



<https://www.tandfonline.com/doi/epdf/10.1080/23288604.2023.2229062?needAccess=true&role=button>

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/khsr20>

## The Politics of Health Policy Agenda Setting in India: The Case of the PMJAY Program

Anuska Kalita & Kevin Croke

To cite this article: Anuska Kalita & Kevin Croke (2023) The Politics of Health Policy Agenda Setting in India: The Case of the PMJAY Program, Health Systems & Reform, 9:1, 2229062, DOI: 10.1080/23288604.2023.2229062

To link to this article: <https://doi.org/10.1080/23288604.2023.2229062>



© 2023 The Author(s). Published with license by Taylor & Francis Group, LLC.



Published online: 11 Jul 2023.



Submit your article to this journal [↗](#)



View related articles [↗](#)



View Crossmark data [↗](#)

# The Politics of Health Policy Agenda Setting in India: The Case of the PMJAY Program

Anuska Kalita  and Kevin Croke

Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, MA, USA

## ABSTRACT

In 2018, India's Prime Minister announced a new health insurance program, Pradhan Mantri Jan Arogya Yojana (PMJAY), aiming to cover over 500 million people. This paper seeks to document and explain the emergence of PMJAY on India's political and policy agendas. We analyze media, election manifestos, legislative debates, and health budgets to compare PMJAY's presence on India's policy agenda to previous health programs. We then apply Kingdon's Multiple Streams Framework to explain the program's emergence and adoption, validating our data and interpretations through consultations with Indian health policy experts. Comparing respective launch years, PMJAY was covered in national newspapers 37 to 212 times more than previous flagship health programs, although it was not more prominent in parliamentary debates or in the health budget. Events in the problem, politics, and policy streams converged to enable its prominence. Health policy elites who favored insurance as a policy to address out-of-pocket health expenditures gained influence after the 2014 election victory of the Bharatiya Janata Party (BJP). PMJAY's naming and branding, scale, timing, implementation style, and design aligned with both the BJP's ideology and political strategy. PMJAY represents the increased prominence of health programs in Indian politics, although primarily on the political and media agenda, rather than on the budgetary and legislative agenda during this period. The political forces that facilitated its emergence also shaped its design in ways that are likely to affect the Indian health system's ability to provide comprehensive financial protection in the future.

## ARTICLE HISTORY

Received 31 October 2022  
Revised 18 June 2023  
Accepted 20 June 2023

## KEYWORDS

Health systems; India; Multiple Streams Framework; political analysis; politics of health reform


## Introduction

The Indian government announced a new health policy known as the Pradhan Mantri Jan Arogya Yojana (PMJAY) in August 2018, aiming to provide health insurance coverage to households for hospitalization expenses. The stated objective of PMJAY is to reduce the high levels of out-of-pocket health expenditure (OOPE) and catastrophic health expenditure (CHE), which push an estimated 60 million Indians into poverty each year.<sup>1</sup> The PMJAY is the most prominent component of Prime Minister Narendra Modi's *Ayushman Bharat* health initiative.

Not only has PMJAY, often called "Modicare," been promoted as Modi's flagship program, it has also been described in India's media as "historic," "revolutionary," a "game-changer," "the world's largest government health insurance program," and "the road to comprehensive universal health coverage."<sup>2-5</sup> This level of media and political attention to a health program had previously been unusual for India. Amartya Sen and Jean Drèze have argued that the topic of health has been "virtually absent

from public debates and democratic politics in India,"<sup>6</sup> demonstrating there were no articles about health issues on the editorial pages of leading Indian newspapers over six-month periods in 2000 and 2003. A decade later, less than 1% of articles in similar publications addressed health.<sup>6</sup> This is mirrored in the Indian government's budget: government health spending (GHE), ranging between 0.9 and 1.5% of GDP, is among the lowest in the world.<sup>7</sup> There is, relatedly, a long-standing debate in Indian health policy circles about whether increased investment in direct provision of public sector health services or expansion of health insurance is the best path to universal health coverage (UHC).<sup>8,9</sup> PMJAY reflects a choice to expand insurance. Understanding the public and political rationale for these choices is, therefore, an important element of the politics of health in India.

This paper documents and explains the emergence of PMJAY on India's political and policy agendas, and asks the following questions: First, does an updated analysis of media and public debates of the kind previously conducted by Drèze and Sen (2013)<sup>6</sup> reflect a new

**CONTACT** Anuska Kalita  [akalita@hsph.harvard.edu](mailto:akalita@hsph.harvard.edu)  Department of Global Health and Population, Harvard T.H. Chan School of Public Health, Boston, MA

© 2023 The Author(s). Published with license by Taylor & Francis Group, LLC.

This is an Open Access article distributed under the terms of the Creative Commons Attribution License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited. The terms on which this article has been published allow the posting of the Accepted Manuscript in a repository by the author(s) or with their consent.

prominence for health on India's public and institutional agendas? If so, how did health policies, previously neglected, gain prominence? Finally, once health emerged as an important political issue, why did the policy response take the form of a hospitalization insurance program such as PMJAY?

To address these questions, we study the agenda-setting and design phases of PMJAY. For India's persistently underfunded health sector, simply gaining a place on the policy agenda is a step forward. However, once a problem arrives on the agenda, a wide range of policies are possible. Policy entrepreneurs, bureaucrats, and experts propose options to political leaders who weigh values, policy substance, interest group pressure, and public opinion. Understanding the agenda-setting and policy design processes requires examining the ideas, institutions, incentives, and processes that led to PMJAY's emergence as a policy priority and to the design and adoption of the policy.

While there is some literature on the politics and political economy of health reforms in India, including studies on agenda-setting for the Rashtriya Swasthya Bima Yojana (RSBY) health insurance program,<sup>10</sup> for maternal mortality,<sup>11</sup> and nutrition,<sup>12</sup> most research has focused either on the description of health policies or their evaluation. Similarly, while there is no shortage of media articles, opinion pieces, and gray literature on PMJAY, most published research to date has focused on the evaluation of the program,<sup>13–20</sup> analyses of claims data, and implementation challenges.<sup>17,21–26</sup> There is limited research on the politics of PMJAY. Our paper aims to address this gap in the literature, focusing on the policy's initial agenda-setting, design, and adoption phases.

### Theoretical Framework

First, we conceptualize our empirical measurement of agenda presence. While Kingdon's Multiple Streams Framework (MSF), our main theoretical framework,<sup>27</sup> offers a US-centric conceptualization of agenda setting, we adapt this concept to better align with India's institutions and parliamentary system. To this end, we consider two components of the policy agenda: we use Cobb and Elder's distinction between public (or "systemic") and institutional agendas, and consider both for our analysis.<sup>28</sup> The public agenda is defined as all issues that are commonly perceived by members of the public or political community as meriting public attention; this can be indicated by, for example, coverage in mainstream media or electoral manifestos. The institutional (or "formal") agenda is the set of items explicitly up for active and serious consideration and deliberation by authoritative decision-makers. Indicators

of institutional agenda can include legislative debates, executive orders, and budget allocations.

Moving from the empirical measurement to the process tracing component of our analysis, we apply Kingdon's MSF to understand how PMJAY gained prominence on the policy agenda and how it was adopted. Kingdon's MSF posits that three "streams" come together to bring an issue onto the policy agenda.<sup>27</sup> First, the issue has to be seen as a persistent, well-defined issue in the *problem stream* rather than an unavoidable or natural feature of the context. Second, a plausible and politically palatable solution to the problem must be available in the *policy stream*. Finally, an opening must emerge in the *politics stream*, for example, through a change in political leadership or a social or economic crisis. Simultaneously favorable conditions in all three streams increase the chance of a policy idea gaining a place on the policy agenda. Policy entrepreneurs take advantage of open policy windows to advance proposals they support, drawing on the stock of ideas developed by experts within policy communities. The next question is whether or not the policy can win adoption, overcoming institutional barriers ("veto gates"),<sup>27</sup> interest group opposition, and political considerations such as issue salience and public opinion. We analyze the adoption of PMJAY as a national policy in light of these theoretical concepts.

