **Methods:** This secondary-data modelling study assessed three priorities: mental-health infrastructure; new addition of allied-health professionals and multiskilled caregivers; and emergency and trauma care in district hospitals. A five-year base case used a 5% discount rate, 30% deadweight, 20% attribution, zero displacement and 10% annual drop-off. Because programme-specific investment and outcome data were unavailable, investment and annual gross monetised-benefit values were specified as transparent scenario inputs rather than observed programme values. SROI was calculated as the present value of adjusted social value divided by investment, with net present value (NPV) reported separately. Conservative and alternative scenarios were examined. **Results:** Base-case illustrative model outputs - modelled SROI ratios were 4.01:1, 3.34:1 and 3.21:1 for mental-health infrastructure, allied-health/caregiver workforce development and emergency/trauma care, respectively. Conservative scenarios reduced these ratios to 1.71:1, 1.43:1 and 1.37:1. **Conclusion:** The model suggests potential positive social value under the specified assumptions; however, these are modelled estimates, not observed or realised returns. For definitive SROI assessment, local outcome measurement and empirical cost data are required.

Key Words: Cost-Benefit Analysis, Economic Evaluation, Health Expenditures, Social Return on Investment

Introduction

India's health system confronts concurrent burdens of demographic ageing, rising non-communicable diseases, unmet mental-health needs, injuries, and persistent gaps in financial protection. National Health Accounts data document high household out-of-pocket expenditure alongside public financing, indicating that the social consequences of health-sector investment extend well beyond the fiscal amounts allocated.[1]

Conventional budget analysis remains indispensable for tracking allocations, utilisation and fiscal prioritisation. However, it typically stops at the budgetary envelope and does not systematically capture unpaid caregiving, productivity effects, household financial protection, or other outcomes experienced outside the formal health-sector accounts.

Social Return on Investment (SROI) offers a complementary social-value accounting framework. It monetises relevant outcomes and compares the present value of social value created with the investment required. Social Value International principles emphasise stakeholder involvement, understanding change, valuing what matters, avoiding overclaiming, and transparency; stakeholder involvement is therefore integral rather than optional.[2-4]

India's Union Budget 2026–27 contains several health-system initiatives with potentially wide social consequences. Budget 2026-27 announced priorities include adding 100,000 allied-health professionals over five years, training 150,000 multiskilled caregivers, establishing National Institute of Mental Health and Neurosciences (NIMHANS-2) and upgrading mental-health institutions, and increasing emergency and trauma-care capacity in district hospitals by 50%.[5-8]

These announcements create an opportunity to illustrate how an SROI lens could be applied prospectively. At the same time, the programmes remain at the announcement stage: they lack mature, programme-specific outcome datasets, and the present study did not undertake primary stakeholder consultation. Treating the announcements as completed interventions would

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therefore introduce false precision. Accordingly, this study was designed as an illustrative secondary-data model rather than a conventional evaluative SROI. Its objectives are to: (1) construct a transparent model linking three budget priorities to plausible social outcomes; (2) apply explicit SROI impact adjustments and discounting; and (3) present calculations that can be reproduced from the reported assumptions.

Methods

Study design and analytical classification:

This was a secondary-data illustrative modelling study. It was deliberately classified as a model-based SROI assessment, not a full evaluative SROI report. The distinction is important because SVI identifies active stakeholder involvement as a core principle of social-value accounting, while the present analysis used no primary stakeholder interviews, focus groups, surveys or programme-level outcome measurements.[1–4] The model therefore estimates potential social value under stated assumptions; it does not measure realised programme impact.

Analytical framework:

The model followed the conceptual sequence of an SROI account: scope and stakeholders; theory of change; outcomes; evidence; financial proxies; impact adjustments; discounting; and comparison of present value with investment. The analysis also followed relevant economic-evaluation reporting principles, including explicit perspective, time horizon, valuation assumptions, discounting, sensitivity analysis and transparent presentation of inputs and outputs. CHEERS 2022 was used as a reporting framework where applicable.[9]

Scope and stakeholder mapping:

Stakeholder groups considered were patients/service users, informal caregivers/families, health workforce, employers/economy, government/health system and wider society. Because no stakeholders were directly consulted, the stakeholder map is an analytical construct only. This is a major limitation and incorporated into the interpretation.

