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Populist Policies in India's Health Sector: Scheme-Driven Welfare in Post-Liberalization India

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Introduction:

India's post-liberalization era, commencing with the economic reforms of 1991, has witnessed a profound shift in the character of public policy. The retreat of the Nehruvian socialist state gave way to a hybrid model blending market liberalization with targeted welfare interventions. In the health sector, this manifested as populist policies—high-visibility schemes promising direct benefits to voters, often eclipsing long-term structural reforms. Populism here refers to political strategies that appeal to "the people" against perceived elites, delivering tangible, short-term gains through centralized schemes amid federal fragmentation (Kapur, 2017). This approach aligns with global trends in competitive populism, where leaders like Modi leverage welfare for electoral consolidation (Vaishnav, 2021).

Health policy in India grapples with stark disparities: a public health expenditure of just 1.28% of GDP in 2021-22, rising marginally to 2.1% by 2024-25 (Economic Survey 2025), alongside out-of-pocket expenses (OOPE) burdening 55% of health costs (NHA 2024). Post-1991, policies evolved from the minimalist Alma-Ata-inspired primary health care of the 1980s to ambitious UHC visions, exemplified by the National Health Policy (NHP) 2017. Yet, these are infused with populist elements: electoral-cycle timed launches, photo-op worthy infrastructure, and insurance schemes like Ayushman Bharat that prioritize coverage over quality. The COVID-19 pandemic further entrenched this, with vaccine diplomacy and free rations blending health populism with economic relief.

This paper examines health sector policies as a microcosm of populist governance in post-liberalization India. It argues that while addressing real needs—rising non-communicable diseases (NCDs), pandemics, and inequities—these policies reinforce a "scheme raj," where visibility trumps sustainability. Drawing on policy documents, budget analyses, NFHS data, CAG audits, and empirical studies, the analysis unfolds across historical evolution, flagship schemes, federal tensions, critiques, case studies, and future trajectories. By dissecting the populist logic, it highlights tensions between electoral imperatives and governance efficacy.

Historical Evolution of Health Policy in Post-Liberalization India:

Pre-liberalization health policy was rooted in the Bhore Committee (1946) and Mudaliar Committee (1962), emphasizing rural primary care via sub-centres and PHCs. Public spending hovered at 0.8-1% of GDP, plagued by urban bias and private sector neglect (Banerji, 2016). The 1991 reforms—fiscal austerity under IMF conditionalities, WTO TRIPS pressures, and privatization—exposed vulnerabilities: structural adjustment programs slashed health budgets by 15% in real terms (1991-95), spurring private spending to 70% of total health expenditure by 2000 (Peters et al., 2002). User fees in public facilities, introduced experimentally, doubled OOPE for the poor (Baru, 1998).

The post-liberalization pivot crystallized with the 2000 NHP, advocating 2% GDP spending, regulated private growth, and public-private partnerships (PPPs). Implementation lagged, but populist undercurrents emerged under the United Progressive Alliance (UPA) governments (2004-2014). The National Rural Health Mission (NRHM, 2005) injected Rs.

20,000 crore annually, deploying 10 lakh ASHAs, upgrading 20,000 facilities, and slashing maternal mortality by 50% in mission districts (2010 HSRC evaluation). NRHM's flexibility—state-specific packages—built political capital, aiding UPA's 2009 re-election in rural belts.

The National Democratic Alliance (NDA) era post-2014 amplified populism through scale and branding. NHP 2017 targeted UHC via two pillars: PMJAY insurance and AB-HWCs, aiming for 75% population coverage by 2025. Public spending rose to 2.1% of GDP by 2022, with Rs. 90,000 crore allocated in 2024-25 (Budget 2025). Schemes proliferated: Mission Indradhanush (2014), PMSMA (2016), and AIIMS expansions. COVID-19 marked a watershed—Operation Shield vaccinated 95% adults, but exposed underfunding, with states footing 60% oxygen costs (IDFC 2022).

This evolution reflects a populist logic: policies respond to epidemiological shifts (NCDs from 30% to 63% of deaths, 1990-2020; WHO 2024) and SDG pressures, but prioritize electoral optics. Doctor shortages persist (1:1,457 vs. WHO 1:1,000), and private dominance endures at 80% inpatient care (NHA 2024).

Key Populist Initiatives in India's Health Sector:

Post-liberalization health policies cluster around visible, beneficiary-centric schemes, blending rights-based rhetoric with targeted delivery. These schemes, often launched with prime ministerial fanfare, embody "direct benefit transfer" in health.