### Context: The PMJAY Program

PMJAY is the central component of the Indian government's flagship health program, *Ayushman Bharat*. It is a government-sponsored health insurance program that provides low-income families with financial coverage of up to 500,000 Rupees (\$7,142 USD) annually for hospitalizations for a list of specific conditions or medical procedures. It identifies eligible families using criteria that combine income and other vulnerability measures with data from the Socio-Economic and Caste Census (2011).<sup>a</sup> Families that meet these criteria (40% of India's population, an estimated 500 million individuals) can receive care at any empaneled private or public-sector hospital by providing either their PMJAY card or other proof of identification and eligibility, such as their Aadhaar number, a national biometric identity number issued to more than 90% of the population.<sup>30</sup>

PMJAY is led by the National Health Authority (NHA), a body with a high degree of functional autonomy. The NHA's governing board is chaired by the Union Health Minister and is headed by a Chief Executive Officer (CEO) with the rank of a Secretary to the Government of India (i.e., with equal rank to the head of the Ministry of Health and Family Welfare

(MoHFW)). States are required to create State Health Agencies (SHAs) for PMJAY implementation.<sup>1</sup> More than 1,300 medical procedures are covered in the benefits package. See Appendix A for further details on PMJAY.

## Materials and Methods

### Data Sources

This study analyzes the following: (i) media articles published between 2005–19 in leading national newspapers in India, (ii) recent election manifestos of the two main national political parties, the Bharatiya Janata Party (BJP) and the Indian National Congress (Congress), (iii) legislative debates on topics of health, health insurance, and health programs between 1999 and 2017 in the Lok Sabha, the Indian parliament's house of elected representatives, and (iv) health budgets since the official launch of the PMJAY in 2018 until 2021.

Additionally, one of the authors, in her role as a participant in government task forces and committees for the formulation of Ayushman Bharat and the National Health Policy (NHP) 2017, has drawn on her experiences and observations. Finally, the authors reviewed and synthesized the secondary literature on India's health policymaking, reports, policy documents, and narrative accounts of health policymaking over the period in question.<sup>8,9</sup>

Given that

one of the authors participated in policy debates described in this paper, it is important to reflect on positionality. Besides participating in numerous policy discussions that preceded the launch of the PMJAY, the first author was living in India during most of the time period covered by this study. We acknowledge that this positionality influenced the research team's access to information and has shaped the authors' subjective interpretation of these events.

### Data Collection

First, we searched all newspapers from India archived on the Factiva service from January 1, 2005, to December 31, 2019. This included the twelve most-read newspapers in India. We conducted a free text search for the major health programs from 2004–2019: National Health Mission (NHM), Rashtriya Swasthya Bima Yojana (RSBY), PMJAY, and Health and Wellness Centers (HWCs). (See Appendix B for details on search procedures.) Since different health policies have been in effect for different lengths of time, we calculated the number of mentions per year from each program's initiation until the end of 2019. As a robustness check, we compared

news items published in the English media with those in the Hindi media by using the same search terms and time periods in the five most-read Hindi newspapers. See Appendix C for details.

We collected legislative questions from the archives on the website of the Lok Sabha using the same search terms as above. We also collected the election manifestos of the BJP and the Congress for the 2014 and 2019 national elections, budget data from the Ministry of Finance archives, relevant policy documents, and published and gray literature through web searches. Given this study's focus on the agenda-setting, design, and policy adoption phases, we restrict the analysis to the 2014–2019 period.

Additionally, we consulted eight senior health policy experts from India and sought their feedback on our analysis and draft versions of the manuscript. These individuals were involved directly with the PMJAY in different capacities during the period considered in our study, representing government institutions (NHA, MoHFW, and NITI Aayog), donor organizations, bilateral agencies, research institutions, and academia.

### Data Analysis

Our quantitative and qualitative content analysis of media articles, legislative debates, and election manifestos used Howland et al.'s (2006) framework, which merges content analysis with the analytical framework developed by Lasswell (1971) to identify stakeholders, policy claims, and narratives used in the media articles, electoral manifestos, and political debates.<sup>31,32</sup> This method allowed us to understand the narrative landscape around PMJAY. This narrative landscape or "policy image" has been theorized to shape agenda presence.<sup>33</sup>

For the qualitative components of this paper, focused on the rise of PMJAY on the policy agenda and the design of the policy, we used theory-informed process tracing methods.<sup>34</sup> Process tracing is a qualitative research methodology that entails reconstructing a series of events through multiple sources, including official documents, media reports, academic literature, and participant observation. It uses the pattern and sequence of events to assess the strength of competing theoretically-informed explanations. We used Kingdon's MSF to focus our process tracing efforts on the problem, politics, and policy streams. We then used policy documents, synthesis of the literature, one coauthor's participation in relevant events, and consultations with involved policy experts to supplement content analysis with a discursive account of the policy processes leading up to PMJAY. [Figure 1](#) presents our data search and collection process.

## Results

### Agenda Setting

Analysis of newspaper articles showed greater annual media coverage of PMJAY than other recent health programs like the RSBY, NHM, and HWCs (Figure 2). There were 4,442 news items about the NHM from its

launch in 2005 until 2019, and 723 news items about RSBY from 2008 to 2019. There were 4,186 newspaper articles about PMJAY in its launch year in 2018 and 2019. Disaggregating these media mentions for each program on a per-year basis, PMJAY was covered in 2,093 news articles per year, seven times more than NHM (296 articles per year), 35 times more than

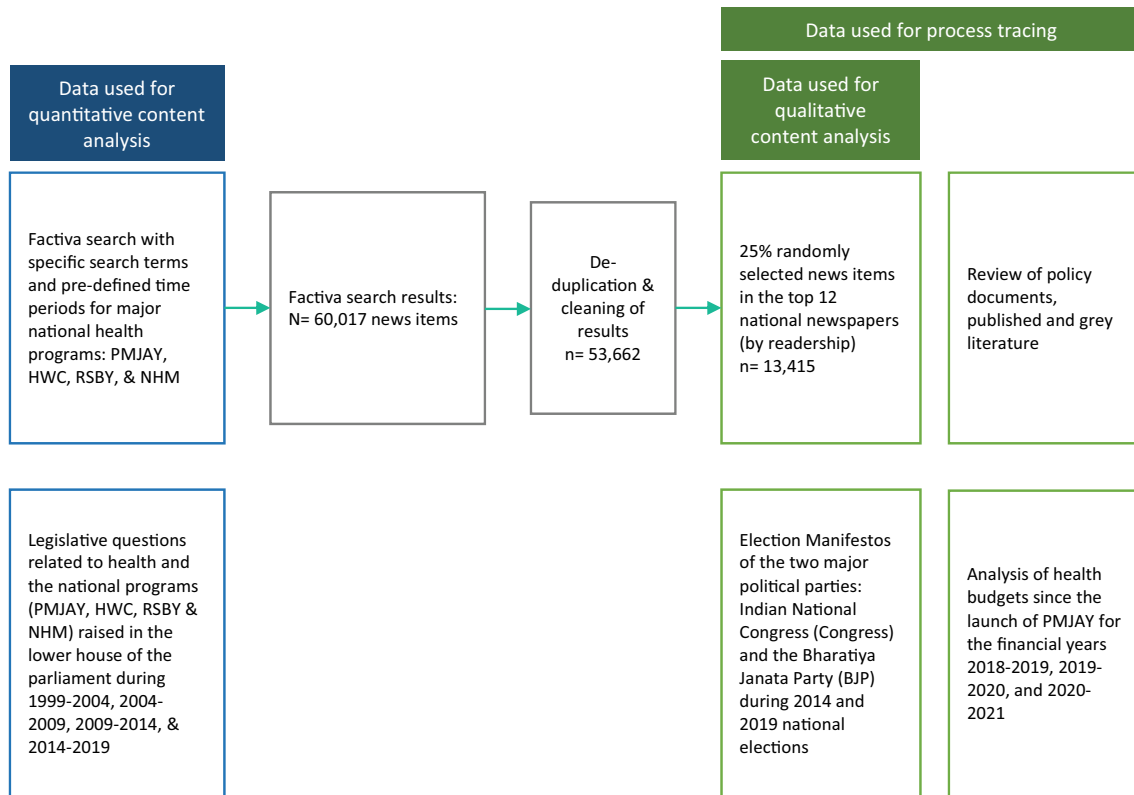


Figure 1. Diagrammatic representation of our data and analysis.