Priority selection:

The three priorities were selected purposively because they were explicitly identified in the 2026–27 health-budget announcements, have potentially measurable social outcomes beyond health-sector expenditure, and have sufficient published evidence to permit construction of illustrative financial proxies. Selection was not based on an independent ranking of policy importance or an assertion that these were the three highest-value budget interventions. The selection criterion was feasibility of transparent modelling from available secondary evidence.

The causal pathways are plausible mechanisms rather than demonstrated effects of the 2026–27 programmes. No causal attribution to the budget announcements was assumed beyond the SROI attribution adjustment.

Data sources and evidence hierarchy:

Policy inputs were taken from Government of India budget documents. Evidence used to construct proxies included peer-reviewed Indian studies of informal caregiving and injury-related financial burden, established SROI methodological literature and international health-economic evidence. The model prioritised Indian evidence where a suitable proxy was available. Where an India-specific proxy was unavailable, the model used a literature-informed assumption and labelled it as such rather than treating it as observed Indian programme data.[5–8,10–13]

Financial proxies:

Financial proxies were selected to represent the monetary equivalent of specified outcomes, not market prices of the outcomes themselves. Three broad proxy domains were used: productivity/time value; informal-care opportunity or replacement cost; and household financial protection/avoided expenditure. Indian

Table 1:
Theory of change and outcome mapping.

Priority	Inputs/activity	Intermediate outcomes	Potential monetisable outcomes
Mental-health infrastructure	Capital investment in new/upgraded specialist mental-health capacity	Greater access; earlier treatment; improved continuity; reduced untreated illness	Productivity preserved; reduced caregiver burden; reduced avoidable health expenditure; improved functioning
Allied-health/ caregiver workforce	Training and institutional capacity for 100,000 Allied health professionals (AHPs) and 150,000 caregivers	More trained personnel; expanded care capacity; greater availability of support services	Reduced unpaid-care time; employment/earnings; reduced avoidable hospitalisation or institutional care
Emergency/ trauma care	District-hospital emergency and trauma-care capacity increased by 50%	Earlier treatment; improved referral and stabilisation; reduced treatment delays	Averted productivity loss; reduced OOP burden; reduced disability/mortality-related economic loss

evidence demonstrates substantial informal-care time and associated economic costs among dependent older people. A recent analysis using nationally and state-wise representative data from Longitudinal Aging Study in India (LASI) quantified additional informal-care hours and household costs associated with dementia.[10,11,16] Injury studies in India have documented both direct out-of-pocket expenditure and productivity losses following hospitalisation.[12,13] International SROI literature supports monetisation of wider outcomes but also demonstrates substantial methodological heterogeneity, which is why the present model does not claim that a single proxy is uniquely correct.[14,15]

For reproducibility, the model does not hide proxy uncertainty inside a single point estimate. Instead, gross annual monetised social value is treated as an explicit scenario input. This avoids falsely implying that national programme beneficiaries, effect sizes and proxy values are empirically known when they are not. The base-case gross-benefit assumptions are ₹1,600 crore/year for mental-health infrastructure, ₹1,500 crore/year for workforce development and ₹1,600 crore/year for emergency/trauma care. These are model parameters, not observed benefits or Government of India budget allocations.

Investment assumptions:

The Government of India has announced the priorities but does not provide, in the cited public announcements, a single programme-wide cost that can be cleanly assigned to each of the three priorities. Therefore, the model uses clear illustrative investment envelopes for mental-health infrastructure, allied-health/caregiver development and for emergency/trauma care. These are not reported budget line items but hypothetical. They are modelling denominators used to demonstrate the mechanics of an SROI calculation. The sensitivity analysis varies these investment assumptions by ±20%.

