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THE POLITICAL JOURNEY OF HEALTHCARE IN SELECT INDIAN STATES

SANDHYA VENKATESWARAN, MAYANK MISHRA & NIKHIL IYER

Centre for Social and Economic Progress (CSEP)
CSEP Research Foundation
6, Dr Jose P. Rizal Marg, Chanakyapuri,
New Delhi - 110021, India

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Designed by Mukesh Rawat

THE POLITICAL JOURNEY OF HEALTHCARE IN SELECT INDIAN STATES*

Sandhya Venkateswaran
Senior Fellow
Centre for Social and Economic Progress
New Delhi, India

Mayank Mishra
Manager, Public Policy
The Quantum Hub Consulting

Nikhil Iyer
Senior Analyst, Public Policy
The Quantum Hub Consulting

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Introduction

There is no doubt that India has made progress in healthcare in the last few decades: in access to health services, in outcomes, and in protecting citizens from the financial risk associated with addressing health concerns. At the same time, there is also little doubt that there is still substantial room for improvement, and India needs to do much better on all of these fronts. Despite India's advancement in many other spheres, why it has met with limited success on the health front is a question that needs to be assessed at the state level.

The "India status" is a consolidation of the status of different states, with the latter displaying extreme variations. The neonatal mortality rate is as low as 3.4 in Kerala but as high as 35.7 in Uttar Pradesh; the share of mothers who attended at least four ante-natal check-ups (ANC) is 25% in Bihar, compared with 90% in Tamil Nadu (National Family Health Survey, 2019). Health is a state subject under the Indian Constitution. Governments at the centre have maintained that the primary responsibility for ensuring good health and well-being lies with states, with states spending more on healthcare than the central government (Press Information Bureau, 2021; 2022). The latest National Health Accounts 2017–18 suggest that 59% of the total government health expenditure in the country is borne by states, whereas the centre's share is 42%, with considerable variations in state-level expenditure. Understanding India's performance on health, therefore, requires interrogating the performance of different states with health.

Undoubtedly, many aspects influence the status of health for a state, including its fiscal health, economic and political stability, the strength of its governance and accountability systems, its institutional capacity, its health policy and system architecture supported by adequate resources, and the presence of the private sector. An overarching factor is the priority given to healthcare by a state's political leaders—how they view and position healthcare in their vision for the state and its development path and the potential incentives they see accruing as a result of healthcare improvements. The political economy of health has charted the path of healthcare in each state, leading to differences in outcomes and financial risk.

This paper examines the political trajectory of health in five Indian states, in terms of the socio-political determinants of attention to health, to understand differences in health status and investments, as well as to gain insights into how health came to be prioritised in some of them, which might be instructive across states.

Methodology and Data

Given the resources and time at our disposal, we decided to select five states for this analysis, covering both well-performing and low-performing states. The criteria for selection included two key aspects: state budget allocation to the Department of Health and Family Welfare and the extent of health reforms/programmes initiated. While many factors reflect the extent of prioritisation of a sector, these were selected as they are key indicators of states' prioritisation of health.

The NITI Aayog's health index classifies 19 states as large states, which were taken as the sample pool for this selection. Of these, four (Assam, Madhya Pradesh, Haryana, and Chhattisgarh) were not included in the selection process due to the lack of availability of health budget data for these states.

For the 15 states forming the long list, the budgets allocated to the respective department(s) of health and family welfare as a proportion of the total state budget were identified. The year 2013–14 was taken as the base year. Our analysis also took into consideration state variations in the distribution of responsibilities; for example, while the Department of Health and Family Welfare oversees public health in Bihar, the same is governed by the Departments for Allopathic Medicine,

Public Health, AYUSH, and Family Welfare in Uttar Pradesh. Table 1 shows the average allocation to these departments as a percentage of the total budget of the state since 2013–14.[1]

Table 1: Classification of the 15 large states

Sr. No.	State	Average budget allocated to department(s) of health and family welfare as a % of the total budget since 2013–14	NITI index[2] incremental score rank	NITI index overall rank
1.	Rajasthan	5.47	13	15
2.	Jharkhand	5.41	20	13
3.	Kerala	5.34	5	1
4.	Tamil Nadu	5.00	1	9
5.	Odisha	4.92	4	18
6.	Uttar Pradesh	4.74	9	20
7.	Karnataka	4.72	16	8
8.	Gujarat	4.67	14	4
9.	Andhra Pradesh	4.60	3	2
10.	Himachal Pradesh	4.58	18	6
11.	Bihar	4.54	7	19
12.	Uttarakhand	4.40	6	16
13.	Maharashtra	2.91	19	3
14.	Punjab	2.56	10	5
15.	Telangana	2.13	2	10

Source: NITI Aayog (2020).

An average budget allocation of at least 4% to the department(s) of health and family welfare was taken as a cut-off; anything below this was taken as poor prioritisation of health. The first 12 states in Table 1 qualified, and the last three states were eliminated.

The second criterion pertained to reforms initiated by the state. Reforms were classified according to their focus on health insurance, drugs and diagnostics, human resources, infrastructure development, and other aspects (Table in Appendix B).

This excludes initiatives pursued under the umbrella of the National Rural Health Mission—which stressed building primary and secondary care infrastructure and services across all states—under a central government scheme started in 2005. The table below[3] lists the major state-level schemes/reforms of these 15 states over the past few decades.

[1] Official data for some states was unavailable through standard sources. In Table 1, Jharkhand data is since 2014–15, Gujarat data is since 2016–17, and Andhra Pradesh, Telangana, and Punjab data since 2015–16. Note that Andhra Pradesh and Telangana were bifurcated from erstwhile Andhra Pradesh in June 2014.

[2] The Niti Aayog State Health Index is an annual tool to assess the performance of states and UTs. It is a weighted composite index based on 24 indicators grouped under the domains of 'Health Outcomes', 'Governance and Information', and 'Key Inputs/Processes'

[3] Insurance schemes targeted at distinct groups of people, such as farmers, journalists, etc. are not included. Reforms focused on digital technologies for health are largely nascent and are not included.

The research methodology for this analysis includes an extensive literature review and key informant interviews with a range of stakeholders including political leaders, current and former bureaucrats, academics, health practitioners, civil society leaders and media (a list of informants is included in the Appendix). The varied base of key informants was aimed at mobilising different perspectives and enabling triangulation of the inputs. A total of about 70 interviews were undertaken across five states. The literature review spanned work on the historical evolution of the states, their political priorities and governance structures, allocations to health, health systems, and outcomes, and states' engagement with the central government and other actors, such as international partners, private industry, civil society, and media.

Results

Among the 12 states shortlisted based on the budget criterion, Rajasthan, Jharkhand, Kerala, Tamil Nadu, and Andhra Pradesh have the highest number of reforms, leading to the selection of these five states as per the second criterion for selection.

Table 2: Shortlisted states based on budget and reforms

Sr. No.	State	Average budget allocated to health and family welfare as a % of the total state budget since 2013–14	NITI index incremental score rank	NITI index overall rank
1.	Rajasthan	5.47	13	15
2.	Jharkhand	5.41	20	13
3.	Kerala	5.34	5	1
4.	Tamil Nadu	5.00	1	9
5.	Andhra Pradesh	4.60	3	2

Source: NITI Aayog (2020).