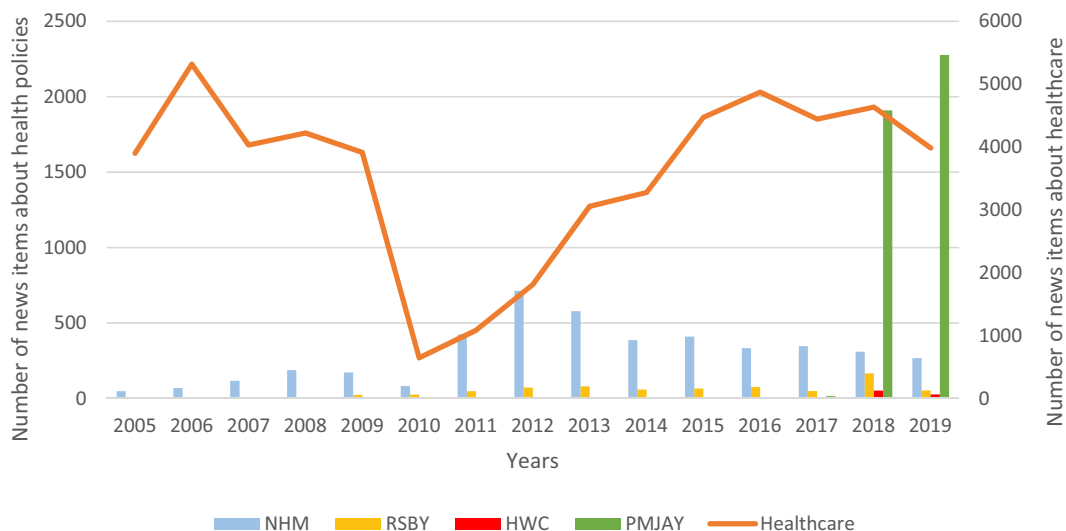


Figure 2. News items about major health programs published in major national newspapers in India between 2005 and 2019.

RSBY (60 articles per year), and 54 times more than the HWC program (39 articles per year). Comparing media coverage of each program in their respective launch years, PMJAY was covered 212 times more than RSBY, 40 times more than NHM, and 37 times more than HWCs. We find similar patterns in the analysis of Hindi media (See Appendix C).

We also conducted qualitative content analysis of a randomly-selected sample of this coverage. We find that the dominant themes in media articles about PMJAY were the program's size, scale, speed of rollout, fraud prevention measures, and adoption by different states. In comparison, the common themes for NHM and RSBY were "shortfalls and criticisms," "impact on health outcomes," and "corruption" associated with the programs. RSBY and HWC were discussed mainly in relation to PMJAY rather than on their own merits (Figure 3). (See Appendix C for the qualitative content analysis of Hindi media.)

Next, we analyzed BJP and Congress election manifestos from the two national elections during 2014 and 2019. In their 2014 manifesto, the BJP proposed the National Health Assurance Mission (the name used for PMJAY at that time) to provide "*universal health care that is (...) accessible and affordable (...) and reduces the out-of-pocket spending on health care.*" It also promised a new national health policy and restructuring of the Ministry of Health and Family Welfare (MoHFW) (Appendix D). Congress focused on the right to health and strengthening existing health service delivery programs such as the NHM. In the 2019 election manifestos, the BJP focused on PMJAY, the promise of tertiary

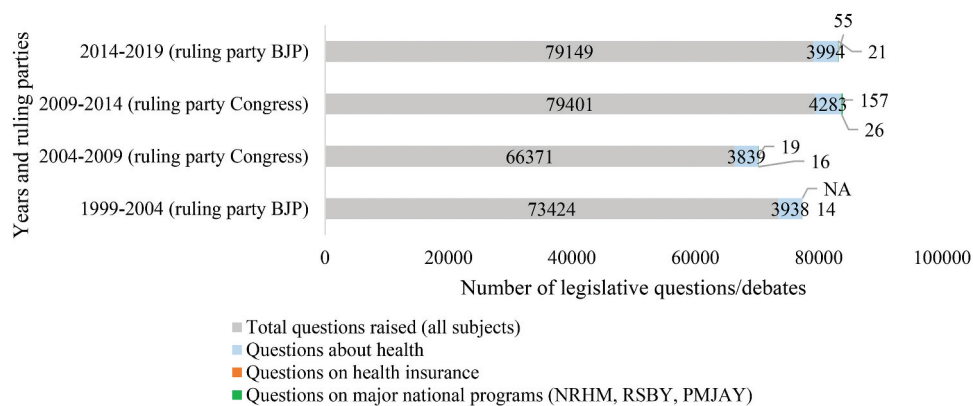
care hospitals, newer technology-enabled programs, and reforms in medical education, while the Congress' focus continued to be on enacting the right to health and strengthening the NHM. Neither of the Congress manifestos contained any mention of the RSBY, a program that the party had launched just a few years ago.

Data from debates in the Indian legislature provide a measure of the salience of health programs on the institutional agenda. We compiled data on legislative questions raised in the Indian parliament from 1999 to 2019, a period spanning four successive governments, to measure health, health insurance, and national health programs in legislative debates. In contrast to the media and election manifesto data, we see limited attention to health-related issues in India's legislature, with no increased attention over the study period (Figure 4). Over the five-year legislative period when RSBY was introduced and rolled out (2004–2009), just 35 out of 66,371 parliamentary questions (0.053%) were about health insurance or RSBY. In the parliamentary sessions that included the period when PMJAY was introduced (2014–2019), 26 out of 79,149 questions (0.033%) were about health insurance or PMJAY. Only 19 questions out of 66,371 (0.028%) were raised about NHM during its initial years (2004–2009).

We also analyzed India's health budgets since the launch of PMJAY (2018 to 2021) to provide a more substantive assessment of institutional agenda presence. Although there was a modest increase in the health budget over this period, the proportional allocations across different budgetary categories did not change dramatically. NHM received the largest share out of



Figure 3. Dominant themes in media articles about the major national health programs.



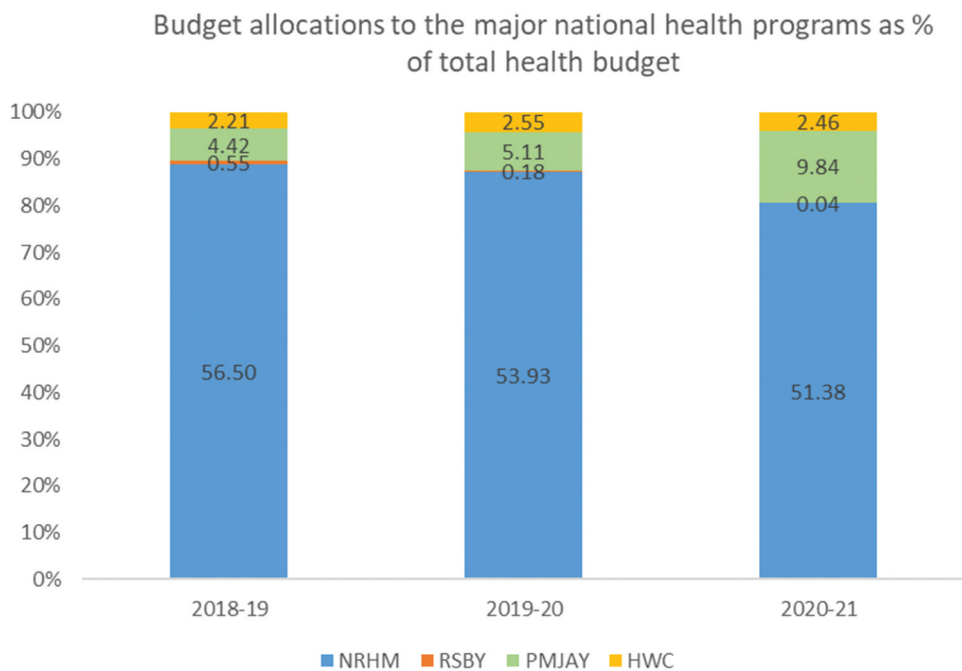
**Figure 4.** Legislative debates on health and health insurance in India across successive governments (1999–2019).