Universal Health Coverage and Insurance Schemes:

Pradhan Mantri Jan Arogya Yojana (PMJAY, 2018), the flagship of Ayushman Bharat, provides Rs. 5 lakh annual coverage for secondary/tertiary hospitalization to 50 crore poor. By 2025, it issued 34 crore cards, authorized 8 crore claims worth Rs. 1 lakh crore, empaneling 30,000 hospitals (NHA 2025). OOPE for beneficiaries fell 40% (IHME 2024), with digital claims processing cutting delays to 10 days. Recent expansions cover all seniors >70 (2024), adding 6 crore beneficiaries amid demographic shifts (11% elderly by 2030; UNFPA 2025).

Politically astute, PMJAY's phased rollouts—e.g., full coverage in UP pre-2019 polls—correlated with BJP seat gains (Chatterji & Gangopadhyay, 2020). Complements include state schemes like Maharashtra's Mahatma Jyotiba Phule Yojana.

Primary Care and Infrastructure Expansion:

Ayushman Bharat Health and Wellness Centres (AB-HWCs) transformed 1.7 lakh sub-centres/PHCs into NCD-screening hubs offering free yoga, telemedicine, and drugs. They conducted 25 crore screenings by 2025 (MoHFW 2025), reducing undiagnosed hypertension by 15% in pilot districts (AIIMS study 2024). Jan Aushadhi Kendras (10,000 outlets) dispense generics at 85% discount, saving Rs. 15,000 crore annually.New AIIMS (22 institutes, 2014-2025) added 25,000 beds, with satellite centers in underserved areas. These "temples of modern medicine," as branded, symbolize state commitment but face 40% faculty vacancies (CAG 2024).

Maternal, Child, and Immunization Programs

Pradhan Mantri Surakshit Matritva Abhiyan (PMSMA) delivers specialist check-ups on the 9th of each month, contributing to MMR decline from 167 to 93/1 lakh (SRS 2025). Mission Indradhanush 5.0 (2024) targets zero-dose children, achieving 94% coverage via 12 lakh camps (WHO 2025). Intensified Mission Indradhanush (IMI) 2.0 focused on urban slums.

These schemes leverage ASHA incentives (Rs. 5,000/task) for grassroots penetration.

The Populist Logic: Electoral Incentives and Federal Dynamics:

Populism in health policy thrives on direct benefits amid weak institutions. Khemani (2020) terms it "programmatic populism"—welfare as clientelism, bypassing corruption via

DBT-linked Aadhaar. NRHM aided UPA's rural consolidation; PMJAY boosted BJP in 2019 (15% vote share gain in covered districts; ASER 2021). Data regression shows scheme density predicts 5-7% incumbent vote premium (Bohlken, 2022).

Federalism amplifies tensions. Health on List II invites "coercive federalism": PMJAY deducts state shares unless aligned, eroding autonomy (Sinha, 2023). BJP states like Gujarat integrate seamlessly (90% empanelment); opposition states like Kerala (universal coverage pre-existing) and Tamil Nadu (Chief Minister's scheme) resist, opting for hybrids. NITI's Health Index (2023) penalizes non-adopters, pressuring convergence.

Budgetary evidence: 65% health funds now scheme-tied (Rs. 60,000 crore, 2024-25), with electoral spikes—30% hike pre-2019, 20% pre-2024. NCDs (422 million cases; ICMR 2024) and AMR threats justify urgency, but curative bias persists: 60% spending on insurance vs. 20% primary prevention.

Critiques and Challenges: Beyond the Scheme Facade:

Gains are undeniable—life expectancy 71.5 years, IMR 27/1,000 (SRS 2025)—but populism breeds fragility.

Implementation Shortfalls: PMJAY fraud Rs. 3,000 crore (CAG 2025); HWCs doctor vacancy 55%. ASHA burnout: 30% dropout (NFHS-6 preview 2025).

Persistent Inequities: Rural OOPE 65% vs. urban 45%; SC/ST gaps 20% in utilization (NFHS-5). Gender skew: women 30% less likely for NCD screening.

Fiscal Unsustainability: Debt-financed schemes strain states (health cess yields Rs. 10,000 crore/year vs. needs). PPPs enable upcoding: average claim Rs. 25,000 vs. cost Rs. 15,000 (Dvara 2024).

Supply Deficits: 2 million nurse shortfall; 70% private reliance. COVID waves killed 5 million excess (Lancet 2024), exposing ventilator gaps despite HWCs.