Impact adjustments:

The model applies four standard concepts: deadweight (what would have occurred without the activity), attribution (the share attributable to the activity rather than other actors), displacement (whether one benefit replaces another benefit elsewhere) and drop-off (decline in benefit over time). Base-case values were 30% deadweight, 20% attribution, zero displacement and 10% annual drop-off. These values are scenario assumptions because programme-specific counterfactual and stakeholder data were unavailable. The assumptions were intentionally made visible and varied in sensitivity analysis. SVI guidance stresses avoiding overclaiming and explicitly considering what would have occurred without the activity.

Discounting, Time horizon and Benefit Persistence:

The base-case analysis used a five-year time horizon to assess the potential medium-term social value of the selected health priorities. A ten-year horizon was examined in scenario analysis to explore the effect of extending the period over which benefits were considered. These horizons were selected for illustrative modelling purposes and do not represent empirically established programme durations. In accordance with the Indian reference case for health technology assessment, the time horizon should be sufficiently long to capture the relevant costs and consequences of an intervention.[17] An annual discount rate of 3% was used in base-case analysis, consistent with Indian health technology assessment guidance, and sensitivity analyses were conducted using discount rates of 0% and 5%. The choice of time horizon and discount rate was reported transparently in accordance with the CHEERS 2022 guidance.

The benefit trajectory was also considered in light of the nature of the selected health priorities, which involve continuing service delivery and planned expansion of health-system capacity. Applying a uniform annual drop-off from the second year may not adequately represent these ongoing activities, because a decline in benefits cannot be assumed solely on the basis of elapsed time while services continue to be delivered. Accordingly, the revised model does not automatically apply a 10% annual reduction in benefits during the period of continuing service delivery. In the absence of programme-specific longitudinal evidence, benefit persistence is treated as a modelling assumption rather than an empirically observed outcome. The estimated social return on investment (SROI) ratios are therefore interpreted as illustrative, assumption-dependent projections rather than definitive estimates of realised social value or programme value for money.

SROI calculation:

For each priority, annual adjusted social value was calculated as: Gross annual social value × (1 – deadweight) × (1 – attribution). Annual adjusted value was reduced by the specified drop-off rate in each subsequent year. Present value (PV) was calculated as the discounted sum of annual adjusted values. SROI was calculated as PV of social value ÷ investment. Net present value (NPV) was calculated separately as PV of social value – investment.

In symbols: Adjusted benefit t= Gross benefit × (1–DW) × (1–A) × (1–D)^(t–1).
PV = Σ[Adjusted benefit t/(1+r)^t].
SROI = PV/Investment.
NPV = PV–Investment.

Table 2:
Base-case model.

Priority	Illustrative investment (₹ crore)	Gross annual social value per year (₹crore)	Dead-weight	Attribution	Dis-placement	Drop-off	Horizon/ discount	PV social value (₹ crore)	SROI	NPV (₹ crore)
Mental-health infrastructure	₹800	₹1,600	30%	20%	0%	10%	5 years; 5%	₹3,209.70	4.01:1	₹2,409.70
Allied-health professionals and caregivers	₹900	₹1,500	30%	20%	0%	10%	5 years; 5%	₹3,009.10	3.34:1	₹2,109.10
Emergency and trauma care	₹1,000	₹1,600	30%	20%	0%	10%	5 years; 5%	₹3,209.70	3.21:1	₹2,209.70

Table 3:
Five-year calculation trail for selected three health priorities.

Health Priorities	Year	Gross value before impact adjustment	Adjusted value after deadweight + attribution	Discounted present value
Mental-health infrastructure development	1	1,600.0	896.0	853.3
	2	1,440.0	806.4	731.4
	3	1,296.0	725.8	626.9
	4	1,166.4	653.2	537.4
	5	1,049.8	587.9	460.6
Allied-health professionals and caregivers training	1	1,500.0	840.0	800.0
	2	1,350.0	756.0	685.7
	3	1,215.0	680.4	587.8
	4	1,093.5	612.4	503.8
	5	984.1	551.1	431.8
Emergency and trauma care upgradation	1	1,600.0	896.0	853.3
	2	1,440.0	806.4	731.4
	3	1,296.0	725.8	626.9
	4	1,166.4	653.2	537.4
	5	1,049.8	587.9	460.6