However, on further analysis, Bihar was selected over Kerala for the reasons outlined below.

One, Jharkhand and Bihar were a unified state until 2000, sharing similarities in terms of demographics, poverty, and development levels. Yet, they seem to have diverged in terms of the attention given to health in the last 20 years; Jharkhand ranks second highest in budget allocations to health, while Bihar is eleventh.

Jharkhand outperforms Bihar on key health indicators, such as the neonatal mortality rate (28.2 and 34.5, respectively; National Family Health Survey, 2019), infant mortality rate (37.9 and 46.8, respectively; National Family Health Survey, 2019), and maternal mortality rate (61 and 130, respectively; Registrar General of India, 2022). Further, a higher share of medical ailments is treated in public health institutions in Jharkhand (26.9%) than in Bihar (18.5%) (National Statistical Office, 2019).

Two, the inclusion of Bihar offers the potential to study three states (Rajasthan, Jharkhand, and Bihar), which have seemingly lagging health systems, in terms of historical inequities in health investments, infrastructure, and outcomes, but which are showing signs of a shift in the prioritisation of health.

Keeping in mind the decision to study five states, the choice of Bihar over Kerala offered more diverse insights, and the final selected states were Tamil Nadu, Rajasthan, Andhra Pradesh, Bihar, and Jharkhand.

Table 3: List of states we studied

Sr. No.	State	Average budget allocated to health and family welfare as a % of the total state budget since 2013–14	NITI index incremental score rank	NITI index overall rank
1.	Rajasthan	5.47	13	15
2.	Jharkhand	5.41	20	13
3.	Tamil Nadu	5.00	1	9
4.	Andhra Pradesh	4.60	3	2
5.	Bihar	4.5	7	19

Source: NITI Aayog (2020).

Tamil Nadu has had a strong focus on health for a long period, has better outcomes (Figures 1 and 2) than the national average on various health parameters; has allocated about 5% of the state's total budget to the Department of Health and Family Welfare in the last decade (Figure 3); and pioneered various measures around publicly delivered healthcare. It was the first state to set up a distinctive Directorate of Public Health in 1923, with its own cadre of personnel, and also to enact a Public Health Act in 1939 (Government of Tamil Nadu,1993). Tamil Nadu also introduced the Dr Muthulakshmi Reddy Maternity Benefit Scheme in 1987, offering women Rs. 18,000 as support for up to two pregnancies each—the highest such amount provided across states in India today (Government of Tamil Nadu, 2018). The Tamil Nadu Medical Services Corporation (TNMSC) was launched in 1995 as the first state-run entity to procure and distribute medicines to public health institutions (Government of Tamil Nadu, 2022). In 2005, the state initiated the World Bank–funded Health Systems Project, revamped in 2019 as the Health Systems Reforms Programme (World Bank, 2019). The state then launched the Chief Minister's Comprehensive Health Insurance Scheme in 2009 (Government of Tamil Nadu, 2009); it was the second state to offer state-wide insurance to below poverty line families after Andhra Pradesh did so in 2007. Tamil Nadu has also been praised for its performance under the NRHM. For instance, the second Common Review Mission (CRM) in 2009–10 noted the "dense network" of primary, secondary, and tertiary healthcare facilities, which are "well maintained" and whose "upkeep (was) of satisfactory levels" (National Rural Health Mission, 2008). This resulted in a caseload higher than the national average, in both out-patient and in-patient departments, and also high levels of antenatal care and deliveries in government health facilities (National Rural Health Mission, 2008). An emphatic remark by the CRM was that all primary health centres (PHCs) in the state were found to be running 24x7 (National Rural Health Mission, 2008).

Rajasthan has allocated more than 5% of its total expenditure to the Department of Health and Family Welfare throughout the past decade, barring one year (Figure 3). Since 2011, the state has introduced a slew of reforms, including procurement and distribution of free medicines, provision of essential diagnostic services in public health institutions across the state, the Bhamashah Health Insurance Scheme, the setting up of Adarsh primary care clinics in urban areas, and the recent proposal of a Right to Health Bill (Dutta, 2022).

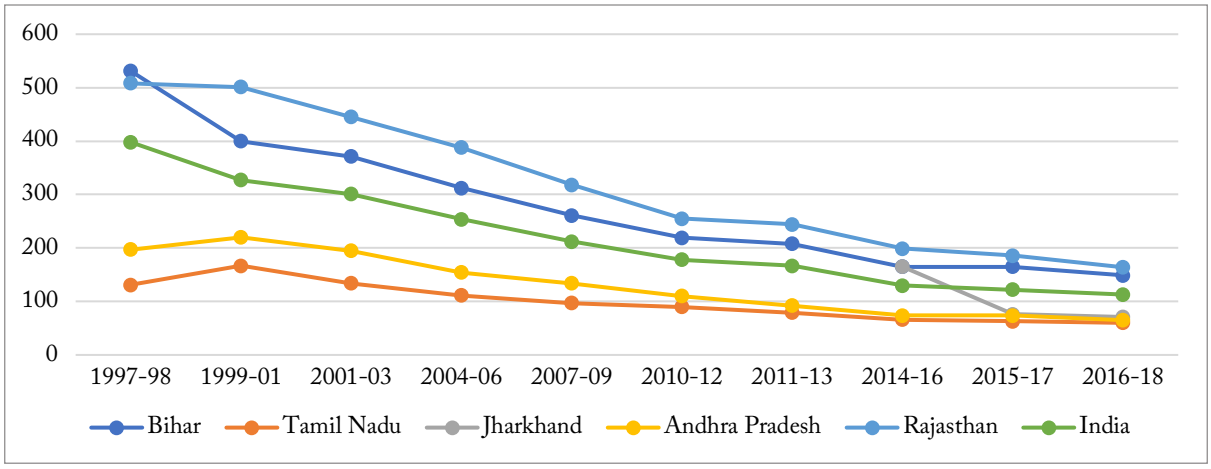
Although Andhra Pradesh's budget allocation has been less than 5% of its total expenditure for most of the last decade (Figure 3), the state has been implementing an expansive health insurance scheme—the first such scheme in the country—with a financial cover of up to Rs 5 lakh per family and has recently announced the setting up of 10,000 more health sub-centres (Hindustan Times, 2021). The state was also an early mover in secondary care as it set up the autonomous Andhra Pradesh Vaidya Vidhana Parishad in 1987, which was tasked with managing community health centres (CHCs), area hospitals, and district hospitals, and ensuring adequate beds and personnel in

these institutions (Chawla & George, 1996; Mahapatra, 1989). In recent decades, it also introduced a post-delivery transportation scheme and provided free lab investigations to patients, including radiology and CT scans at PHCs and CHCs (Prakasamma, 2009). Further, the state is ranked second in the NITI Aayog's health index (Round 3), with the third highest incremental change in score.

