The Hoover Institution's

Annual Survey of India 2026

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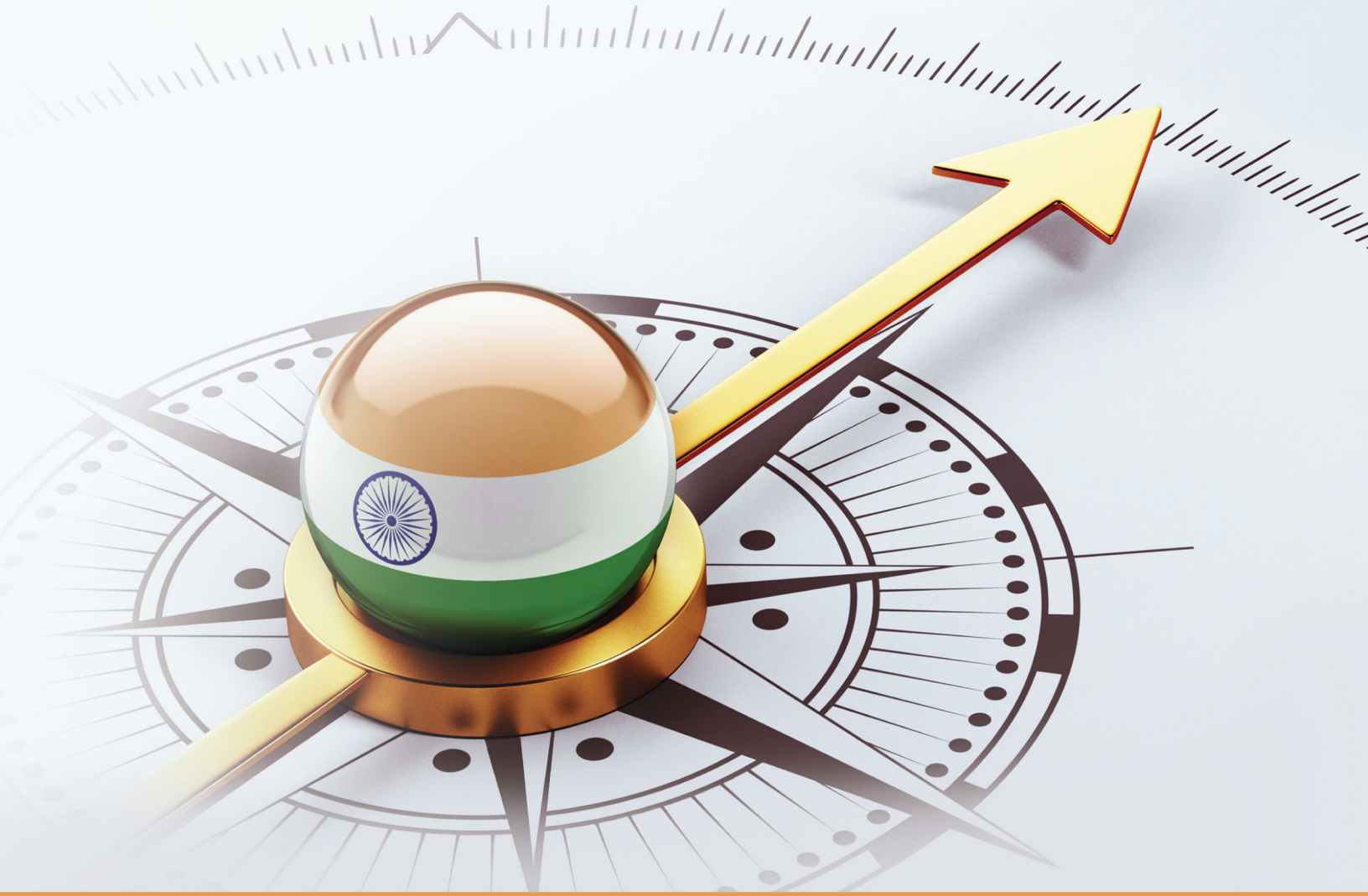

Huntington Program on Strengthening US-India Relations

6. India's March to Universal Health Coverage

Azad Singh Bali

India has a poor track record on conventional health policy indicators, lagging behind other countries at similar levels of economic development. This poor healthcare performance has not posed a political problem for successive governments, allowing them to neglect the sector. Recently, however, healthcare and, more broadly, social policy have become prominent in the national political discourse. An ambitious reform—the Pradhan Mantri Jan Arogya Yojana (PMJAY) program—implemented in 2019 aims to provide healthcare coverage to about 550 million Indians. It is already the world's largest single-payer program and offers hope that it will strengthen India's march toward realizing universal healthcare coverage. The increased attention to the sector has started to pay dividends with improvements in key health indicators, including in infant and maternal mortality rates over the past decade, as well as in stemming the tide of high out-of-pocket (OOP) payments for healthcare bills.[1] This chapter provides an overview of recent trends in India's healthcare system, traces the evolution of health policy and its disparate programs, and examines gradual efforts to achieve universal healthcare. Key challenges and constraints in improving the health system are outlined, and the concluding discussion canvasses recommendations to further strengthen healthcare in the country.