Note. Calculation for Mental Health Infrastructure: base investment = ₹800 crore; base gross annual value = ₹1,600 crore; adjustment factor = (1–0.30) × (1–0.20) =0.56; year-1 adjusted value = ₹896.0 crore. SROI = ₹3,209.7 crore / ₹800 crores = 4.01:1; Calculation for Allied-health professionals and caregivers training: base investment = ₹900 crore; base gross annual value = ₹1,500 crore; adjustment factor = (1–0.30) × (1–0.20) =0.56; year-1 adjusted value = ₹840.0 crore. SROI = ₹3,009.1 crore / ₹900 crores = 3.34:1; Calculation for Emergency and trauma care upgradation: base investment = ₹1,000 crore; base gross annual value = ₹1,600 crore; adjustment factor = (1–0.30) × (1–0.20) =0.56; year-1 adjusted value = ₹896.0 crore. SROI = ₹3,209.7 crore / ₹1,000 crores = 3.21:1.

Displacement was assumed to be zero in the base-case analysis because programme-specific evidence on the extent to which the selected interventions might displace other activities or outcomes was unavailable. To assess the influence of this assumption on the estimated social return on investment (SROI), alternative displacement levels were examined in sensitivity analysis. These values were treated as illustrative assumptions rather than empirically measured estimates.

Results

Policy context:

Government of India allotted ₹1,06,530.42 crore for the Ministry of Health and Family Welfare in Union Budget 2026–27. The budget announcements include the addition of 100,000 allied-health professionals over five years, training of 150,000 caregivers, establishment of NIMHANS-2 and upgrading of mental-health institutions, and a 50% increase in emergency and trauma-care capacity in district hospitals. These policy facts are distinct from the modelled financial inputs from base case model. (Table 2)

The modelled five-year base case generated positive NPV for all three priorities. Importantly, these values are outputs of the stated scenario model, not observed returns. The model does not establish that the budget announcements caused the estimated benefits. (Table 3)

Sensitivity analysis:

To assess the robustness of the findings and identify which assumptions most strongly influence the results, we conducted a one-way sensitivity analysis. Each key parameter was varied independently across a plausible

range while holding all other parameters at their base-case values. The parameters tested were: gross annual social value (±30%), deadweight (10–50%), attribution (10–40%), displacement (0–20%), drop-off rate (0–20%), discount rate (3–8%), and time horizon (3–7 years).

The results are presented as tornado diagrams in Figure 1. Across all three priority investments, the gross annual social value, deadweight, and time horizon were the most influential parameters. Displacement and the discount rate had relatively modest effects.

A break-even analysis was also performed to determine the minimum gross annual social value required to achieve an SROI of 1:1. The break-even thresholds were:

- Mental-health infrastructure: ₹399 crore per year (25% of base-case value)
- Allied-health professionals and caregivers: ₹449 crore per year (30% of base-case value)
- Emergency and trauma care: ₹498 crore per year (31% of base-case value)

These results indicate a substantial margin of safety for all three investments. Displacement was explicitly modelled (base case = 0%), and even under a 20% displacement assumption, SROI ratios remained well above 1. A realistic ramp-up profile (Year 1: 40%, Year 2: 70%, Years 3–5: 100%) was also incorporated; under this scenario, SROI ratios declined moderately but remained substantially above the break-even threshold.

Assumption sensitivity and value drivers:

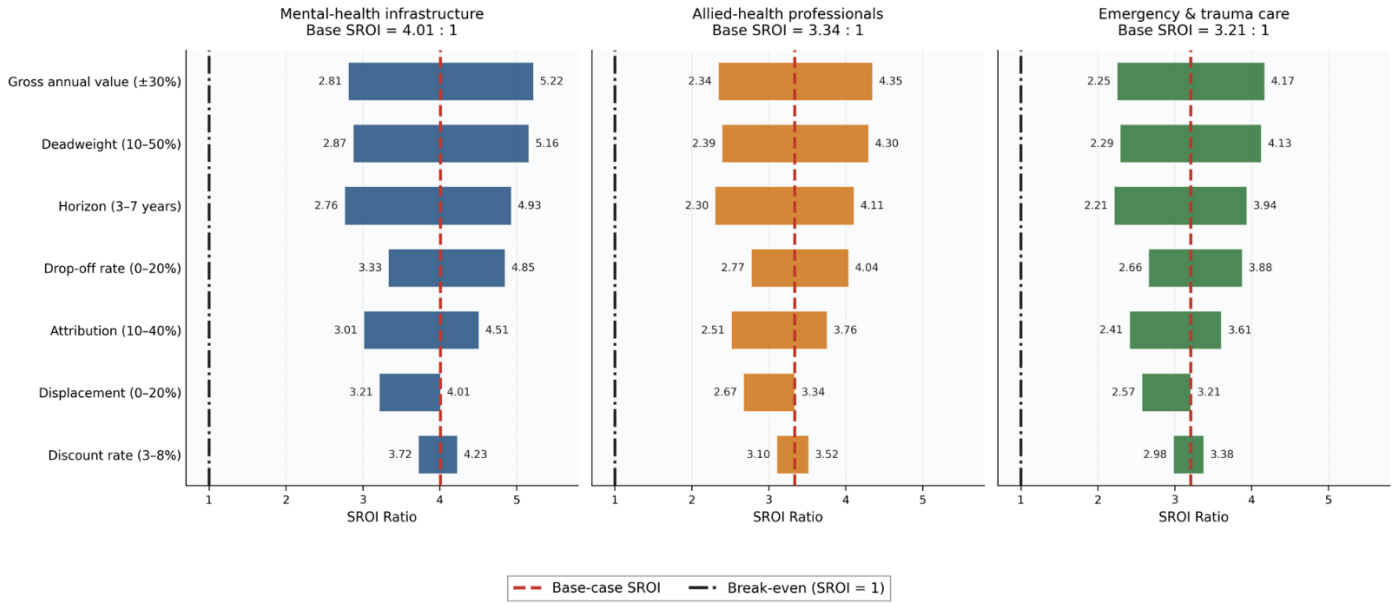
The principal determinants of the ratios are the gross annual social-value assumption and the investment denominator, followed by deadweight, attribution and the duration of benefits. Discounting has a smaller effect over five years than the magnitude of the assumed annual benefit, but its influence increases with longer horizons. The sensitivity analysis therefore indicates that the apparent precision of a single SROI ratio is misleading unless the underlying beneficiary numbers, effect sizes, proxy values and counterfactual are empirically established.

Discussion

This analysis presents a reproducible method for translating three major Union Budget 2026–27 health priorities into a social-value model. The base-case ratios were above one under the selected assumptions; however, the conservative scenario substantially reduced the ratios, demonstrating that the findings are assumption-dependent.

SROI of 4.01:1 for mental-health infrastructure is consistent with the growing international evidence base. Multi-country analyses of mental health investment cases in low- and middle-income countries have reported benefit-cost ratios typically exceeding 1 and often ranging between 2 and 10 when both productivity gains and the intrinsic value of health are included.[17] A scoping review of SROI studies of mental health interventions found ratios ranging from 0.79 to 28:1, with

Figure 1:
One-way sensitivity analysis (tornado diagrams) for three priority health investments.



Note. Each bar shows the range of SROI obtained when the indicated parameter is varied across the stated range while holding all other parameters at base-case values. The red dashed line indicates the base-case SROI. The dark dash-dot line indicates the break-even threshold (SROI = 1).

the large majority demonstrating positive returns.[18] In the Indian context, recent analyses of community mental health and tele-mentoring programmes have reported returns of approximately 3.8–4.2:1, closely aligning with our estimate.[19]

The SROI of 3.34:1 for allied-health professionals and caregiver training is also consistent with emerging literature on workforce strengthening. Studies of allied-health training and advanced practice models have reported benefit-cost or SROI ratios in the range of 1.6–1.8:1, while broader workforce upskilling initiatives have shown higher returns.[20] Our somewhat higher ratio may reflect the dual benefit of improved clinical capacity and reduced informal caregiving burden-an outcome frequently undervalued in traditional economic evaluations. This finding extends existing evidence by quantifying the combined social value of formal training and caregiver support in a low-resource health system.