Bihar has seen its allocation to the Department of Health and Family Welfare as a percentage of its total expenditure almost double in the past decade (Figure 3), although it could be argued that budget increases on a lower base are more likely than on a higher base. Nevertheless, Nitish Kumar's first term from 2005 to 2010 saw the recruitment of more than 2,000 doctors by the state to make up the deficit in its health workforce, the setting up of over 400 healthcare centres, including PHCs and CHCs (National Rural Health Mission Report on Bihar (2005-10)), and the setting up of the Bihar Medical Services and Infrastructure Corporation Limited (http://www.bmsicl.gov.in/). It is worth noting that the start of Nitish Kumar's first term in 2005 coincided with the launch of NRHM, which helped bolster his performance in healthcare. A public health scholar noted, "NHM was a blessing for Nitish Kumar, and conversely, for NHM to be implemented well in the state, the kind of good governance under Nitish Kumar was needed". Yet, Bihar has consistently found itself lagging in NITI Aayog's health index.

Among the 15 large states[4] whose budgets were analysed, Jharkhand was one among only four states which have almost consistently allocated an average of above 5% of its total expenditure to its Department of Health and Family Welfare in the past decade (Figure 3). There was a special focus on improving maternal health—we see this in the enthusiasm with which Jharkhand adopted the Janani Suraksha Yojana in 2006 and the Janani Shishu Suraksha Karyakram in 2011, initiated by the central government to ensure better provision of maternal and child health (Bhatia et al. 2021). It set up the Jharkhand Medical and Health Infrastructure Development and Procurement Corporation Limited in 2013 for procuring and distributing medicines and equipment in government institutions (Press Trust of India, 2022). It also enacted a state-level insurance scheme in 2017 and launched Atal Clinics in urban areas in 2018 (Elets News Network, 2019). The state ranked first in terms of incremental score in the first edition of NITI Aayog's health index for 2015–16 and ranked 13th out of 19 large states in the latest edition in 2019–20. Carved out from Bihar in 2000, Jharkhand has paved its own distinct development journey, which raises the question of whether and how the prioritisation of health differed in the two bifurcated states.

Figure 1: Maternal mortality ratio

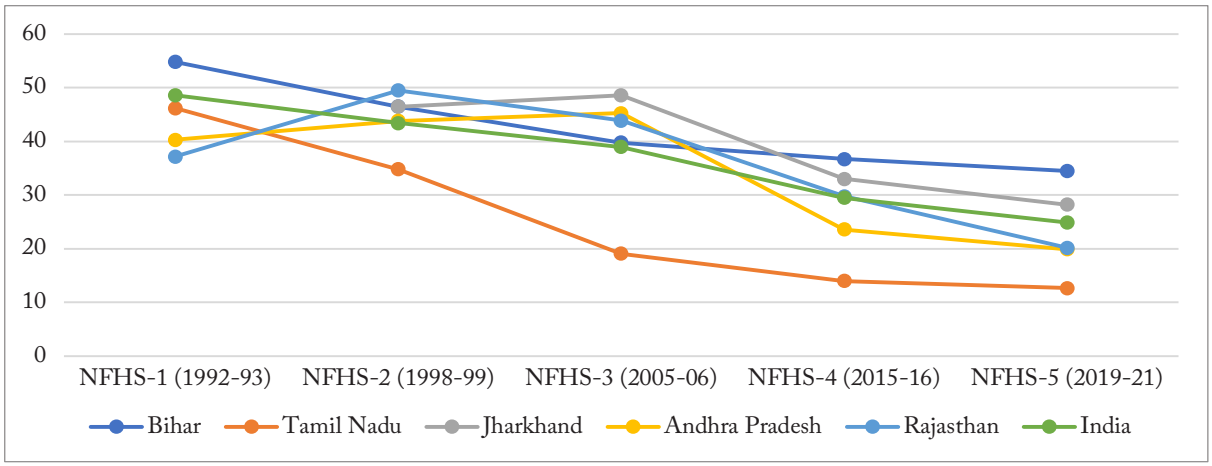


Source: Ministry of Health and Family Welfare (2019)

Note: The MMR for Bihar and Jharkhand was measured together until 2015.

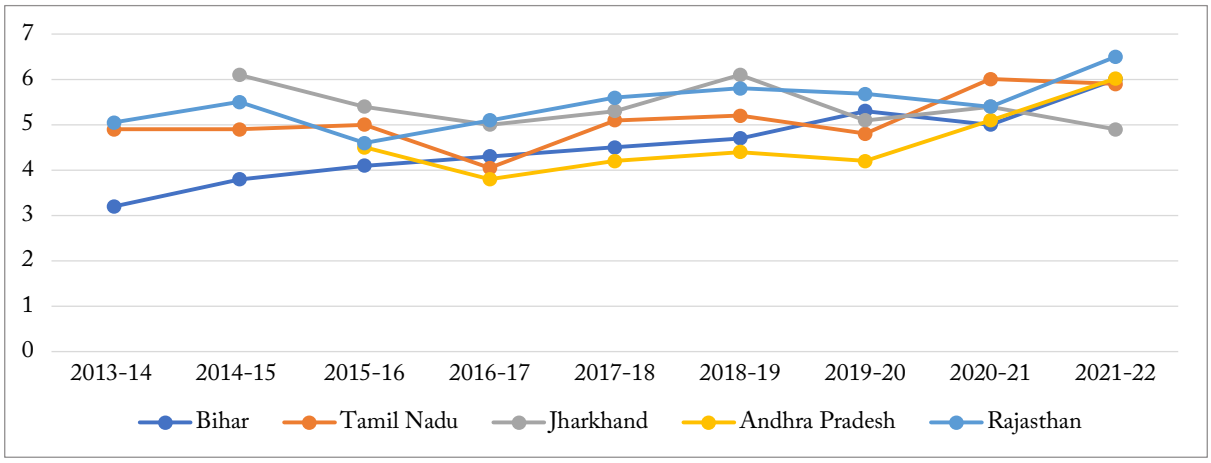
[4] Tamil Nadu, Kerala, Andhra Pradesh, Rajasthan, Uttarakhand, Himachal Pradesh, Bihar, Gujarat, Jharkhand, Odisha, Punjab, Karnataka, Maharashtra, Telangana, and Uttar Pradesh.

Figure 2: The neonatal mortality rate



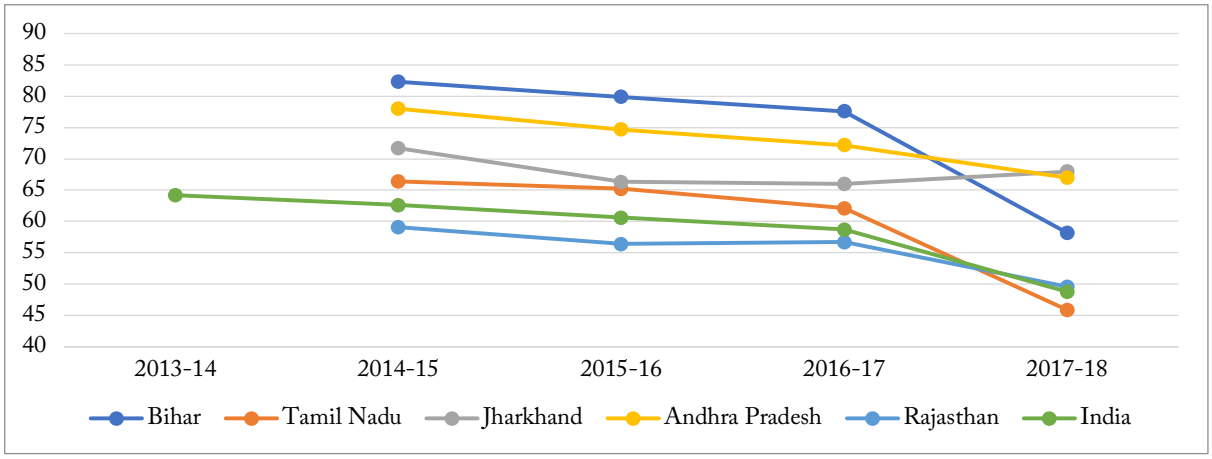
Source: National Family Health Survey (1995; 2000; 2007; 2017; 2019)
Note: Jharkhand state was formed in 2000. Data before that is for erstwhile Bihar state)

Figure 3: State-wise budget for H&FW as a % of total expenditure



Source: Annual Budget documents from state finance department websites; Authors' calculations.
Note: Data for Jharkhand is not available for 2013–14. Data for pre-2015 Andhra Pradesh is not included since it was before the bifurcation of the state.