POLICY HISTORY

India's early health policy documents provided for healthcare through a network of primary healthcare centers (PHCs), secondary care through community healthcare centers (CHCs) across the country, and advanced treatment at specialized hospitals in large cities. These centers, poorly resourced and run, often lacked essential medical supplies and equipment and were thus avoided by patients other than those without other options.[2] Despite concerted efforts to staff these health centers, chronic shortages continue. A recent review of healthcare infrastructure noted a shortfall of about 36 percent in the number of PHCs required for the catchment area and a 50 percent shortfall in specialists relative to manpower requirements in urban areas.[3]

For most people seeking affordable healthcare services, district and specialty hospitals in urban areas were the only option. Unable to keep pace with the growing demand, most public hospitals could only provide inadequate and low-quality services. This gap was filled by private healthcare providers, which have since continued to flourish.

The 1950s saw the expansion of new programs for those employed by the government and those

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working in the formal sector, offering a comprehensive range of medical services to members and their dependents either at their own hospitals or at recognized private hospitals. Despite the formal sector accounting for a small share of the population, expenditures for these programs gradually increased to as high as 10 percent of total government expenditure on healthcare.[4] The government also established the Employees State Insurance Scheme (ESIS) for those employed in the formal private sector and their dependents.

The Alma Ata declaration in 1978, in which governments agreed to improve access to healthcare as a basic right and strengthen primary health services, refocused the attention of many developing countries on healthcare. In India it resulted in a national health plan in 1983 with ambitious health targets but offered few details on how it intended to achieve them in India's complex federal structure.

The macroeconomic crisis that India faced in 1991–92 resulted in reductions in health budgets. The scaling back of public spending on healthcare, coupled with a weak regulatory framework, fueled the growth of private healthcare providers. Public spending on healthcare (as a share of GDP) declined from 1.4 percent in the mid-1980s to 0.9 percent by 2001.[5]

A new national health policy was announced in 2002, explicitly inviting the private sector into healthcare. The policy change fueled the devolution of responsibility for healthcare, coupled with mushrooming private providers. The marriage of privatization and decentralization in the sector was not unique to India but mirrored reforms underway in many other developing countries. In India, this combination resulted in increased fragmentation of the health system.

Faced with stark inequities across the healthcare system, a newly elected Congress-led government in 2005 launched the National Rural Health Mission (NRHM) and later the National Health Mission (NHM), aimed at strengthening primary care with a special emphasis on maternal and child health. The central government subsidized the program on a matching basis, and state governments were responsible for delivering the NRHM programs. Studies have found that many states were simply unable to spend expanded resources, and even within states, the better-off districts were able to claim more funds, thus widening existing disparities.[6] Furthermore, given the increased central support, several astute state governments scaled back their own spending on the sector.[7] The mission laid the foundation for strengthening maternal and infant health but did little to reduce OOP expenditures on health, which started to have pernicious effects on the financial health of those in the informal sector.[8]

It was evident that India's existing network of public hospitals and health centers were unable to cope with the sheer demand. Rather than shoring up existing infrastructure, a new program called the Rashtriya Swasthya Bima Yojana (RSBY) was launched in 2008 allowing the informal poor to receive care at empaneled (or registered) private or public providers. The scheme provided free inpatient services, up to a maximum of INR 30,000 (US$330 in 2025) per year per family. The program was popular and gradually expanded to cover forty-one million families. The program faced many implementation challenges, including healthcare providers misusing the program.[9] At the end of the day, its benefit levels were too low to reduce OOP spending on healthcare.[10]

Following the realization of the RSBY's deficiencies, in 2010 the government established the High-Level Expert Group (HLEG), who recommended several reforms including universal access to essential services, increased stewardship under the central government's direction and scaling up public spending from 1.2 percent in 2011 to 3.0 percent of GDP by 2022. Similar to other health policy promises, little was done to realize the recommendations of the HLEG.