Comparisons sting: Thailand's UHC covers 99% via taxes, OOPE 12%; Brazil's SUS integrates care. India's fragmentation echoes Latin American pitfalls (Gupta et al., 2025).

Overlaps—60 maternal schemes—cause "policy bloat" (IDR 2024), diluting Rs. 5,000 crore.

Case Studies: Successes, Failures, and Federal Variations:

Success: Mission Indradhanush in Uttar Pradesh

Phases 1-5 immunized 2 crore children, coverage from 52% to 92%. Populist tools—PM videos, incentives—overcame hesitancy, averting 50,000 deaths (MoHFW 2025). UP's BJP alignment maximized federal funds.

Failure: PMJAY in West Bengal

Enrollment <15% target; state-run Swasthya Sathi competes, causing dual claims. CAG flagged 25% ghost cards; OOPE unchanged at 60% (WB Health 2024).

Federal Contrast: Kerala vs. Gujarat

Kerala's Aardram (pre-PMJAY) achieves 95% coverage via taxes, MMR 19/1 lakh. Gujarat's PMJAY integration yields 85% empanelment but higher fraud (10% claims rejected). Kerala's model prioritizes public systems; Gujarat's leans PPP-populism.

COVID-19: National vs. State Responses

Central vaccine procurement (2.2 billion doses) succeeded optically but delayed states. Maharashtra's jabs-first policy saved 20% excess deaths vs. Bihar (IHME 2024).

These reveal populism's variability: triumphs in aligned states, friction elsewhere.

Future Trajectories: Reforming Populist Health Policy:

1.Prospects demand hybrid reforms:

2.Financing Leap: 3% GDP by 2030 via GST health ring-fence, sin taxes (Rs. 20,000 crore potential).
3.Supply Revolution: NMC's 50% seat hike to yield 1 million doctors by 2030; nurse training via 1,000 colleges.
4.Federal Compact: NITI-led UHC pact with 50:50 funding, state flexi-tools.
5.Tech-Led Prevention: AB DM HIMS for 100 crore NCD profiles; AI diagnostics in HWCs.
6.Equity Mandates: Annual audits, affirmative quotas in PMJAY.
Scenario modeling: Tax-funded single-payer could cut OOPE to 30% by 2035 (WHO simulation 2025). Populist risks—2029 polls—may spawn "UHC 2.0," but fiscal glide paths are key. Lessons from Rwanda (community insurance) suggest scalable hybrids.
Global headwinds—climate health risks, AMR—necessitate resilience beyond schemes.

Conclusion:

Health policies in post-liberalization India epitomize the logic of populist welfare. National Health Policy (NHP) 2017 and flagship programmes such as Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (PMJAY) combine an equity-oriented rhetoric with highly visible, targeted benefits that can be directly linked to political credit and electoral dividends. In doing so, they seek simultaneously to counteract some of the most glaring inequities generated or exacerbated by economic liberalization, while also reproducing a political economy in which welfare is mediated through leaders, schemes, and symbolic gestures rather than thick, universal entitlements. The trajectory of health policy since the 1990s thus reveals a hybrid order: one that blends neoliberal macroeconomics, insurance-based risk pooling, and private sector expansion with a discourse of inclusion, rights, and "leaving no one behind.

"Within this hybrid, populist health policies have undoubtedly delivered concrete gains. The expansion of publicly financed health insurance, the gradual move toward comprehensive primary healthcare under the Health and Wellness Centre model, and intensified efforts in maternal and child health have contributed to significant improvements in a range of indicators. Maternal mortality has more than halved over the past two decades; institutional deliveries have become the norm; and catastrophic health expenditure, while still widespread, has been at least partially cushioned for some of the poorest households. PMJAY's headline figure of covering approximately 40 per cent of India's population and offering high-value hospital care has become a powerful symbol of state responsiveness, especially to those who were historically excluded from formal social protection.

Yet these achievements coexist with deep and persistent voids. Coverage statistics mask steep inter-state and intra-state disparities; enrolment does not always translate into actual access; empanelled hospitals are unevenly distributed, with rural and tribal areas continuing to suffer from provider deserts. The celebrated halving of the maternal mortality ratio sits uncomfortably alongside chronic shortages of specialists, nurses, and paramedical staff in public facilities, and the continued over-reliance on poorly regulated private providers. Vacancies in primary and secondary care infrastructure, irregular drug supplies, and weak referral systems erode the promise of schemes that focus on tertiary care reimbursement. Moreover, the rapid expansion of publicly financed insurance has created new spaces for fraud, overbilling, and supplier-induced demand, reinforcing patterns of rent-seeking and moral hazard that strain public budgets and weaken trust.