Figure 4: Out-of-pocket expenditure as a % of total health expenditure



Source: National Health Accounts from 2013-14 to 2017-18.
Note: State-wise data for OOPE as % of THE not available in the National Health Accounts (2013–14)

Discussion

Varied attention to health and its motivation

The states' analysis highlights, not surprisingly, very different journeys in how states have developed over decades and what has been prioritised by different state leaders. Admittedly, history, political orientation and ideology, and economic and social context, among other factors, have combined to chart each state's path and its implications for social and economic progress. This paper attempts to interrogate the implications of changing political leadership and consequent changes in priorities in the context of the attention given to health in each state. The paper draws on political economy analysis frameworks developed by various scholars for this analysis (World Health Organization et al., 2018; Kingdon, 2011; Shiffman, 2009; Berger & Luckmann, 1966; Buse, Mays, & Walt, 2012; Cobb & Elder, 1972; Edelman, 1988; Shiffman & Ved, 2007; Campos & Reich, 2019; Sparkes et al., 2019).

There are at least four areas of inquiry around which insights emerged. First, *why* did health receive or not receive political attention in a state across different political regimes? Second, *when* did this happen in terms of the state's social and economic development journey? Third, *what* kind of attention was given to health (and the underlying drivers for the same)? Fourth, *how* did health get primacy over other competing priorities?

The "why": Reasons for healthcare receiving attention across political regimes

Why health received (or did not receive) attention from a political leader was driven by 1) the inherent ideology of the leader; 2) his/her need to seek political legitimacy (leveraging and building on a previous political leader's legacy) among the electorate, potentially translating into political dividend; 3) the establishment of new norms that reset the *de minimis* voter expectations from the state.

Tamil Nadu's history of the Dravidian movement, centred on social welfare, equity, and raising the position and material condition of marginalised caste groups, has been a driving force in the state's politics for decades (Kalaiyarasan & Vijayabaskar, 2020). Social justice is embedded in political ideology, across parties; there is a deeply embedded expectation of quality social services among the electorate. In addition to ideology, potential loss aversion has contributed to the continuing focus on health as citizens have come to expect a certain quality of services and benefits such as health insurance.

In contrast, the history of both Rajasthan and Andhra Pradesh points to political leaders' need to establish their legitimacy among the electorate as a driving force for their attention to health, as part of a broader focus on social issues. Since 2011, when Ashok Gehlot introduced the free medicine scheme, each successive government's term has witnessed the introduction (or continuation, often under different branding) of health reforms. While the Andhra case is quite different in terms of the role of the private sector and the World Bank (discussed subsequently), both Dr Y.S. Rajasekhara Reddy's and his son Jaganmohan Reddy's focus on health could be viewed, at least in part, as a means of establishing their distinct identity and strengthening their political legitimacy outside the political regime and priorities of their predecessors. Naidu was seen as urban-centric and market-friendly, while the Rajiv Aarogyashri Community Health Insurance Scheme allowed YSR to position himself as a votary of rural-centric, state-led development. For Jagan, continuing his father's legacy in health attention was an added factor, which only reinforced his need to build his own legitimacy.

The state of Bihar witnessed increased attention to health only when Nitish Kumar came to power, and it was Nitish's focus on development that differentiated his regime from that of his predecessor, Laloo Prasad, as it addressed at least basic services, including health and other development areas.

Jharkhand remains the outlier, where attention to health did not come about in any significant manner, barring perhaps during the tenure of Raghubar Das, who was the state's first non-tribal chief minister (Press Trust of India, 2014). Political legitimacy in Jharkhand had largely rested upon representing tribal interests. Das, enjoying a clear majority in the state assembly, and desiring to further the Bhartiya Janata Party's development agenda as espoused during the Lok Sabha campaign in 2014 (Anuja, 2014), may have thus been motivated to pursue health reforms. Many believed that good performance on developmental issues such as health would help Das counter allegations over his non-tribal identity.

The "when": The location of health in the states' social and economic development journey

States experience a hierarchy of prioritisation, in terms of timing, across the multitude of concerns in the state. Bihar, Jharkhand, and Tamil Nadu have all experienced identity-based politics. Yet, we see different trajectories for when health came to be prioritised in the state.

Health has been a political issue in Tamil Nadu since the 1920s, when the Justice Party came to power (Amrith, 2009). Over the last century, the Dravidar Kazhagam party and its offshoots have consistently made health a political priority, such that it has created a culture where the electorate organically demands action on health issues. This prioritisation is a result of the state's focus on social justice, whereby the polity and bureaucracy both became more representative of and sympathetic to the development of marginalised communities (Mehrotra, 2006).

In Bihar and Jharkhand, identity battles have been more recent. The emotive nature of identity concerns, leveraged and amplified by political leaders, led to identity taking primacy over all other concerns. A large part of Bihar's history is defined by Lalu Prasad's politics around caste identity, focused exclusively on representation at the cost of law and order and any significant development when it came to factors such as healthcare, electrification, and road connectivity. As a senior editor of a national TV channel noted, "Lalu Prasad Yadav was a master of caste-based politics. He believed that development work does not get you votes, but only caste identity would."[5] Jharkhand state too owes its formation to politics around tribal identity, as local leaders demanded a separate state comprising areas where tribal people were dominant (Mathew & Moore, 2011, p.6). In both states, therefore, a large part of the political focus has been on identity issues.

Common to Bihar and Jharkhand was the high level of poverty at the start of the twenty-first century and the absence of even basic services. Nitish Kumar recognised this and accordingly addressed development; he focused first on the basics of governance (law and order) and then on infrastructure and electricity. Bihar's political trajectory, therefore, moved from identity politics to basic development and social services such as healthcare and education. As one senior journalist with extensive experience covering Bihar since 1995 suggested, "people bore the brunt of *jungle-raj* for 15 years (under Lalu Prasad and Rabri Devi), and they were fed up with deteriorating law and order. Nitish came into power based on a desire for development." Jharkhand too has struggled with high levels of poverty, which became a higher priority concern over health and education in the initial years.

It is worth noting how identity issues and politics morphed into politically motivated healthcare improvements . In both Bihar and Jharkhand, it can be argued that, over time, the electorate began to aspire to and expect better levels of development, employment, and other factors that impact quality of life. In the past two decades, people also saw the positive effects of the National Rural Health Mission at the ground level in the form of more and better buildings, better availability of

[5] Key informant interview.

medicines, personnel, etc. This may have given them confidence in the state's capacity to deliver good healthcare, in turn motivating the electorate to demand action on health. The electorate's demands morphed from mere political representation through identity politics to more concrete developmental outcomes. In some cases, these demands may even be linked to identity issues, for instance, demanding better healthcare for tribal communities through the provision of ambulances in remote areas in Jharkhand (Jadhav, 2020).