A new government was elected in 2014 but did little to address the inherent challenges within RSBY's program design. However, several other reforms were introduced that aimed at improving health outcomes by investing in environmental and social determinants of health. This included India's flagship sanitation program (Swachh Bharat) focused on rural and urban sanitation and other programs (Ujjwala) to provide subsidized cooking stoves and fuel to poor families, reducing reliance on the wood-fire stoves identified as a source of pulmonary disease in rural India.[11]

In 2018, a year before the general (national) elections, the national government announced Ayushman Bharath, later renamed the PMJAY. The program subsumes the RSBY, is paid for by central and state governments, and is implemented by state governments. Similar to the RSBY, the program covers hospitalization and tertiary care at recognized hospitals across India up to INR 500,000 or US$5,500 in 2025.

After decades of policy neglect, the PMJAY represents the largest expansion of government involvement in what is a deeply fragmented and fractured health system: a public health system that primarily serves the rural poor and offers essential primary care services juxtaposed with a largely unregulated private sector that dominates secondary and tertiary curative care markets. The reform aims to realise the vision laid out in the National Health Policy 2017—that calls for expanding public spending on healthcare and engaging the private sector more effectively to reduce the fragmentation in India's healthcare system.

HEALTH SYSTEM PERFORMANCE

The World Health Organization (WHO) ranking of health systems in 2000 placed India at 112 out of 192 countries.[12] Its relative position did not improve in the 2018 Global Health Access and Quality Index, which placed India at 145 out of 195 countries in terms of quality and accessibility. This performance has been attributed to poor progress on conventional healthcare indicators and to the fact that individuals have borne the brunt of most healthcare expenditure themselves.

HEALTHCARE INDICATORS

On conventional health-related indicators, India falls behind other economies at similar levels of economic development, particularly those in Southeast Asia, though it is similar to the global average for low-middle-income countries. The National Health Policy 2017 and the NHM have set targets in health outcomes to be achieved by 2026. These include reducing maternal, infant, and neonatal mortality as well as communicable and noncommunicable diseases.

The recent reduction in the maternal mortality ratio (MMR) is a significant accomplishment in India's health system. India's MMR declined from an estimated 570 maternal deaths per 100,000 live births in 1990 to 97 per 100,000 live births as of the 2023 update, slightly shy of the target set out in the NHM of 87 by 2026.[13] India's reduction of MMR (an 86 percent decline over the past thirty-three years) surpasses the global average reduction rate (a 48 percent decline) during the same period, positioning India to achieve the Sustainable Development Goals (SDG) targets of an MMR below 70 by 2030.[14] These headline numbers, however, mask wide variations across states, with some achieving SDG targets already—Kerala (19), Maharashtra (38), and Tamil Nadu (49)—while others fall far below the national average. Moreover, some states, including Haryana, West Bengal, and Punjab, have experienced a slight increase in MMR, reiterating the importance of sustained efforts across multiple fronts to cement these gains. Programs such as the Janani Suraksha Yojana—a conditional cash transfer program to incentivize mothers to give birth in a health facility—rolled out as part of the NHM in

2005, have had a significant effect on antenatal care and reducing neonatal mortality.[15] Current policy efforts to improve MMR include a wide range of targeted health interventions, including expanding the conditional cash transfers to expectant mothers, incentivizing giving birth at health centers and hospitals, providing prenatal and antenatal care, and offering sustained monitoring under the NHM.[16]

Similar progress has been recorded in the under-five mortality rate (U5MR), which declined from 45 per 1,000 live births in 2014 to 31 per 1,000 live births in 2021. Twelve states/Union Territories, including Kerala (8), Delhi (14), and Tamil Nadu (14), have already achieved the SDG target for U5MR (fewer than 25 deaths per 1,000 live births by 2030). These gains, too, mask wide variations in performance across states, which stem from different levels of economic development, state capacity, and demographic profiles. For example, the gains in MMR and U5MR are heavily skewed toward high-performing states, primarily in the South. The performance of many of the eastern and northeastern states, such as Odisha, Assam, and the populous Uttar Pradesh, is poor.

Data published in June 2025 using the Sample Registration System documents significant improvements in the infant mortality rate (IMR), declining by about a third to 18 per 1,000 live births in urban areas and to 29 in rural areas between 2013 and 2022. We continue to see differences in IMR trends across rural India: Kerala (9), Sikkim (5), and Tamil Nadu (11) at one extreme and Madhya Pradesh (43) and Uttar Pradesh (41) at the other.