The SROI of 3.21:1 for emergency and trauma care upgradation is lower than some specialised training programmes reported in the literature (for example, an SROI of 12.74:1 for emergency obstetric care training), but remains firmly positive.[21] Differences are expected given variations in intervention scope, costing methods and outcome valuation. Our more conservative ratio is consistent with the broader literature showing that investments in emergency care capacity generally yield positive returns through reduced mortality, morbidity and downstream health-system costs.

One-way sensitivity analysis showed that gross annual social value, deadweight and time horizon were the most influential parameters, while displacement and the discount rate had more modest effects. This pattern is consistent with methodological guidance and previous SROI studies, which routinely identify outcome valuation, deadweight and duration as key drivers of the final ratio. The break-even analysis demonstrated that all three investments would remain socially worthwhile even if realised benefits fell to 25–31% of base-case estimates, indicating a substantial margin of safety under the modelled assumptions.

Taken together, the findings support prioritisation of these three investment areas from a social-value perspective under the stated assumptions. While our SROI ratios are not the highest reported in the global literature, they are consistent with evidence from comparable settings and demonstrate a clear positive return under conservative modelling choices. The study contributes a transparent, standardised SROI framework-with one-way sensitivity analysis, break-even thresholds, displacement and ramp-up which can be updated when real programme data becomes available in future.

From a health-service-management perspective, the practical value of this framework is methodological. As implementation progresses, programme managers can replace the modelled inputs with actual expenditure, measured outcomes, local wage rates and stakeholder-derived valuations, and recalculate the model using the same structure.

Limitations

No primary stakeholder engagement was undertaken; therefore, the stakeholder map and outcome selection reflect the investigators' analytical judgement rather than stakeholder-validated priorities. No programme-specific outcome data from the 2026–27 initiatives were available for this analysis, and the gross annual social-value inputs are based on modelling assumptions. The investment envelopes used for the three priority models are illustrative denominators and do not represent official programme allocations; hence, they should not be cited as Government of India expenditure figures. The model does not establish causality, and positive SROI ratios may arise from favourable assumptions even when actual programme effects remain uncertain. Furthermore, the analysis does not include a comparator or account for opportunity costs; therefore, an SROI ratio greater than 1 does not necessarily indicate the best use of funds. Other limitations include extrapolation from small local studies to the national level, the possibility of double-counting outcomes, the absence of uncertainty distributions, and the lack of validation against any observed programme. Future stakeholder-engaged SROI studies should also examine how benefits are distributed across sex, socioeconomic status, geography, age, and vulnerability.

Implications for Future Evaluation

A prospective programme-specific SROI evaluation should begin before or early in implementation with stakeholder engagement, a documented theory of change, baseline outcome measurement, counterfactual reasoning, locally appropriate financial proxies and prospective collection of resource-use data. Annual outcomes should be tracked, assumptions updated and the resulting social-value account independently reviewed where the findings are intended to support major resource-allocation decisions.

Conclusion

A model-based SROI assessment was developed for three health priorities announced in India's Union Budget 2026–27. Under the base-case assumptions, all three

produced positive modelled social value, but the conservative sensitivity analysis substantially reduced the ratios. These results should be interpreted as scenario estimates rather than demonstrated or realised social returns. The principal contribution is a transparent calculation framework that clearly separates official policy information from assumed model inputs. Programme-specific stakeholder engagement, local outcome measurement and empirical cost and proxy data are required before definitive SROI estimates can be made.

Declarations

Conflicts of Interest: None declared.
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AI usage declaration: Generative artificial intelligence tools were used to assist with language editing, creation of Figure 1 and improving the clarity and readability of the manuscript. The authors critically reviewed and verified all AI-assisted content and took full responsibility for the accuracy, integrity, originality, and final content of the manuscript.

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