Notes: In the 2009–2014 period, there was an increase in the number of questions about NHM, with 118 questions out of 79,401 (0.15%). 48.7% of these questions were about corruption and shortfalls in the program’s implementation that had come to light during those years, reflecting the dominant themes in the media as depicted in Figure 3.

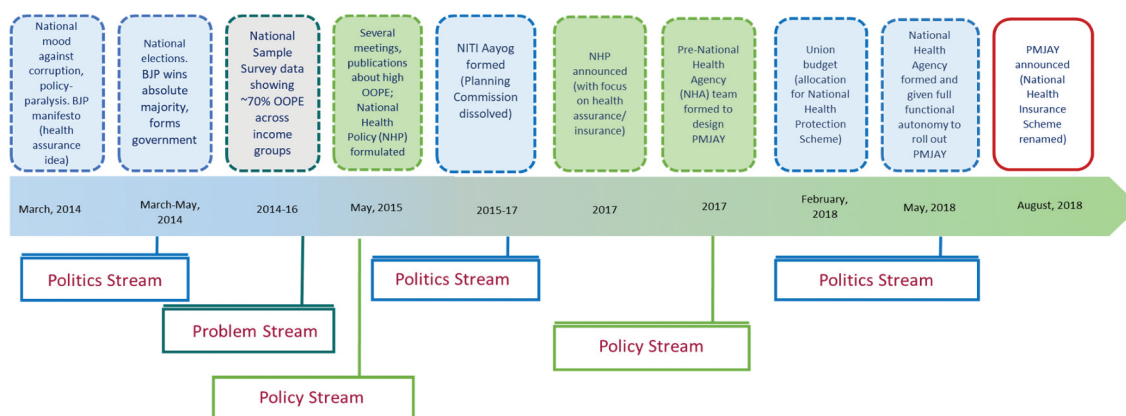
the programs discussed in this study (Figure 5). However, there was a decreasing trend in the percentage of the budget allocated to NHM and RSBY allocations over this period, and a parallel increase in PMJAY, indicating substitution of funds across these programs rather than allocation of new money (Figure 5). Furthermore, allocations to the PMJAY were between 4.4 and 9.8% of the health budget (2018–2021), a relatively modest share compared to the proposed scale of the program’s coverage and to the prominence of the program in the public agenda.

### PMJAY’s Design and Adoption

This section presents the results from a process-tracing analysis conducted with Kingdon’s MSF framework. Figure 6 presents a timeline of events in the different MSF streams leading up to PMJAY. We first examine whether the PMJAY case plausibly fits Kingdon’s theory—in other words, whether or not there were relevant and significant developments in each of the three “streams” that led to PMJAY’s adoption. Second, we combine the literature on health policymaking in India with the political science literature on contemporary



**Figure 5.** Budgetary allocations to four national health programs since the launch of PMJAY (2018–2021). Note: HWC is a budgetary sub-head under NRHM.



**Figure 6.** Timeline of events leading up to PMJAY.

Indian politics to develop an account of why, once health was pushed onto the agenda, the policy instrument chosen was hospitalization insurance for the lower-income 40% of Indians.

### **Problem Stream**

Kingdon suggests that research can bring policy attention to neglected issues by conceptualizing, measuring, and defining them as concrete “problems” to be addressed. In India’s case, the availability of data on OOPE, utilization of private sector health services, and changing epidemiological trends contributed to the problem stream. OOPE had long been recognized as a problem in India’s health sector.<sup>35</sup> However, credible, nationally representative measurements of this problem were infrequent. India’s National Sample Surveys (NSS) have measured health spending in detail sporadically, first in 1995–96 and again in 2004. The 2014 NSS provided the first detailed national data on OOPE since the initiation of RSBY. Analysis of this data showed that OOPE in India, at 68% of total health expenditure, remained among the highest in the world.<sup>36</sup> OOPE had also become a problem facing not just the poor but increasingly also the rising middle and lower-middle classes.<sup>37–40</sup> These findings also demonstrated that six years of RSBY implementation had not reduced OOPE or CHE.<sup>41–44</sup> The NSS also showed that the majority of Indians accessed health services from private sector providers. Simultaneously, India has seen a rising burden of chronic diseases, especially cancers and heart disease. PMJAY designers believed that few public sector hospitals had enough specialists and capacity to treat the increasing volume of patients with these conditions. While the private sector offered such super-specialty care, it was unaffordable to most Indians. This led the PMJAY team toward a financing reform aimed at leveraging the private sector, especially for tertiary care.

The 2014 NSS report’s publication in 2016 also coincided with the global announcement of the Sustainable Development Goals (SDGs), with an explicit focus on financial risk protection that added to the problem stream. Following the announcement of the SDGs, a number of policy consultations were organized by sectoral experts to discuss the problem of high OOPE in India, which included members of government committees, advisors to the Prime Minister, and representatives from global health organizations.

Kingdon’s model highlights the role of “policy entrepreneurs” who advocate for specific policies, seeking to match policies, problems, and political windows of opportunity. In this case, several such influential figures, who had traditionally favored a more public sector-led health care delivery model, came to agree with policy proposals for health financing and delivery reforms that involved both the public and private sectors. For example, *The Lancet* series on Universal Health Coverage (UHC) in India, published in 2015, demonstrated this shift.<sup>45</sup> One of the authors of this series went on to head the health portfolio of the NITI Ayog (the Indian government’s think tank that replaced the earlier Planning Commission), and many others have continued in active policy entrepreneurial roles. Media attention through multiple opinion pieces in leading national newspapers, combined with national and international stakeholders’ focus on action toward achieving the new SDGs and UHC goals, contributed to greater prominence of the problem of OOPE on India’s health policy agenda.

### **Policy Stream**

The policy stream had several factors related to policy entrepreneurs, ongoing debates, and the influence of existing policy templates that led to the choice of PMJAY over other options. While the 2014 NSS

findings provided a stark reminder that the OOPE problem persisted, many policy solutions were possible. Why and how did a policy with the features of PMJAY emerge? Per Kingdon, the policy stream is the purview of the “policy community” of bureaucrats, academics, and policy entrepreneurs with a sustained professional interest in a given issue.

The choice of health insurance reflects a major debate in the Indian health policy community over the past twenty years.<sup>8,9</sup> Circa 2000, the Millennium Development Goals (MDGs) and growing global attention to health issues brought renewed focus on gaps in India’s health sector. The main policy response of the Congress-led coalition government was the NHM (started in 2005); it sought to reinvest in the underfunded public sector health care delivery system, focusing on maternal and child health and infectious disease control. Public sector health spending was increased, and several major policy changes ensued.<sup>6,8</sup>

While NHM was the government’s flagship health policy, policy makers also sought to address high OOPE through a national government-provided health insurance scheme known as RSBY launched in 2008 and adopted by states in a phased manner in subsequent years.<sup>9</sup> The RSBY program, inspired partly by state-level insurance schemes in Andhra Pradesh and Karnataka, emerged from efforts to secure economic security for informal sector workers and was led by the Ministry of Labor rather than the MoHFW.<sup>10,46</sup> This reflected a divide among senior officials and Congress-affiliated policy elites about the desirability of direct provision of health services through the public sector versus publicly-sponsored insurance as a tool to address OOPE. Insurance-based solutions were supported by a group of technocrats, influential donors,<sup>46</sup> and private-sector health providers, who had grown in size and influence dramatically in India.<sup>8</sup>

Shortly after the Congress-led coalition won reelection in 2009, then-Prime Minister Manmohan Singh requested that India’s Planning Commission go beyond RSBY to develop a policy framework for UHC. This High-Level Expert Group’s (HLEG) proposals included a national health insurance program, legislative adoption of the right to health, reforms to the health workforce and health governance, and increased health spending to 6% of GDP.<sup>47</sup> However, these proposals were not received positively by the government and were not taken up before the 2014 election,<sup>8,9</sup> in which the Congress-led coalition lost power to the BJP.