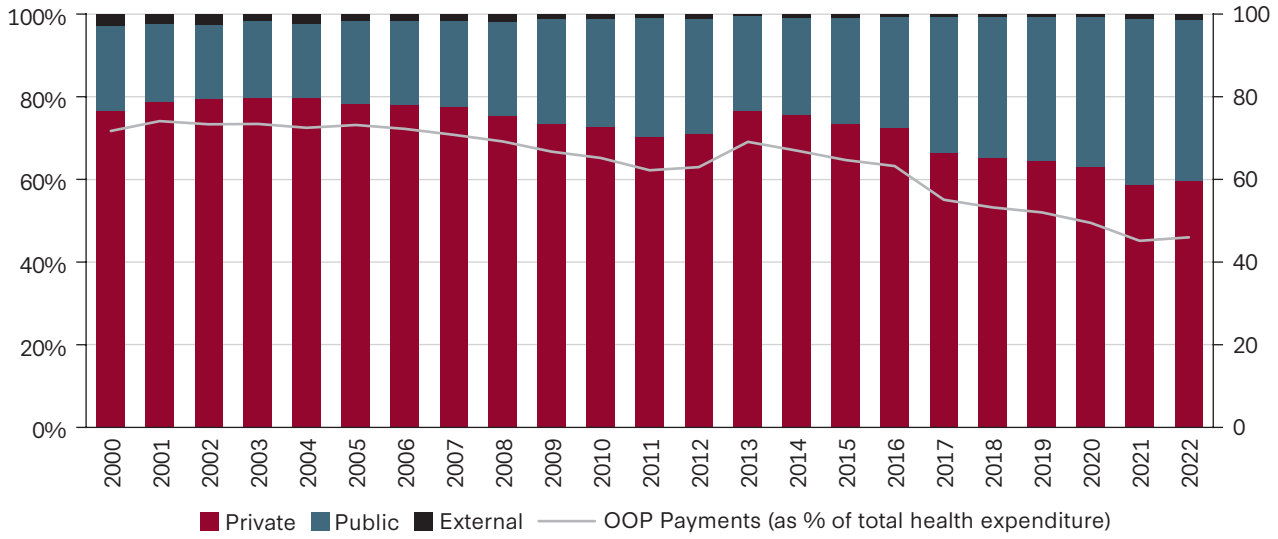
Another concern in India's health system relates to the spread of what are described as noncommunicable diseases (NCDs). An Indian Council of Medical Research study highlighted that cardiovascular diseases, cancers, chronic respiratory diseases, and diabetes—all sharing common behavioral risk factors such as an unhealthy diet, a lack of physical activity, and the use of tobacco and alcohol—are the principal drivers of NCDs in India. A recent study benchmarking global progress on reducing NCDs found that the probability of dying from an NCD between birth and age 80 years increased in India from 2010 to 2019, in contrast with the decrease seen in high-income countries and emerging economies in East Asia. The increase was larger for women than men, raising issues around equitable access to preventive health services. The largest NCD mortality, from ischemic heart disease and diabetes (including chronic kidney disease due to diabetes), occurred during the 2010–19 period. India did experience decreases in NCD mortality from other NCDs.[17]

India's health system thus faces multiple challenges in managing its disease burden: The less developed eastern and northeastern states bear the brunt of conventional communicable diseases and public health challenges, while the more developed southern and western states are increasingly experiencing a higher burden of lifestyle diseases. Wide variations in health status present additional challenges for the central government to develop policies that are equally effective across the country.

RECENT TRENDS IN INDIA'S HEALTH EXPENDITURE

India has historically spent between 3 and 4 percent of GDP on healthcare (3.8 percent in the most recent fiscal year). Of this share, public spending has accounted for between 1 and 1.4 percent of GDP, with the private sector making up the difference (mostly through OOP payments); see figure 6.1. Sustained low levels of public spending severely limits the government's capacity to improve the population's health. State governments, in turn, account for about three-fifths of all public spending, with the central government essentially paying for national programs around public health.

FIGURE 6.1 Changing composition of total health expenditure



Source: World Bank, 2025.

The gradual expansion of curative care programs such as RSBY and PMJAY, along with the COVID-19 pandemic, has increased public spending on healthcare in recent years—accounting for 40 percent of total health expenditure. It is too early to tell whether the increased public spending associated with the pandemic (even though expenditure on vaccination programs was paid for by the Ministry of Finance rather than the Ministry of Health and Family Welfare) will continue going forward. Budgetary documents indicate a 10 percent increase in public outlays over the past two budgets. Despite these increased budgetary outlays, total public spending on health (about 1.4 percent of GDP) is lower than the goals outlined in the National Health Policy 2017 and lower than in other countries at similar levels of income.