Rajasthan's experience is also of note here. "Healthcare was a low priority issue for the citizens until the free medicines scheme was introduced," noted an ex-Member of the Legislative Assembly from the state.[6] The Free Medicines Scheme, introduced in 2011, began to change the political culture of the state. A public health expert reasoned, "the popularity and positive outcomes of the scheme meant that Raje (the successor CM) would have had to incur a heavy political price for discontinuing it".[7] In turn, the state saw a slew of other schemes in later years, such as health insurance, model PHCs, and now a justiciable Right to Health.

The "what": The kind of attention accorded to healthcare

The five states reveal that "attention to health" can be interpreted in varied ways and that outcomes are driven by what gets the electorate's attention. Several states saw the prioritisation of health insurance, which is arguably the easiest reform action and one that potentially offers the most electoral incentives. In state after state, insurance schemes have enabled chief ministers to establish a direct connection with voters, by promising quality care, often in private facilities. Such public insurance schemes were undertaken by Andhra Pradesh, Tamil Nadu, Rajasthan, and Jharkhand. Others undertook deeper reforms, such as the establishment of the Public Health Directorate and Tamil Nadu Medical Services Corporation in Tamil Nadu, primary care reforms in Tamil Nadu and Rajasthan, and the introduction of the public health cadre in Tamil Nadu. Thus, health reforms were driven by multiple factors including the capacity of the state to deliver, the influence of the national government and external institutions, and the effectiveness of bureaucrats and civil society organisations.

Tamil Nadu has a history of strong state capacity and good governance (Dasgupta, 2010). Without debating the precise indicator of state capacity, what is clear is that the social justice and welfare focus of the state is embedded both within political regimes and the bureaucracy and electorate. The nature and identity of the state bureaucracy is itself an outcome of the social justice focus and process, leaving little ambiguity in the priorities and focus areas of the bureaucracy and expectations from them. A former Tamil Nadu state health secretary noted that this resulted in a "strong work culture and work ethic"[8] which encouraged bureaucrats to pursue social welfare.

States' emerging capacity, in the form of their willingness and ability to deliver on political promises and policies, infuses confidence in political leaders and enables them to continue to take on ambitious reforms. For instance, even as far back as the 1980s, Tamil Nadu decided to retain a separate public health cadre despite the central government's advisory to states to merge all health cadres.[9] In contrast, while politics in Bihar too has focused on inclusion, but since it has remained limited to representation and did not extend to material or developmental improvements, the state's capacity was not built up.

Other states, less confident of their capacity to deliver on political promises, such as Rajasthan and Bihar, have restricted themselves to actions that need relatively lower capacity. Rajasthan introduced

[6] Key informant interview.
[7] Key informant interview.
[8] Key informant interview.
[9] Key informant interview.

the free medicine scheme - Mukhyamantri Nishulk Dawa Yojana (Government of Rajasthan, 2011.) and the health insurance scheme - Bhamashah Swashtya Bima Yojana (Government of Rajasthan, 2015), both of which could be managed and moderated from the seat of its government in Jaipur. Meanwhile, Bihar, after the initial expansion of health facilities and its workforce, did not take on any further significant reforms. After the introduction of the free drugs and insurance programmes in Rajasthan, footfall at PHCs improved, indicating that trust in the public health system has grown (Vyas, 2017).

In Andhra Pradesh, the economic ideology was dominant for a long period, contrary to Tamil Nadu's social ideology, which likely impacted the prioritisation of bureaucrats. Andhra Pradesh, despite its much-publicised state insurance programme, did not go beyond insurance to address primary healthcare, due to the absence of a holistic vision and the failure to conceptualise far-reaching healthcare reforms by the state political leadership.

The influence of bureaucrats can be transformative—bureaucrats led the setting up of the Medical Services Corporation for the procurement and distribution of drugs in both Tamil Nadu (in 1995) and Rajasthan (in 2011). Similarly, in Rajasthan, the free medicines scheme emerged primarily from the drive of a bureaucrat (India Today, 2012). Bureaucrats had an opportunity to pursue reforms in Andhra during YSR's tenure in 2004–09, as there was sufficient political willingness; yet, a former state health secretary argued that "bureaucrats failed to provide substantive inputs beyond the insurance scheme".[10] In Jharkhand as well, "the bureaucracy faced an increased onus to implement welfare schemes, as Ministers' tenures were uncertain and short lived," as a civil society stakeholder conveyed to us.

Isomorphic mimicry played a role too, as evident in Rajasthan, where the Rajasthan Medical Services Corporation was based on Tamil Nadu's TNMSC (World Bank, 2014), while in Andhra Pradesh, Jagan Mohan Reddy set up YSR Health Clinics based on the AAP model of Mohalla Clinics (Sunday Guardian Live, 2020).

The "how": The role of external stakeholders

External stakeholders played a role in promoting attention to health. The private health industry in Andhra Pradesh, starting from the time of N.T. Rama Rao, was instrumental in shaping the way the health sector has grown in the state. The World Bank, during the time of Chandrababu Naidu, brought about health reforms[11] in Andhra Pradesh through their loans. Civil society in Rajasthan was instrumental in pushing for the Free Medicine scheme and the Right to Health.[12] The media in Bihar brought attention to the abysmal state of healthcare post the encephalitis deaths in June 2019. While each of these played an instrumental role, none played a transformational role in bringing about a holistic vision for the health sector and embedding health as a key priority. Apart from the private sector in Andhra Pradesh, the role of stakeholders has not been consistent across states. The nature of each state's state–civil society and state–media relationships (as reflected through the Jharkhand experience) influenced the extent to which these actors could push the state towards deeper reforms.

The central government was instrumental in bringing attention to health through the National Rural Health Mission and by setting objectives, providing resource support, ring-fencing states' resources for health, specifically in states such as Bihar and Jharkhand, and supporting knowledge sharing

[10] Key informant interview.

[11] The World Bank's support to the AP health sector started with the Andhra Pradesh First Referral Health System Project (1995–2002), during Naidu's tenure, which focused on improving the quality, effectiveness, and coverage of health services at the secondary level.