Federal dynamics are central to understanding both the innovations and the fragmentations that characterize India's post-liberalization health policy regime. On the one

hand, health being a State subject has allowed several states—Kerala, Tamil Nadu, Odisha, Chhattisgarh, and more recently Telangana and Rajasthan—to experiment with different models of public provisioning, insurance, and contractual arrangements. These experiments have generated important lessons on primary healthcare strengthening, community health worker integration, and price regulation. On the other hand, the proliferation of central schemes layered upon state initiatives has produced a complex patchwork of overlapping benefits, parallel information systems, and fragmented accountability chains. Vertical programmes for tuberculosis, maternal health, NCDs, and health insurance often operate in silos, diluting the integrative potential of district health systems and making coordination across levels of government more difficult.

The COVID-19 pandemic exposed and intensified these contradictions. The crisis revealed the fragility of hospital-centric, scheme-driven models that prioritize inpatient care financing over investments in public health infrastructure, surveillance, and preventive services. High-visibility announcements of insurance coverage for COVID-19 treatment did little to compensate for shortages of oxygen, beds, workforce, and basic primary care capacity. States with relatively stronger public health systems fared better in managing waves of infection, underscoring the importance of long-term system-building over episodic risk-pooling schemes. At the same time, the pandemic also underscored the political salience of populist welfare: free vaccination campaigns, food transfers, and emergency cash schemes became powerful tools of crisis governance and political legitimation.

Against this backdrop, the scheme-driven model of health policy appears double-edged. In the short term, it sustains political legitimacy by delivering tangible benefits that are easily communicated, branded, and personalized. Leaders can claim credit for specific schemes; beneficiaries can directly associate a hospital admission or a financial protection episode with a particular party or prime minister. This visibility matters in an electoral democracy, especially when set against the slower, less spectacular work of building robust public health systems and institutions. However, in the long term, an excessive reliance on schemes and insurance mechanisms risks undermining health security. It can divert attention and resources away from the unglamorous but essential functions of surveillance, primary care, regulation, public health workforce development, and social determinants interventions.

Furthermore, the populist inflection of health policy—its emphasis on targeted benefits, leader-centric narratives, and programmatic branding—can weaken the framing of health as a justiciable right. When access to healthcare is perceived as largesse granted by benevolent leaders or as a favour delivered through a specific scheme, the underlying entitlement is rendered contingent and reversible. Beneficiaries become clients rather than rights-bearing citizens. This not only constrains the possibilities of legal and political accountability but also fragments popular demands: citizens may mobilize to protect or expand specific schemes rather than articulate broader claims for universal, high-quality public healthcare.

Transitioning from this “thin” populism of schemes to what might be termed “systemic populism” offers a possible way forward. Systemic populism would retain the democratic impulses of visibility, responsiveness, and inclusion but relocate them within durable, universal public systems rather than transient programmes. In this model, the state does not withdraw from the populist terrain; instead, it reorients it: electoral incentives are linked not to one-off announcements but to sustained investments in primary care, district hospitals, public health laboratories, health information systems, and human resources. Political credit is derived from

functioning public facilities, predictable drug supplies, effective regulation of private providers, and measurable improvements in life expectancy and quality-adjusted life years, not just from the issuance of insurance cards.

As India aspires to attain upper-middle-income status and build a "Viksit Bharat" by 2047, the stakes of this reorientation are profound. Demographic and epidemiological transitions—rapid urbanization, an ageing population, and the growing burden of non-communicable diseases and mental health disorders—will stretch any health system that remains heavily dependent on out-of-pocket spending and fragmented insurance. Climate change, emerging infectious diseases, and antimicrobial resistance further underscore the need for robust public health capacities that cannot be conjured up overnight through new schemes. In this context, continuing to treat health policy primarily as a vehicle for short-term populist legitimation is not only insufficient but actively dangerous.

In sum, post-liberalization India's health policies have walked a tightrope between mitigating the inequities of market-led growth and reinforcing a leader-centric, scheme-driven welfare order. The achievements of NHP 2017, PMJAY, and related initiatives in expanding coverage and improving selected health outcomes are real and significant, but they are not sufficient to guarantee resilient, equitable health security for a billion-plus population. The challenge ahead is to move beyond a narrow populist welfare paradigm toward a model of systemic populism that builds universal public systems with visible safeguards and enforceable rights. Only by embedding populist aspirations within enduring institutions can India hope to reconcile electoral politics with the long-term project of health for all by 2047.

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