The gradual increase in public health spending over the past decade has been associated with a decline in OOP spending. National Health Account estimates published in 2024 for the year 2022 (the most recent data available) suggest that OOP expenditures account for about 45 percent of all spending—a significant decline from about 70 percent two decades earlier. Despite these gains, OOP expenses continue to have harmful effects on vulnerable households. It is not uncommon for patients and their families to borrow or sell assets to pay hospital bills, which temporarily or permanently pushes them into poverty.[18]

A distinct change in recent health financing trends is the growth of private health insurance. Rising healthcare costs, a supportive regulatory environment, and the absence of a robust, functioning public health system that provides quality care have contributed to the growth of private health insurance. Private health insurance accounts for about 7.5 percent of all health spending (up from about 3 percent a decade earlier). There is a growing appetite for private insurance, as evidenced by a fivefold increase in annual premiums collected over the past decade, and the sector is projected to grow at an annual rate of 11 percent per year, outpacing growth in other Asian countries.[19] The growth of private health insurance is welcome news to India's rapidly growing middle class, which is not covered by any of the government's flagship programs and find private hospitals too expensive and inaccessible.

INDIA'S FLAGSHIP UNIVERSAL COVERAGE REFORM

India's universal coverage reforms underway have two main components. The first focuses on strengthening the nation's primary healthcare infrastructure, and the second aims to provide tertiary care to vulnerable or poor households. The government has introduced a network of subhealth centers and primary health centers (Ayushman Arogya Mandirs, or AAMs) that provide essential care and preventive health services. As of late 2024, there were about 170,000 AAMs across the country. These AAMs aim to provide a wider spectrum of services than those offered by earlier health centers and are an individual's first port of call to access essential health services, practice healthy lifestyles, and reduce the incidence of NCDs. It is too early to assess the efficacy of the network, and there is limited data on their functioning or infrastructure. Despite announcements that the government has approved plans to improve the infrastructure of AAMs, it is unclear to what extent the limitations around staffing, resourcing, and accountability that constrained the delivery of primary healthcare have been addressed. The government has also rolled out public pharmacies that provide generic medicines at subsidized prices. As of 2025, there were about fifteen thousand such pharmacies across India. They account for a negligible (but growing) share (around 1 percent) of total pharmaceutical spending in India.[20]

The second key pillar of India's health reform is PMJAY, which replaced RSBY in an expanded form. The palliative care component covers services at designated public or private hospitals for about fourteen hundred types of medical interventions up to a benefit level of INR 500,000 (US$5,500) per year, per family. The program is meant for the 40 percent of India's lowest-income population, identified using the 2011 socioeconomic caste census—about 110 million families. Some state governments have expanded the number of people eligible for the program. The program thus targets about 120 million families or 550 million people. In late 2024 the program was extended to cover those above the age of seventy (approximately 60 million) across all income groups.[21] The premiums for the program are paid for by central and state governments in a sixty-to-forty ratio, except for three poor states where the ratio is ninety to ten.

As of April 3, 2025, a total of 31,846 hospitals were empanelled, of which 17,434 were public and the remainder private.[22] Private hospitals, which make up 46 percent of the network, contribute 54 percent of all hospitalizations under the scheme, reinforcing the reliance on private healthcare providers.[23] Andhra Pradesh, Karnataka, Gujarat, and Uttar Pradesh have the largest volumes of authorized admissions and corresponding financial outlays.[24]

As of late 2025, 41 million families (out of approximately 55 million) have enrolled in the program. Many of the high-performing southern states with functioning public health systems, including Karnataka, Tamil Nadu, and Kerala, had established programs that were subsequently merged with PMJAY. Understandably, any reform of this size and scale has teething issues. First, not all state governments and territories have implemented the program; some have similar state-level programs. While curative healthcare has traditionally been a state responsibility, some state governments were happy to cede this space to the national program given the additional fiscal support and the salience of health policy in recent policy discourse. Odisha and New Delhi have signed agreements to implement the program in 2025, while West Bengal is the only major remaining state yet to roll out the program.

Second, private hospitals frequently report delayed government reimbursements and concerns over the adequacy of treatment packages under PMJAY. For instance, private hospitals in Haryana have previously threatened to stop treating scheme patients due to pending

reimbursements.[25] The program does not cover outpatient treatment, pathology and radiology, or pharmaceuticals, which often account for a significant share of the hospital bill.

There is limited publicly available disaggregated data on the utilization of PMJAY or claims data. The Economic Survey of the Government of India (2024–25), published earlier this year, reports that the program has reduced OOP spending by 1.25 lakh crores (or about US$14 billion) since its inception and has paid for about 80 million hospital admissions.[26] In the initial years of the program, only two-thirds of all budgetary allocations were spent, but this has improved since 2023 as the scope of the program has expanded. The program has an allocated budget of US$1 billion in the current fiscal year.