The BJP’s election in 2014 represented a turning point. Having promised a new National Health Policy (NHP) in its manifesto, BJP leaders commissioned work on the NHP and convened task forces with domain

experts, policy advocates, activists, and donors. Despite the mention of a “National Health Protection Scheme (NHPS)” by the BJP in 2014, the design of the policy was unclear throughout most of the BJP’s first term. Health policy entrepreneurs, both within and outside the government, debated between a focus on direct public sector provision of health or greater focus on insurance. However, there was a growing acceptance among policy makers, both in the Planning Commission and the new NITI Aayog, that the substantial increases in funding required to strengthen the public sector would not be forthcoming. The resulting policy stalemate made newer reform options more palatable to this group. Relatedly, strategic purchasing for hospital care was perceived as a promising policy lever that had not been fully tested due to the limited scope of RSBY and limitations in its design.

The first health insurance-related policy change made by the new BJP government was increased coverage from RSBY’s 30,000 INR to 100,000 INR. Next came the creation of the NHA, primarily as a purchaser and separate from the MoHFW’s role as the provider of health services. These decisions, influenced by examples from Thailand, Turkey, and Mexico, were intended as steps toward strategic purchasing under the NHPS. Next, the 2018 budget announcement, in advance of the 2019 elections, presented an opportunity for a “big bang” proposal aimed at building popular support for Modi’s second term. This was when a team of policy entrepreneurs in the NHA, NITI Aayog, and other organizations started working on designing a program at a larger scale than the NHPS. The new NHP was announced in March 2017, after more than a year of debate in policy circles. This policy document first described the idea of the program, which became PMJAY (Figure 6).

The policy entrepreneurs involved in the PMJAY played a significant role in shaping its design. A team linked to the MoHFW and NITI Aayog, along with other organizations, was set up to design the PMJAY. This team was the precursor to the NHA, and many members became early NHA employees. They were PMJAY’s main policy entrepreneurs. Other policy actors included donor agencies like GIZ and the World Bank, who also took part in policy consultations and task forces to provide technical support to the NHA. Some representatives from these agencies were closely involved with the design and agenda-setting of the RSBY as well; this overlap is reflected in the similarity of the core designs of the two programs. Six years of RSBY implementation and many years of state insurance schemes provided a policy template readily available to the BJP (Appendix A).

Further, underlying this were technological and regulatory developments that enabled PMJAY. As noted by Shroff et al., RSBY had been facilitated by the opening of India's insurance industry to the private sector in 1999 and related regulatory reforms.<sup>10</sup> The biometric Aadhaar ID system helped identify beneficiaries without a separate enrollment process, a frequent challenge under RSBY. The rapid development of information technology (IT) infrastructure in India enabled hospitals to conduct e-verification of beneficiaries and processing of cashless and cardless claims.

### Politics Stream

In the *politics stream*, a key development in PMJAY's emergence was the 2014 national elections in which the BJP defeated the incumbent Congress-led government in a landslide, gaining a majority of 282 out of the 543 seats in parliament (Figure 6). The BJP had explicitly mentioned reducing OPE as a priority and had campaigned on a manifesto that included a new health policy and a national health assurance (or protection) program. The 2014 elections not only gave BJP an absolute majority (the first in Indian politics since 1984); it also did not produce any official opposition party in the legislature: a party in the lower house of the parliament (Lok Sabha) must have at least 10% of the total seats (543) to be considered the opposition party. The closest was Congress, with 44 seats. This large majority made it easier for the BJP to avoid coalition politics and navigate veto gates at the national level.<sup>29</sup>

The BJP's majority win also enabled it to make sweeping changes to government institutions, such as the dissolution of the Planning Commission of India, which since 1950 had been in charge of the five-year plans that determined programs and budgets for all public policies. Modi's government replaced the Planning Commission with a new agency known as the National Institution for Transforming India (NITI Aayog), which strongly supported PMJAY (Figure 6). Several of its members were involved in consultations that led to PMJAY's design and were also on the NHA's governing body. The NHA was created through the Prime Minister's cabinet as a new institution instead of making it a directorate within the MoHFW. The NHA, rather than the MoHFW, was made the lead agency charged with implementing PMJAY and entering into direct agreements with states.

The demographics of the BJP's electoral coalitions and the evolution of its economic ideology shed further light on the choice of a program like PMJAY. While the Congress traces its roots to the Indian independence movement, the BJP emerged from the Bharatiya Jana Sangh, established in 1951.<sup>b</sup> Although electoral coalitions in India are complex, regionally-varying, and

dynamic, the Congress' electoral base has traditionally been considered to be the liberal, English-speaking elites, the rural poor, and religious minorities. By contrast, the BJP has historically sought to appeal to higher income and caste Hindus as well as aspirational groups in India's rising middle and lower-middle classes (earning between \$2 USD and \$10 USD per day), primarily urban and Hindu.<sup>48–51</sup> Political scientists have also highlighted how the BJP has built mixed religious and nationalist appeals with selective social welfare initiatives, in part to expand its electoral appeal outside of its base.<sup>48–56,57</sup> This evolution of the BJP's economic ideology played a role in the emergence of PMJAY.<sup>46</sup> Additionally, in contrast to the Congress' focus on the direct delivery of goods and services through the public sector, several of the BJP's reforms have reflected a move away from a direct provision role to a financing and facilitating role for the government.<sup>51</sup>

Another key theme in the politics stream influenced the design of PMJAY—the prevailing public opinion or the national mood before the 2014 elections demanding action against corruption, policy paralysis, and weak governance associated with the Congress-led government.<sup>52–56,58–60</sup> Several cases of corruption and fraud by commercial insurance companies and providers under the RSBY were publicized during this period (Figure 3). The BJP fought the 2014 elections on promises of ridding India of corruption and making governance more efficient and effective (Appendix D).

To dissociate PMJAY from the problems of RSBY, the BJP's election manifesto promised a shift to health “assurance,” which, in practical terms, meant reducing the role of commercial insurers in PMJAY. Relatedly, the name “RSBY” was changed to Rashtriya Swasthya Suraksha Yojana i.e., “national health security program” instead of “national health insurance program.” The initial operational guidelines of PMJAY emphasized the state-government-led purchasing organizations (known as the “Trust Model”) with limited roles for insurance companies (or the “Insurance Model”). This highlighted a contrast with RSBY, and gave states flexibility to choose among institutional models and purchasing roles for government.<sup>1</sup>

Politics was further evident in the policy's naming and branding and in decisions about its state-level adoption. *Pradhan Mantri Jan Arogya Yojana* (PMJAY) translates to the “Prime Minister's Program for the Health of the People”; the acronym PMJAY's pronunciation in several Indian languages means “victory to the PM.” Prior to the 2019 national elections, state-level adoption of the PMJAY became a symbol of support for the BJP from state political parties. States that refused to adopt it signaled their opposition.

The PMJAY's strong association with the Prime Minister made several state-level opposition parties hesitant, especially in West Bengal, Delhi, and Odisha. For example, in the letter dated January 10, 2019, in which West Bengal announced its withdrawal from PMJAY, the state chose to call the scheme *Jan Arogya Yojana*, dropping the prefix PM, and insisted on retaining the name of its existing state insurance program, *Swasthya Sathi*. West Bengal's Chief Minister Mamata Banerji, in her election 2019 speeches, accused Modi of mailing propaganda to her constituencies by sending them information about PMJAY. The government of Delhi requested that the scheme's name be *Mukhya Mantri Aam Aadmi Swasthya Bima Yojana Ayushman Bharat*. The proposed name had "Chief Minister" (*Mukhya Mantri*) and *Aam Aadmi* (the name of Delhi's ruling party and a key state-level opposition of the BJP). In Odisha, Chief Minister Naveen Patnaik announced his state insurance scheme in June 2018, just before the PMJAY, albeit with a very similar design, with the name *Biju Swasthya Kalyan Yojana*—"Biju" being the name of his party (Biju Janata Dal, another state-level opposition to the BJP) as well as Patnaik's father (who was a chief minister of Odisha for multiple terms). In a similar style to Modi, Patnaik sent personal letters to the beneficiaries during the run-up to the 2019 elections. While these three states have continued without the PMJAY to date, several states have eventually attached names of their existing state health insurance schemes or political parties to PMJAY through co-branded PMJAY cards. Such negotiations about the name of a health policy were unprecedented in Indian politics, as states have typically adopted federal programs, including the NHM, RSBY, and HWCs, without hesitation.