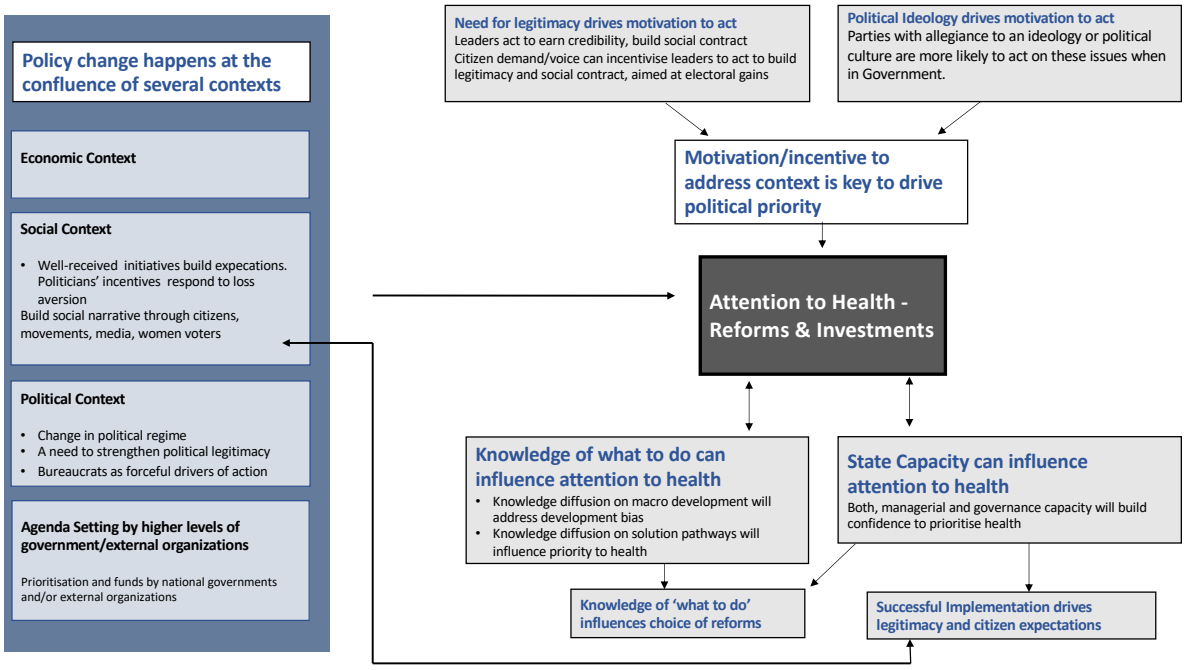
[12] Key informant interviews.

across states. By leveraging states' financial dependence on the centre, as well as their political alignment (in the case of Bihar and Jharkhand), the central government has been able to ensure minimal attention to health in states that are highly dependent on the centre. Where health reforms have occurred in states as a result of the central government, state priorities have been completely aligned with the centre's priorities. In the words of a key informant who worked with the state health department, Jharkhand was "keen to follow in toto" the central government's command. The central government's role in measuring states' performance and reporting outcomes is also vital. This is evident in the National Family Health Surveys and NITI Aayog's health index. The centre also has an opportunity to incentivise states to do better through awards and recognition—such as for best incremental performance in the NITI health index.

The findings from the states studied suggest that while the economic, social, and political context provides the underlying rationale for health reforms, the actual momentum is provided by changes in political regimes, combined with an underlying ideology, as found in Tamil Nadu, or (more commonly) the need to seek political legitimacy, as found in Rajasthan, Andhra Pradesh, and Bihar (Figure 5). These act as the motivation for prioritisation of health, along with knowledge of healthcare solutions and confidence in the capacity of the state to deliver, which in turn strengthen the motivation to implement reforms and influence the kind of action introduced. The case of Tamil Nadu, Rajasthan, and Andhra Pradesh exemplify the role of state capacity and know-how in choosing and executing reforms. Instances of isomorphic mimicry and policy diffusion, found in Rajasthan, Andhra Pradesh, and Bihar make clear that knowledge is a key variable for driving health reforms.

Robust implementation of reforms, such as in Tamil Nadu, creates ongoing citizen expectations. This exerts electoral pressure on political leaders to continue to focus on these areas. The same was evident in Rajasthan where successive political regimes continued with previous popular reforms.[13] This then forms a virtuous cyclical process, where well-received reforms reinforce citizen expectations, fuelling demand and pressure on political regimes to continue to deliver on these aspects.

Figure 5: Framework for political attention to health



Source: Author's analysis.

[13] An example of this is the continuation of the health insurance scheme (albeit with a different name) by Ashok Gehlot in 2019 that was launched by Vasundhara Raje Scindia in 2015 (Wadhwahan, 2019).

Conclusion

What then does this analysis suggest in terms of cross-state diffusion of insights with regards to the prioritisation of health? There are at least five areas that emerge from our analysis.

One, in the absence of an ideology that can drive social reforms, linking the legitimacy of a political regime with health (and other social development) can help drive action (Venkateswaran, Slaria, & Mukherjee, 2022). Social movements, targeted electoral constituencies such as women, the media, and possibly civil society can play a role in questioning the status quo on social development and demanding greater action. These need to be built up proactively so that the demands of electorates are significant enough to influence the political regime.

Two, knowledge of the significance of health for development, and what the state leadership can do, can influence both attention to health as well as appropriately targeted action. Policy diffusion, facilitated proactively, with specific attention to the benefits of reforms already undertaken elsewhere, can contribute to prioritising health. Empowering experts and bureaucrats to advise the government through relevant councils and committees can help drive the conceptualisation of policy solutions. Showcasing the success of health reforms and schemes, and their electoral benefits in a particular state can incentivise politicians in other states to adopt the same.

Three, a focus on state capacity is key, as it impacts the confidence to undertake reforms and the choice of reform as well. Strengthening such capacity is imperative to enable reform that can yield both social and political dividends.

Four, the central government plays a significant role in agenda-setting at the state level, especially in states dependent on central funds. The central government's potential to alter states' health trajectories suggests that it should play a greater role in improving primary healthcare and other areas of relative neglect. Left to their devices, states may prioritise health insurance schemes and focus on tertiary care, particularly on private hospitals. Insurance schemes have high recall value among the electorate as they tend to attribute the benefit to the incumbent government, particularly to the chief minister. Andhra Pradesh saw the introduction of the first such state-level scheme in 2007 (Aarogyasri Health Care Trust, 2019), followed by Tamil Nadu and Rajasthan (Makkar, 2015). A national-level health insurance scheme was soon implemented in 2018 under the PM-Jan Arogya Yojana. The focus on insurance is evident even in comparatively poorer states such as Bihar and Jharkhand. This focus comes at the cost of improving primary-care services, as politicians tend to prioritise expenditure on insurance rather than on improving health facilities in rural areas, creating proper living quarters for personnel in remote areas, etc. Until there is strong, explicit demand for primary care among the electorate, it is unlikely that state leaders will prioritise primary care. In this context, the central government has to continue its thrust on primary care.

Five, civil society, the private sector, and other local and international organisations have the potential to influence the trajectory of healthcare at the state level. For states positively inclined towards engaging with external actors, civil society offers the potential to influence the prioritisation of health. Civil society played a critical role in the introduction of the free medicines scheme in 2011 and the Right to Health Bill in 2022 in Rajasthan (Times News Network, 2019). In Jharkhand, the prioritisation of expanding healthcare to remote areas and underserved communities through the proliferation of Sahiyas was influenced by civil society organisations (Jain, 2021). In Andhra Pradesh, the private sector has played an instrumental role, where the model of healthcare, while improving outcomes, negatively impacted household expenditure on health. The potential role of external actors is significant, and states need to be cautious of how their influence aligns with the vision of healthcare in the state.

Influencing or driving political attention to health is possible in states where is does not currently exist through both internal and external stakeholders playing a more proactive role. Central government as also bureaucrats within states on the one hand, and civil society, social movements, media on the other, offer considerable potential to alter the trajectory of healthcare prioritisation through their interventions.