Supporting both primary and tertiary care is a digital health strategy announced in 2019, centered around the Ayushman Bharat Digital Mission, which creates individual health accounts built upon the national biometric identification system (Aadhaar). About 586 million individual health accounts aim to offer portability of care and allow patients to access and share their health records (e.g., diagnostic reports, lab results, etc.) with healthcare service providers.[27] Some state governments have begun to experiment with using individual health accounts to better target national programs, such as those to control NCDs. Preliminary data from the state of Chhattisgarh suggest that integrating individual health accounts is associated with improved follow-up care among hypertensive and diabetic patients.[28] Scaling up India's digital health mission, as well as creating buy-in among patients accessing care at public and private healthcare providers, will require addressing the usual impediments associated with digitalization of public services, including regulatory and infrastructure hurdles.[29]

India's march toward universal healthcare coverage is, in many respects, cautious. The first pillar of primary care aims to strengthen existing networks of health centers and improve their functioning, while tertiary care is provided at empanelled hospitals similar to RSBY. The program has slowly begun to expand the number of beneficiaries in response to pressure from interest groups and will likely raise the annual limit of INR 500,000 per family currently imposed. The caution stems from two reasons. The first is budgetary—despite repeated calls to significantly increase public spending, successive governments have found it politically difficult to do so. The benefits provided under PMJAY are pale in comparison to programs available to those employed in the formal public sector (particularly those working in the government). However, scaling the program to the same level is fiscally prohibitive. Second, given the limited capacity in the public sector to provide the necessary care, expanding the scope of PMJAY would require working with private-sector providers. The reform experience of RSBY and of other countries where governments have expanded tax-funded insurance programs offers a sobering lesson about the need to establish sufficient monitoring and accountability mechanisms to ensure that hospitals (particularly private providers) provide quality care at affordable prices.[30]

KEY CHALLENGES IN SUSTAINING UNIVERSAL HEALTH COVERAGE

The journey toward universal health coverage is often described as a long and arduous march, in which governments work toward addressing impediments over multiple decades.[31] Preparatory work for India's march began in 2005 with the NHM and realistically started in 2019, slowly overcoming specific health policy challenges.

India's health policy challenges are extensively catalogued: There has been little policy attention to the sector, and successive governments have done little to coordinate the various disparate agencies involved in the sector. By sheer neglect,

India had become one of the most privatized healthcare systems. The PMJAY represents the government's acceptance of the reality that the private sector is the only viable option for delivering curative health services.

Introducing a publicly funded insurance program such as PMJAY into a fragmented system is challenging, as governments struggle to regulate healthcare providers and ensure they remain responsive to citizens' needs. This requires incentivizing healthcare providers to offer quality care at affordable prices and disincentivizing them from pursuing their own monetary motives. This balancing act requires not only technical know-how to shape the design of the program but also a wide spectrum of operational and political capacities among the implementing agencies.[32] The former is evident in the design of India's universal coverage reforms, but weaknesses across the operational and political capacities remain.

On the operational front, while total expenditures on health in India are not particularly low given the country's relatively young population, the government's health expenditure—amounting to around 1 percent of GDP over the past two decades (mostly focused on recurrent expenditures)—has not allowed needed investments in bolstering health infrastructure.

While the number of physicians per 1,000 individuals has risen over the past two decades from 0.5 in 2000 to 0.73 in 2022, this still falls short of the guidelines recommended by the WHO of 1 per 1,000 patients.[33] In addition, about 3 million nursing personnel and 0.8 million AYUSH (Ayurveda, yoga and naturopathy, Unani, Siddha and homoeopathy) doctors serve a population of 1.4 billion.[34] Recent efforts to address the shortage of trained personnel include expanding the capacity of medical colleges and extending retirement ages across several state governments. Current data from the Ministry of Health and Family Welfare suggest that India has 0.6 hospital beds per 1,000 people, which has been constant since the 1980s.[35] Wide variations in the distribution of hospital beds accentuate the shortage of critical infrastructure.[36]

Nearly 50 percent of the Ministry's budget is focused on the NHM and providing for premier medical institutions such as the network of All India Institute of Medical Sciences across India.[37] PMJAY accounts for about 10 percent of the budget, leaving little fiscal space to address chronic staffing shortages and infrastructure needs. Budgets across states paint a similar picture.