The PMJAY design reflects the political imperative to undertake a social welfare program for lower-income Indians, with a primarily financing and regulatory (versus direct provision) role for the government, and without significant short-run health spending increases. Notably, the program built on the existing RSBY template, taking forward a broader BJP pattern of expanding social programs initiated under previous governments. As Vaishnav (2018) has noted, "When in opposition, [the BJP] criticized many of the Congress Party's key social welfare schemes as being too costly and socialist. However, since it came to power, the party has doubled down on nearly every such scheme."<sup>48</sup> Yet in expanding these programs, many took on a distinct pattern mirroring the BJP's and Modi's persona, "featuring grand announcements, ambitious targets, and tightly centralized monitoring," as noted by Aiyar (2019).<sup>51</sup> PMJAY, during this period, fits this political and ideological model for the BJP and Modi's approach to public policy.

## Discussion

This paper was motivated by the long-standing puzzle highlighted by Sen and Drèze (2013) of the absence of health from India's policy and political agenda.<sup>6</sup> Our results demonstrate that the PMJAY program occupies a much more prominent place on the policy agenda than previous health policies—most notably on the public (media and campaign) agenda and partially on the institutional agenda. This emergence can be understood as a confluence of several factors: a well-defined problem of rising OOE, debates within the policy community, available models from previous, smaller-scale insurance policies, and a major shock to the political system, which gave Prime Minister Modi's BJP a free hand to design new initiatives and empowered policy entrepreneurs who favored insurance.

Our paper adds to the literature on agenda-setting and policy adoption in global health. We contribute to understanding both public and institutional agenda-setting, combining media and content analysis with parliamentary and budget data. The paper also demonstrates that to explain the PMJAY, it is necessary to understand not only the evolution of thinking within the Indian health policy community, but also the intersection of these policy ideas with the ideological commitments and the political strategies of the BJP.

This paper has several limitations. The measures of agenda presence do not capture all relevant media sources, and we also lack state-level measures of parliamentary debate and budgetary allocations. Although we did a validity check with news items in Hindi newspapers, we did not include publications in other Indian languages. Furthermore, since Factiva does not have archives of Hindi newspapers, our source for Hindi news coverage differs from our main dataset (Appendix C). This single case study is also limited in its ability to subject Kingdon's theory to formal testing: our retrospective analysis of the fit between the Multiple Streams Framework and the PMJAY policy design and adoption process may omit other important drivers of agenda presence and policy adoption. Additionally, our study would have been strengthened with the inclusion of data from stakeholder interviews. As such interviews were not possible due to resource constraints, we have incorporated significant written feedback from eight senior health policy stakeholders. However, key informant interviews might have yielded additional insights. Notwithstanding these limitations, our analysis underscores several lessons which could be transferable to other policy contexts.

First, it highlights the importance of the interaction between media and government in framing an issue and

shaping agendas. At the same time, it reinforces the need to measure both public (media-based) and institutional agenda presence, which may conflict. Media coverage was the original measure used by Sen and Dreze to suggest that health has been absent from India's policy agenda,<sup>6</sup> and it is where we see the most dramatic differences between PMJAY and previous policies. But media coverage—even when largely positive in tone—is not itself a measure of policy success. Skilled policy actors seek to generate favorable media coverage, and attempt to direct attention to issues that they believe reflect favorably on them.<sup>60–62</sup> In the current Indian context, the BJP government has been widely seen as more successful than other parties in its use of both traditional and social media to frame issues in its favor. This is reflected in the high levels of positive media attention to PMJAY that we document in the period before the program had been scaled up to any significant degree and, indeed, before budget allocations corresponding to the program's intended scale were made.

Second, our paper highlights the importance of political leadership in health reforms as well as the tradeoffs that this may entail. The PMJAY was largely championed by the Prime Minister's Office, creating several necessary conditions for its adoption. A number of other countries have seen similar politician-led UHC reforms focused on the expansion of insurance.<sup>62–64</sup> A political push from the highest office can guarantee the issue's presence on the governmental agenda. But taken to extremes, this could lead to a conflation of the policy with a single political leader, compromising its objective evaluation among critics, rejection by the opposition, and even its sustainability when governments change.<sup>65</sup> Given the global rise of populism and personality-driven politics, reformers may wish to consider the costs and benefits of the personalization of health policy initiatives.

A third lesson from our paper is the role of institutional politics, especially in determining where the policy is housed and, consequently, how much implementation and financial support it receives. India's low government health spending as a proportion of GDP has been relatively constant despite repeated promises from the Congress and the BJP to raise government health expenditure to 2.5–3% of GDP.<sup>52–56</sup> Low levels of spending on health have persisted even when budget allocations for PMJAY were included. Our budget analysis suggests that increases in the budget for PMJAY have come at the expense of other health programs, such as NHM, even as a larger portion of health spending continues to be allocated to the NHM. This could foreshadow future contention between the provider and the purchaser (i.e., between the MoHFW, a federal government

ministry of career civil servants in charge of the entire public-sector healthcare delivery system, and the newly created NHA, comprised largely of non-civil servant professionals in charge of PMJAY). The creation of the NHA and PMJAY suggests a longer-term goal of establishing strategic purchasing through a purchaser-provider split. However, such a split, combined with more budget to the NHA, would imply a reduction in the scope of the MoHFW and its vast network of providers. Other countries have experienced conflicts between ministries of health and new purchasing organizations when this occurs.<sup>60,62</sup> Recognizing the political implications of these reforms could inform strategies for better policy implementation.

Reflecting on the broader trajectory of health policy in India, we note that dramatic differences in the public agenda presence of health over time coexist with strong elements of path dependence on policy substance. A comparison of RSBY and PMJAY designs indicates that although the intended scale of the programs is quite different, the differences in design are more modest (Appendix A). PMJAY, like RSBY, has limited its focus to hospitalizations, even though most OOPe in India is for outpatient care and medicines.<sup>36</sup>

Path dependence is further illustrated at the state level: many states simply renamed or co-branded their ongoing insurance schemes as “PMJAY” (in some cases with newly revised or expanded lists of beneficiaries) and integrated them into the new IT platform.<sup>1</sup> Political leaders felt pressure to implement PMJAY quickly, given the proximity to the 2019 elections. This (path-dependency-inducing) choice to adopt the existing template of health policies was the fastest, least disruptive option, but may not have been consistent with reflection about the costs and benefits of the existing models.<sup>66–68</sup>

Further, our analysis of the parliamentary debates showed continuing low salience of the subject of health among legislators. Health policy reformers may wish to consider different political strategies for setting public and institutional agendas.<sup>71,70</sup> On the public agenda, high profile announcement of a new large-scale program may garner public support and make it harder for the opposition to undo a reform. But such announcements may ring hollow over time unless leaders also take steps to place the issue on the institutional agenda, such as by increasing overall government expenditure on health. This in turn may require engagement with senior economic policy makers and political leaders, including economic and political analyses.

Looking ahead, some analysts have argued that PMJAY is likely to create a leverage point for increased health spending in India. The argument is that by creating an entitlement among a large population, politicians

will feel “locked in” via policy feedback effects to support commensurate spending increases.<sup>69</sup> Critics of PMJAY have argued that path dependence will cement a focus on private, inpatient curative care paid via fee-for-service, crowding out primary care and expenditures in the public sector.

Irrespective of how one perceives the PMJAY, it has placed health financing in the public discourse in an unprecedented fashion. The media coverage of PMJAY has gained even greater salience in the context of the COVID-19 pandemic, although the media narrative has been more critical than in its first year and has focused much more on the program’s design and utilization.<sup>72–74</sup> It remains to be seen whether this public attention will translate into transformative health system reforms, especially following the COVID-19 crisis, which is likely to cast a long shadow on health policy discussions in India in the near future.