Appendix

A. List of people interviewed

Tamil Nadu	
Name	**Designation/ Organisation**
P.W.C. Davidar	Former Project Director, TN Health Systems Project; Former Principal Secretary, Transport; Former Principal Secretary, Personnel
R. Poornalingam	Former Secretary, Health
Girija Vaidyanathan	Former Secretary, Health
V S Sambandan	Director, The Hindu Centre for Public Policy
S Jothimani	Member of Parliament, Lok Sabha (Indian National Congress)
Monica Dasgupta	Research Professor, Sociology, Maryland Population Research Center, ex-World Bank Consultant
Prof. Muraleedharan	Professor, IIT Madras
G. Ananthakrishnan	Senior Editor, The Hindu
Arulraj Ramakrishnan	MBBS, MRCP, CCT, Kovai Medical Center and Hospital. Also, had experience working with NHS UK

Rajasthan	
Name	**Designation/Organisation**
Dr D.K. Mangal	Director, IIHMR, Jaipur
Dr S.D. Gupta	Chairman, IIHMR
Rathin Roy	Economist; ex-PM EAC
Rakshita Swamy	SAFAR
Ajay Mehta	ex-CEO, Seva Mandir
Abhishek Gopalka	Partner, BCG
Divya Santhanam	Population Foundation of India
Neelima Khetan	CSEP
Dr Arvind Mayaram	Former Secretary, Finance, GOI; current Economic Advisor, Govt. of Rajasthan
Pavitra Mohan	Basic Health Services
Priyanka Singh	CEO, Seva Mandir
Aditi Mehta	Former Secretary, Health (Rajasthan)
Chhaya Pachauli	Prayas; Jan Swasthya Abhiyan
Bharat Singh	ex-Member of Legislative Assembly, Sangod

Andhra Pradesh	
Name	**Designation/Organisation**
R Srivatsan	Anweshi Research Centre, Hyderabad
Sunita Reddy	Assistance Professor, Centre for Social Medicine and Community Health, JNU
Dr Anuradha Katyal	Access Health International
Dr Suresh Sanikommu	Jan Swasthya Abhiyan
Lavu Sri Krishna Devarayalu	Member of Parliament, Lok Sabha (YSRCP)
Kesineni Srinivas	Member of Parliament, Lok Sabha (TDP)
Vijaysai Reddy	Member of Parliament, Lok Sabha (YSRCP)
Dr G.N. Rao	Founder, L.V. Prasad Eye Institute, Hyderabad
Sujatha Rao	Former Secretary, Health (UOI)
Bose	People's Budget Initiative
P.V. Ramesh	Former Secretary, Health (AP)
Dr G.S. Rao	Managing Director, Yashoda Hospitals
Prof Purendra Prasad	Department of Sociology, University of Hyderabad
Uma Sudhir	Executive Editor, South India Division, NDTV
Hari Kasula	Founder, Pramanya Strategic Consulting Limited
Dr Jayaprakash Narayana	Retired Bureaucrat, Former MLA, Founder, Lok Satta Party and Foundation for Democratic Reforms

Bihar	
Name	**Designation/ Organisation**
Rameshwar Singh	Former Secretary, Finance (Bihar)
C. K. Mishra	Former Secretary, Health (Bihar)
Dr Jyoti Sharma	Professor, Public Health Foundation of India
Dr Shakeel Ur Rahman	Jan Swasthya Abhiyan; Member, Centre for Health and Resource Management (CHARM)
Dr Sanjay Jaiswal	Member of Parliament, Lok Sabha (BJP)
M.R. Sharan	Author of Last Among Equals
Dr Vikash Keshri	Senior Research Fellow, Georgia Institute of Global Health
Dr Taru Jindal	Author, A Doctor's Experiment in Bihar
Sridhar Srikantiah	CARE India
Rajesh Jha	Ex-Executive Director, Centre for Health Policy, ADRI
Rajesh K Thakur	*New Indian Express* Journalist covering Bihar for 20 years
Madhuri Kumar	Senior Journalist, *Times of India* – active in Bihar since 1995
Devesh Kumar	Former Journalist, Member of Bihar Legislative Council
Ajay Alok	Spokesperson, JDU
Sanjay Kumar	Co-Director, Lok Niti - CSDS

Jharkhand	
0.2467 in	**Designation/ Organisation**
Dr Ajoy Kumar	ex-Member of Parliament from Jamshedpur Lok Sabha Constituency
Haldhar Mahto	State Lead for Jharkhand, Public Health Resource Network
Anup Hore	State Lead, Center for Knowledge and Development
Heer Chokshi	Manager, Communications and Program Development, Palladium (worked with USAID in Jharkhand)
Abhishek Angad	Jharkhand Correspondent, *Indian Express*
Chetan Chauhan	National Editor, *Hindustan Times*
Prabhakar Kumar	Senior Journalist, *NDTV*
Mahesh Poddar	Rajya Sabha MP
Ranjan Panda	Lead (Health and Nutrition), Transforming Rural India Foundation
Bulbul Sood	Former Country Director (India), Jhpiego
Dr Nirmala Nair	Founder, Ekjut
Aparajita Gogoi	Executive Director, C3

B. Prominent state-level health reforms/ initiatives

Sr. No.	State	Health Insurance	Drugs and Diagnostics	Infrastructure	Human Resources	Other schemes
1.	Rajasthan	2015 – Bhamashah Health Insurance Scheme 2022 – Chiranjeevi Health Insurance Yojana	2011 – Nishulk Dawa Yojana 2013 – Nishulk Jaanch Yojana	2016 – Adarsh PHCs 2019 – Janata Clinics in urban areas		2022 – draft Right to Health Bill
2.	Jharkhand	2017 – Mukhyamantri Swasthya Bima Yojana	2013 – Jharkhand Medical and Health Infrastructure Development and Procurement Corporation Limited	2019 – Atal Mohalla Clinics		2006 – Mukhya Mantri Janani Shishu Swasthya Abhiyan (MMJSSA), a derivative of the Janani Suraksha Yojana
3.	Kerala	2012 – Karunya Arogya Suraksha Padhathi	2007 – Kerala Medical Services Corporation	2018 – Ambulance service e-network on the lines of Uber 2019 – Comprehensive Health Security Scheme to upgrade PHCs to family health centres		2015 – Sampoorna Arogya Keralam (smart health card mission) 2017 – Aardram Mission (to convert PHCs to family health centres)
4.	Tamil Nadu	2009 – CM Comprehensive Health Insurance Scheme	1994 – TN Medical Services Corporation	1990s – Danish International Development Agency (DANIDA) funded primary-care infrastructure 1996 – 24-hour PHCs for care in the evenings, and emergency services for women	Since 1923 – Directorate of Public Health, and distinct public health management cadre at the district level	2022 - Makkalai Thedi Maruthuvam for door-to-door medical checkups 2022 – discussions on Right to Health Bill 2005 – World Bank's TN Health Systems Reform Project 2003 – Health Policy of Tamil Nadu 1987 – Dr. Muthulakshmi Reddy Maternity Benefit Scheme 1939 – Public Health Act
5.	Odisha	2018 – Biju Swasthya Kalyan Yojana				