The architecture of PMJAY relies heavily on leveraging the private sector to expand secondary and tertiary care access for the poor. While many hospitals have registered or been empanelled to treat PMJAY patients, most of them are relatively small (i.e., the average registered hospital has forty-eight beds), suggesting that many large multispecialty hospitals that provide advanced care have not registered to treat PMJAY patients.[38] A recent study in Maharashtra found that only 13 percent of private hospitals were empanelled in the program. Relatively low and opaque reimbursement rates and delayed claims processes and reimbursements are common, discouraging large hospitals from joining the network.[39] The issue, however, is not specific to PMJAY but extends across the sector. Some hospitals have recently stopped processing cashless reimbursements (i.e., when patients access services without paying the hospital) due to prolonged delays in reimbursements, leading the Association of Healthcare Providers in India to lobby insurance companies to revise their reimbursement schedule.[40] This is not unique to India but a common challenge across all publicly funded health insurance programs and requires public health agencies to work collaboratively with healthcare providers to adjust and calibrate reimbursement rates.[41]

Another challenge relates to addressing inequities in access to services in rural and urban centers. Hospitals that register with PMJAY tend to be confined to urban centers, perpetuating the disparities entrenched in the system. Achieving equitable access necessitates not only strengthening the public health system but also concurrently reforming reimbursement and regulatory structures to incentivize healthcare providers to deliver care in rural communities.[42]

Political capacities play an equally important but often overlooked role in implementing healthcare reform.[43] They are helpful in overcoming resistance, holding powerful healthcare providers accountable, and overcoming policy inertia in large federal societies such as India. Despite the increased salience of health policy in the national policy discourse, the program is ultimately implemented across states with different capacities and experience in delivering and running such programs. K. Sujatha Rao, a retired secretary in the Ministry of Health and Family Welfare, notes that "the attention of health ministers [in state governments] has disproportionately focused on the procurement and transfer of doctors and nurses. Most have sought to maintain the status quo and been wary of fundamental changes, discouraged out-of-the-box thinking or radical solutions . . . [and there is] a lack of appreciation of the complexities of the health sector."[44] Strengthening the political resolve across state governments to improve the performance and functioning of health centers and district hospitals within their jurisdictions will play an important role in strengthening public health infrastructure. In addition to affordability and accessibility, citizens' trust in the health system is a useful yardstick to assess universal health coverage in developing countries.[45] Do individuals, particularly from vulnerable sections of society, believe that healthcare providers—either public or private—will remain responsive to their needs and provide quality care? Apart from a few select high-performing southern states, political will and resolve across states are needed to address existing trust deficits in the public system.[46] Similarly, addressing the perverse practices of some errant private healthcare providers that exploit patients' vulnerabilities requires active political stewardship.[47]

India has several other extremely generous public health insurance programs: the ESIS established in 1952, the Central Government Health Scheme (CGHS) established in 1954, and generous programs for defense and railway personnel. These programs collectively account for 10 percent of the Ministry's budget—a share similar to that allocated to providing healthcare for half a billion individuals.[48] This stark difference represents the disparity in benefits offered under PMJAY. Scaling this beyond the current family threshold of INR 500,000 per year is invariably challenging given the fiscal costs associated with it. However, many treatments for chronic and complex healthcare needs exceed the limit, reducing the financial protection offered by the program, leaving vulnerable households to absorb the remaining substantial costs, and increasing the risk of impoverishment.[49] Rationalizing the differences across public health insurance programs is not easy, as the reform experience from Thailand suggests, and is invariably a political exercise.

Finally, the slow onset of other health policy challenges such as antimicrobial resistance (AMR, where microorganisms such as bacteria evolve and become resistant to drugs, such as antibiotics, that are meant to kill them) and chronic kidney disease will also need to be addressed. India has recently been identified as one of the global epicenters for AMR caused by several interrelated challenges related to water and sanitation, regulation of industrial affluents, farming practices, and quality of pharmaceuticals. Addressing these challenges in silo is akin to shaping an animal balloon—they require a systemic perspective and concerted efforts across multiple policy domains.[50]

STRENGTHENING THE RESOLVE TO SUSTAIN UNIVERSAL HEALTHCARE

Three practical recommendations can be canvassed to further strengthen the march toward universal healthcare.

Fiscal Space: Increased public spending on healthcare is needed to improve both the scale and scope of PMJAY. The current threshold of INR 500,000 and the exclusion of outpatient care and diagnostic tests are unlikely to provide comprehensive financial protection. However, it is equally unlikely that current public health spending will increase dramatically from 1.4 percent of GDP to 2.5 percent over the next few years, as envisioned in the National Health Policy 2017. Similar to the reform experience in other developing countries, part of the fiscal space required for increased spending on PMJAY can be created by rationalizing the design and benefits of other public healthcare programs for those in the formal sector. While it is unrealistic to scale down the benefits provided under the CGHS, extending certain design features of the PMJAY—such as negotiated prices at empanelled hospitals—to other programs is likely to exert downward pressure on program costs. This is similar to the experience of Thailand, where the government was unable to scale back generous commitments made to health program civil servants but was able to moderate the growth of these costs.[51]