## Conclusion

This paper provides insights into agenda-setting, policy design, and adoption in India, focusing on a highly publicized health reform, PMJAY. Research on the politics of health reforms in India is scarce. Using a combination of data sources, our analyses highlight the importance of political and electoral factors in health reforms. We conclude with lessons for policy makers in India and other countries to consider when designing political strategies to enable agenda-setting and adoption of reforms.<sup>73</sup>

## Notes

[a] SECC-2011 is a study of socio economic status of rural and urban households in India and allows ranking of households based on predefined vulnerability parameters. These parameters go beyond the more conventional and financial measures of income, wealth, or expenditures to determine vulnerability. The SECC-2011 includes seven extended vulnerability parameters: (i) the type of material used to build the house and the size of the house, (ii) households without any adult member between ages (18 and 59 years), (iii) households with female heads, (iv) households with heads with disabilities, (v) households belonging to historically disadvantaged castes and tribes, (vi) households with no literate adult above the age of 25 years, and (vii) landless households deriving majority of their income from manual labor.

[b] The BJP traces its roots to the Bharatiya Jana Sangh (BJS), established in 1951 as the political wing of the group Rashtriya Swayamsevak Sangh (RSS). The BJS advocated the rebuilding of India in accordance with Hindu culture and called for the formation of a strong unified state. In 1967 the BJS gained

a substantial foothold in the Hindi-speaking regions of northern India. In 1977, it joined three other political parties to form the Janata Party and took over the reins of the government. This was the time that the incumbent PM, Indira Gandhi declared “emergency” in the country, suspending the constitutional rights of the citizens, and as a result the Congress party lost the 1977 elections. However, the JP was plagued by factionalism and internal disputes, and the government collapsed in July 1979. The BJP was formally established in 1980, following a split by dissidents within the Janata coalition, whose leaders wanted to prohibit elected BJS officials from participating in the RSS due to criticisms of political and religious extremism. The party won only two seats in the 1984 Indian parliamentary election, but grew in strength on the back of the Ram Janmabhoomi movement, which was agitating to build a Hindu temple at the site of the demolished Babri mosque. By 1991 the BJP had considerably increased its political appeal, capturing 117 seats in the Lok Sabha and also formed governments in four states. The National Democratic Alliance (NDA)—a coalition of 20 national and regional parties led by the BJP, has held power in India on four occasions, including short-lived governments after elections in 1996 and 1998, and a full five-year term from 1999 to 2003. The party lost the majority in 2004 and then again in 2009 to the UPA coalition led by Congress (Encyclopædia Britannica, 2019).

## Acknowledgments

We gratefully acknowledge the valuable insights and comments from Vipul Aggarwal, Alexo Esperato, Kheya Melo Furtado, Praveen Gedam, Nachiket Mor, Stefan Nachuk, and three others who choose to remain anonymous.

## Disclosure Statement

No potential conflict of interest was reported by the author(s).

## Funding

This study was undertaken as a part of the India Health Systems Project (at the Harvard T.H. Chan School of Public Health) funded by the Bill and Melinda Gates Foundation and Tata Trusts.

## ORCID

Anuska Kalita  <http://orcid.org/0000-0001-9912-7471>

## Ethics Statements

This was not a human subjects study, and no ethical approvals were required.

## Data Availability Statement

All data is publicly available.

## References

- National Health Authority. Government of India; 2019. [www.pmjay.nic.in](http://www.pmjay.nic.in)
- Press Trust of India. PM Modi rolls out 'game-changer' PMJAY-Ayushman Bharat scheme. *The Times of India*. 2018 Sept 23.
- Roy S. Narendra Modi: 'Ayushman Bharat a historic step towards affordable healthcare.' *The Indian Express*. 2019 Sept 24.
- Sudan P, Bhushan I. In one year, PM-JAY has created a framework for comprehensive universal healthcare. *The Indian Express*. 2019 Sept 23.
- Sharma NC. Ayushman Bharat is a revolutionary step towards a new India-PM Modi. *Mint*. 2019 Oct 1.
- Drèze J, Sen A. *An uncertain glory: India and its contradictions*. UK: Princeton University Press; 2013.
- WHO. *Global health expenditure database world health organization*. 2019.
- Rao S. *Do we care?: India's health system*. New Delhi: Oxford University Press; 2017.
- Reddy KS. *Make health in India: reaching a billion plus*. New Delhi (India): Orient BlackSwan; 2019.
- Shroff ZC, Roberts MJ, Reich MR. Agenda setting and policy adoption of India's national health insurance scheme: rashtriya Swasthya Bima Yojana. *Health Syst Reform*. 2015;1(2):107–18. doi:10.1080/23288604.2015.1034310. Published Online First: 2015 Feb 17.
- Shiffman J, Ved RR. The state of political priority for safe motherhood in India. *BJOG*. 2007;114(7):785–90. doi:10.1111/j.1471-0528.2007.01374.x.
- Balarajan Y, Reich MR. Political economy of child nutrition policy: a qualitative study of India's Integrated Child Development Services (ICDS) scheme. *Food Policy*. 2016;62:88–98. doi:10.1016/j.foodpol.2016.05.001.
- Bauhoff S, Sudharsanan N. Evaluating health insurance programmes: an insurance cascade framework. *Econ Polit Wkly*. 2021;56(23):22–28.
- Garg S, Bebartha KK, Tripathi N. Performance of India's national publicly funded health insurance scheme, Pradhan Mantri Jan Arogya Yojana (PMJAY), in improving access and financial protection for hospital care: findings from household surveys in Chhattisgarh state. *BMC Public Health*. 2020;20(1):949. doi:10.1186/s12889-020-09107-4.
- Hooda SK. Penetration and coverage of government-funded health insurance schemes in India. *Clin Epidemiology Glob Health*. 2020;8(4):1017–33. doi:10.1016/j.cegh.2020.03.014.
- Ghosh SM, Qadeer I. Pradhan Mantri Jan Arogya Yojana: a paper tiger. *Soc Change*. 2019;49(1):136–43. doi:10.1177/0049085718821767.
- Angell BJ, Prinja S, Gupt A, Jha V, Jan S. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana and the path to universal health coverage in India: overcoming the challenges of stewardship and governance. *PLoS Med*. 2019;16(3):e1002759–e59. doi:10.1371/journal.pmed.1002759.
- Rajiv M, George LS, Mainu CR, Raj A, Aravind MS. Facilitators and barriers for Pradhan Mantri Jan Arogya Yojana empanelment by private hospitals in Kerala: a qualitative analysis. *Ann Community Health*. 2021;9(1):157–162.
- Sriee GVV, Maiya GR. Coverage, utilization, and impact of Ayushman Bharat scheme among the rural field practice area of Saveetha Medical College and Hospital, Chennai. *J Fam Med Prim Care Rev*. 2021;10(3):1171–76. doi:10.4103/jfmpc.jfmpc\_1789\_20.
- Prinja S, Singh MP, Guinness L, Rajsekar K, Bhargava B. Establishing reference costs for the health benefit packages under universal health coverage in India: cost of health services in India (CHSI) protocol. *BMJ Open*. 2020;10(7):e035170. doi:10.1136/bmjopen-2019-035170.
- Joseph J, Sankar HD, Nambiar D. Empanelment of health care facilities under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in India. *PLoS One*. 2021;16(5):e0251814. doi:10.1371/journal.pone.0251814. Published Online First: 2021 May 28.
- Reddy NKK, Bahurupi Y, Kishore S, Singh M, Aggarwal P, Jain B. Awareness and readiness of health care workers in implementing Pradhan Mantri Jan Arogya Yojana in a tertiary care hospital at Rishikesh. *Nepal J Epidemiology*. 2020;10(2):865–70. doi:10.3126/nje.v10i2.27941. Published Online First: 2020 Sept 3.
- Dong D, Naib P, Smith O, Chhabra S. Raising the bar: analysis of PM-JAY high-value claims. *PMJAY Policy Brief*. publication: National Health Authority; 2019. <https://pmjay.gov.in/>
- Smith O, Dong D, Chhabra S. PM-JAY and India's aspirational districts. *PMJAY Policy Brief 3*. National Health Authority; 2019. <https://pmjay.gov.in/>
- Smith O, Dong D, Chhabra S. PM-JAY across India's states: need and utilization. *PMJAY Policy Brief 2*. <https://pmjay.gov.in/publication>: National Health Authority, 2019.
- Naib P, Gautam K, Mishra G. Utilization of neo-natal care packages under PMJAY: findings from preliminary analysis. *Working Paper 2*. National Health Authority; 2019. <https://pmjay.gov.in/>
- Kingdon JW. *Agendas, alternatives and public policies*. New York (USA): HarperCollins College Publishers; 1995.
- Cobb RW, Elder ED. *Participation in American politics; the dynamics of agenda-building*. Boston (USA): Allyn and Bacon; 1972.
- Tsebelis G. *Veto players: how political institutions work*. NJ (USA): Princeton University Press; 2002.
- UIDAI. *Unique Identification Authority of India*. Government of India; 2019. <http://uidai.gov.in>
- Howland D, Becker M, Prelli L. Merging content analysis and the policy sciences: a system to discern policy-specific trends from news media reports. *Policy Sci*. 2006;39:205–31. doi:10.1007/s11077-006-9016-5.
- Laswell HD. *A Pre-View of Policy Sciences*. New York (USA): American Elsevier Publishing Co., Inc; 1971.