Private Sector Regulatory Reform: Studies have found that health insurance products in India offer significantly weaker customer protections compared to countries with similar legal systems.[52] This stems from the weak enforcement of regulations and gaps in the design of the redress mechanisms, and they collectively create incentives for insurers to deny legitimate claims. The claims ratio (the number of claims insurers pay out for every one hundred they receive within a specific period) was 88.5 percent in 2023–24.[53] While India's health insurance sector is relatively nascent, there are frequent media reports of excessive administrative burdens and delays in reimbursement. Moreover, most health insurance companies do not offer health coverage for preexisting illnesses or chronic treatment for conditions such as cancer or kidney disease. Addressing these gaps through stricter regulations on empaneled hospitals and insurance companies merits consideration. Many jurisdictions require health insurance companies to cover all preexisting illnesses after a reasonable waiting period.[54] Similar rules exist in India but are not enforced. Greater scrutiny of insurance companies and healthcare providers will play an important role in ensuring that the system remains responsive to patients' needs. For example, since the inception of PMJAY, the National Health Authority has found instances of fraud, penalizing 1,504 errant hospitals and suspending a third of them from the program.[55]

Sustaining PHC Strengthening: The role of Ayushman Arogya Mandirs as the first port of call for essential health services is a welcome step. The increased health budgetary outlays associated with the Pradhan Mantri Ayushman Bharat Health Infrastructure Mission (PM-ABHIM), amounting to 5 percent of the Ministry's budget, are reassuring. However, the infrastructure must be matched with human resource planning to ensure that the AAMs function effectively. Even state governments lack meaningful mechanisms for monitoring performance or enforcing accountability on the facilities' managerial and medical staff.[56]

CONCLUSION

India's health policy indicators have improved significantly in recent years after the central and some state governments began to pay greater attention to expanding health protection. Remarkable strides and gains have been realized

in controlling infant and maternal mortality and even turning the tide on OOP spending.

The adoption of NHM, followed by RSBY and later PMJAY, represented a marked departure for health policy in India. For the first time, the government matched policy goals with specific details for realizing them. The programs indicate that the central government's has assumed stewardship of the sector, notwithstanding the important role state governments play in delivering health services.

The government has finally accepted that it has no option but to work with private providers for delivering healthcare services. At the same time, it has taken measures to improve the performance of public providers and increased hospital managers' autonomy. For instance, hospitals have more leeway and flexibility and increased funding via PMJAY to use at their discretion and have experimented with performance-linked payment for some services.

Traditionally, high OOP payments for health expenses has been one of the most egregious fault lines in India's health system. The launch of PMJAY has been associated with improved risk pooling. Financing it from tax revenues rather than contributions and insurance premiums recognizes the reality of the informal economy. The program provides the sector much-needed funding from the general budget, and allows the government to set standards in the sector. However, the programs do little to protect the nonpoor who are not covered by the program.

A strong regulatory framework is essential for healthcare systems dominated by private provision and financing. While the Indian government has established regulatory frameworks for the pension sector (the Pension Fund Regulatory and Development Authority) and the insurance sector (the Insurance Regulatory Development Authority of India), there is a need to consider a specific regulatory agency to deal with the health sector, given the inherent challenges and diverse actors involved. Existing regulations that govern hospitals, pharmacies, and providers are not enforced. Recent policy discourse recognizes the gap but offers no concrete steps to address it.[57]

PMJAY has garnered wide support across stakeholders and offers an avenue for India to overcome its reliance on OOP payments and achieve universal health coverage. PMJAY embodies ideas spelled out in the 2002 and 2017 National Health Policy around increased stewardship of the sector, and working with providers in the private sector to meet India's health policy aspirations. Similarly, it advances the interests of key actors—public and private hospitals and insurance companies—by facilitating new markets. State governments, who were primarily responsible for healthcare, welcome the increased funding, as most of it is borne by the central government. Most importantly, it offers hope to a large section of India's society who do not fully trust public hospitals and are locked out of private hospitals.

India has rolled out a complex national healthcare program. Its efforts to achieve universal coverage now depend on its ability to navigate the fault lines of private provision aided by a weak regulatory environment and to expand PMJAY to cover the remaining population.

NOTES

1. These are direct costs that individuals accessing care must pay—and they are not covered by insurance or other government programs.

2. Sujatha Rao, *Do We Care? India's Health System* (Oxford University Press, 2017).

3. Ministry of Health, Government of India, *Rural Health Statistics in India in 2024* (Ministry of Health, Government of India, 2024).

4. Azad Singh Bali and M. Ramesh, "Health Care Reforms in India: Getting It Wrong," *Public Policy and Administration* 30, no. 3–4 (2015): 300–319.

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