33. Baumgartner FR, Jones BD. Agenda dynamics and policy subsystems. *J Polit.* 1991;53(4):1044–74. doi:10.2307/2131866.
34. Dunning T. Improving process tracing: the case of multi-method research. In: Bennett A, Checkel JT, editors. *Process tracing: from metaphor to analytic tool.* Cambridge: Cambridge University Press; 2014. p. 211–36.
35. Selvaraj S, Karan AK. Deepening health insecurity in India: evidence from national sample surveys since 1980s. *Econ Polit Wkly.* 2009;40:55–60.
36. NSSO. Key Indicators of Social Consumption in India: Health, (National Sample Survey 71st Round). Delhi (India): Government of India; 2014.
37. Ravi S, Ahluwalia R, Bergkvist S. Health and Morbidity in India (2004–2014). New Delhi (India): Brookings India; 2016.
38. PRICE. ICE 360° Survey, 2016: Household Survey on India's Citizen Environment and Consumer Economy. New Delhi (India): People Research on India's Consumer Economy; 2016 .
39. Bhattacharya P. Indian household's healthcare woes. *Mint.* 2016 Dec 20.
40. Mor N, Kalita A. Financing Universal Healthcare in India. *Mint.* 2015 May 11.
41. Karan A, Yip W, Mahal A. Extending health insurance to the poor in India: an impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare. *Soc Sci Med.* 2017;181:83–92. doi:10.1016/j.socscimed.2017.03.053. Published Online First: 2017 Apr 5.
42. Khetrapal S, Acharya A, Mills A. Assessment of the public-private-partnerships model of a national health insurance scheme in India. *Soc Sci Med.* 2019;243:112634. doi:10.1016/j.socscimed.2019.112634. Published Online First: 2019 Nov 8.
43. Nandi S, Schneider H, Dixit P. Hospital utilization and out of pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh State, India: lessons for universal health coverage. *PloS One.* 2017;12(11):e0187904–e04. doi:10.1371/journal.pone.0187904.
44. Nandi S, Schneider H, Garg S. Assessing geographical inequity in availability of hospital services under the state-funded universal health insurance scheme in Chhattisgarh state, India, using a composite vulnerability index. *Glob Health Action.* 2018;11(1):1541220–12. doi:10.1080/16549716.2018.1541220.
45. Patel V, Parikh R, Nanraj S, Balasubramaniam P, Narayan K, Paul VK, Kumar AS, Chatterjee M, Reddy KS. Assuring health coverage for all in India. *Lancet (British Edition).* 2015;386(10011):2422–35. doi:10.1016/S0140-6736(15)00955-1.
46. Virk AK, Atun R. Towards universal health coverage in India: a historical examination of the genesis of Rashtriya Swasthya Bima Yojana - The health insurance scheme for low-income groups. *Public Health.* 2015;129(6):810–17. doi:10.1016/j.puhe.2015.02.002. Published Online First: 2015 Apr 7.
47. Reddy KS, Balasubramaniam P, Bhokare S, et al. High level expert group report on universal health coverage for India. Delhi (India): Government of India, 2011.
48. Vaishnav M. What is the secret to the success of India's Bharatiya Janata Party (BJP)? USA: Carnegie Endowment for International Peace; 2018.
49. Misra S. Understanding the rise of the Bharatiya Janata Party. Delhi (India): ORF; 2018.
50. Baxter C. The Jana Sangh. USA: University of Pennsylvania Press; 2016.
51. Aiyar Y. Modi consolidates power: leveraging welfare politics. *J Democr.* 2019;30(4):78–88. doi:10.1353/jod.2019.0070.
52. Bharatiya Janata Party. Ek Bharat Shreththa Bharat - Sabka Saath, Sabka Vikas. Election Manifesto 2014. New Delhi (India): BJP; 2014.
53. Indian National Congress. Your voice our pledge. Lok Sabha Election 2014 - Manifesto of the Indian National Congress. New Delhi (India): Indian National Congress; 2014.
54. Indian National Congress. Lok Sabha Elections 2009 - Manifesto of the Indian National Congress. New Delhi (India): Indian National Congress; 2009.
55. Indian National Congress. Congress Will Deliver. Lok Sabha Elections 2019 - manifesto of the Indian National Congress. New Delhi (India): Indian National Congress; 2019.
56. Bharatiya Janata Party. Sankalp Bharat Sashakt Bharat. Sankalp Patra - Lok Sabha 2019. New Delhi (India): BJP; 2019.
57. Thachil T. Elite parties, poor voters : how social services win votes in India. New York (NY, USA): Cambridge University Press; 2014.
58. CSDS. National election study 2013 - pre-poll survey findings. *India Today.* 2013.
59. CVOTER. Election survey. *Times Now.* 2014.
60. Sparkes S, Bump J, Özçelik E, Kutzin J, Reich MR. Political economy analysis for health financing reform. *Health Syst Reform.* 2019;5:183 194.
61. Gilardi F, Gessler T, Kubli M, Müller S. Social media and political agenda setting. *Political Commun.* 2022;39(1):39–60. doi:10.1080/10584609.2021.1910390.
62. Fox AM, Reich MR. The politics of universal health coverage in low and middle-income countries: a framework for evaluation and action. *J Health Polit Policy Law.* 2015;40(5):1023–60. doi:10.1215/03616878-3161198.
63. Lakin J. The possibilities and limitations of insurgent technocratic reform: Mexico's popular health insurance program, 2001–2006. [PhD dissertation]. Cambridge (MA): Harvard University; 2008.
64. Wong J. Healthy democracies: welfare politics in Taiwan and South Korea. Ithaca (NY): Cornell University Press; 2004.
65. Reich MR. Restructuring health reform, Mexican style. *Health Syst Reform.* 2020;6(1):e1763114–11. doi:10.1080/23288604.2020.1763114.
66. Lakin JM. The end of insurance? Mexico's Seguro Popular, 2001 - 2007. *J Health Polit Policy Law.* 2010;35(3):313–52. doi:10.1215/03616878-2010-002. Published Online First: 2010 May 26.

67. Pierson P. Increasing returns, path dependence, and the study of politics. *Am Polit Sci Rev.* 2000;94(2):251–67. doi:10.2307/2586011.
68. Pierson P. *Politics in time: history, institutions, and social analysis.* Princeton (NJ): Princeton University Press; 2011.
69. Roberts M, Hsiao W, Berman P, Reich MR. *Political analysis and strategies in getting health reform right: a guide to improving performance and equity.* New York: Oxford University Press; 2004.
70. Sparkes SP, Bump J, Reich MR. Political strategies for health reform in Turkey: extending veto point theory. *Health Syst Reform.* 2015;1(4):263–75. doi:10.1080/23288604.2015.1093063.
71. Chalkidou K, Jain N, Cluzeau F, Glassman A. Medicare post-election: recommendations to enhance the impact of public health insurance on UHC goals in India. *CGD Note: Center for Global Development;* 2019.
72. Sarkar S. Only 18k of over 5.31 lakh eligible under Ayushman Bharat got free COVID-19 treatment. *The Week.* 2021 June 22.
73. Upadhyay A. Under Ayushman Bharat, huge disparities among states where Covid patients availed scheme. *India Today.* 2021 Jun 16.
74. Perappadan BS Inpatient care utilisation under PMJAY badly hit by lockdown: analysis. *The Hindu.* 2020 August 10.