6.	Uttar Pradesh	2019 – Mukhyamantri Jan Arogya Yojana				2000 – WB UP Health Systems Development Project 2017 – Hausala Sajhedari, a PPP to encourage family planning 2018 – Draft Health Policy
7.	Karnataka	2018 – Arogya Karnataka Yojana, which subsumed a range of smaller insurance schemes		2008 – Arogya Kavacha-108 for ambulance services		2007 – Madilu, a post-natal maternity benefit scheme 2016 – Thayi Bhagya Scheme for facilitating deliveries in registered private hospitals 2022 – Mathrupoorna Yojane for cash assistance to pregnant women
8.	Gujarat	2012 – Mukhyamantri Amrutum Yojana				2009 – Chiranjeevi Yojana to incentivise deliveries in private facilities 2009 – Bal Sakha Yojana to enlist the services of private paediatricians
9.	Andhra Pradesh	2007 – Rajiv Aarogyashri Scheme	1987 – AP Medical Services and Infrastructure Development Corporation (also responsible for the construction and maintenance of hospitals and staff quarters for medical personnel) 2016 – NTR Vaidya Pariksha Scheme (for diagnostics at PHCs and CHCs)	2006 – 104 helpline for ambulance services 2016 – Talli-Bidda Express for post-delivery drop-off for mother and child 2020 – Nadu-Nedu Scheme to set up 11,000 YSR health clinics by upgrading PHCs	1987 – AP Vaidya Vidhana Parishad (responsible for managing infrastructure and personnel availability at the secondary care level)	1995 – WB AP Health Systems Project

10.	Himachal Pradesh	2019 – HIM CARE Yojana, to complement the PM Jan Arogya Yojana		2018 – Swasthya Mein Sahabhagita Scheme (investment subsidies of 25% up to Rs. 1 crore to private allopathic doctors to set up clinics/ hospitals in rural areas) 2019 – Sampoorna Swasthya Yojana (to upgrade CHCs to hospitals)		
11.	Bihar	2022 - Mukhyamantri Jan Arogya Yojana	2010 – Bihar Medical Services and Infrastructure Corporation Limited			2006 – Janani Bal Suraksha Yojana, to complement the Janani Suraksha Yojana by the central government
12.	Uttarakhand	2019 – Atal Ayushman Uttarakhand Scheme	2015 – e-Aushadhi Yojana (to maintain data on procurement and distribution of medicines)		2015 – Uttarakhand Medical Service Selection Board (to create an efficient system of human resource management)	2019 – World Bank-Uttarakhand Health Systems Development Project
13.	Maharashtra	2012 – Rajiv Gandhi Jeevandayi Arogya Yojana	2014 – Free Medicines Scheme		1962 – public health cadre, which continues to function today 2020 –Director of Health (Urban) position set up to focus on primary care in urban areas	1995 – Navsanjeevni Yojana (to focus on health issues in tribal areas) 1999 – World Bank-Maharashtra Health Systems Development Project
14.	Punjab	2019 – Mukhyamantri Sehat Bima Yojana		1996 – Punjab Health System Corporation (to provide preventive, promotive and curative care at hospitals and CHCs)		2020 – Punjab Clinical Establishments (Registration and Regulation) Act
15.	Telangana	2007 – Rajiv Aarogyashri Scheme		2021 – Basti Dawakhana Scheme, to provide healthcare to urban slum dwellers		2017 – KCR Kits, including cash assistance, to women who delivered in public hospitals

References

Aarogyasri Health Care Trust. (2019). *Guidelines for Rajiv Aarogyasri Scheme, Fifth Edition, March 2013*. https://www.ysraarogyasri.ap.gov.in/documents/10181/0/Scheme_Manual.pdf/e67a112b-6407-4ce5-b50d-a52c18399e3d.

Amrith, Sunil. (2009). Health in India since Independence. Brooks World Poverty Institute. *Working Paper 79*. https://tinyurl.com/yz3b8knf.

Anuja. (2014, November 11). BJP promised social, economic security in Jharkhand Manifesto. *Livemint*. https://www.livemint.com/Politics/n4z0ZdZgUKkaVuror0NyON/BJP-promises-social-economic-security-in-Jharkhand-manifest.html.

Berger, P.L., & Thomas Luckmann. (1966). *The social construction of reality: A treatise in the sociology of knowledge.* Penguin.

Bhatia, M., L.K. Dwivedi, K. Banerjee, A. Bansal, M. Ranjan, & P. Dixit. (2021). Pro-poor policies and improvements in maternal health outcomes in India. *BMC Pregnancy Childbirth*, *21*(1), 389. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8135986/.

Buse, K., Nicholar Mays, & Gillian Walt. (2012). *Making health policy*. McGraw-Hill Education.

Campos, P. A., & Michael R. Reich. (2019). Political analysis for health policy implementation. *Health Systems & Reform*, *5*(3), 224–235.

Chawla, Mukesh, & Alex George. (1996). *Hospital autonomy in India: The experience of ABVVP hospitals*. Harvard University. https://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.533.7982&rep=rep1&type=pdf.

Cobb, R. W. & Charles D. Elder. (1972). Individual orientations in the study of political symbolism. *Social Science Quarterly*, *53*(1), 79–90.

Dasgupta, Monica, et al. (2010). How might India's public health system be strengthened? Lessons from Tamil Nadu. *Economic and Political Weekly*, *45*(10). https://tinyurl.com/vkrsmz4u.

Dutta, Sumi Sukanya. (2022, May 17). In depth | Rajasthan shows the way with first Right to Health draft bill; may have lessons for the country. *Money Control*. https://www.moneycontrol.com/news/trends/in-depth-rajasthan-shows-the-way-with-first-right-to-health-draft-bill-may-have-lessons-for-the-country-8524421.htm

Edelman, Murray. (1988). *Constructing the political spectacle*. University of Chicago Press.

Elets News Network. (2019, August 16). Jharkhand govt starts Atal Mohalla Clinics in 15 districts. *Elets*. https://ehealth.eletsonline.com/2019/08/jharkhand-govt-starts-atal-mohalla-clinics-in-15-districts/.

Government of Rajasthan. (2011). Mukhyamantri Nishulk Dawa Yojana. https://health.rajasthan.gov.in/content/raj/medical/en/department-of-medical--health---family-welfare/CM-free-drug-plan.html.

Government of Rajasthan. (2015). Bhamashah Swashtya Bima Yojana. http://rajswasthya.nic.in/FAQ_Updated.pdf

Government of Tamil Nadu. (2009). *Government order No. 46*. https://www.cmchistn.com/circular/1a.%20G.O%2049%20-%20Dated%20-%2004-02-2009%20-%20Framing%20of%20Scheme-min.pdf.

Government of Tamil Nadu. (2018). *Government order No. 436*. Department of Health and Family Welfare. http://cms.tn.gov.in/sites/default/files/go/hfw_e_436_2018.pdf.

Government of Tamil Nadu. (2022). *Directorate of Medical and Rural Health Services*. Department of Health and Family Welfare. https://tnhealth.tn.gov.in/tngovin/dms/dms.php.

Government of Tamil Nadu. (2022). *About us*. Tamil Nadu Medical Services Corporation. https://tnmsc.tn.gov.in/html/aboutus.php.

Government of Tamil Nadu. (1993). Public Health Act, 1939. https://www.indiacode.nic.in/bitstream/123456789/13300/1/the_tamil_nadu_public_health_act_1939.pdf.

Hindustan Times. (2021, October 9). Andhra govt plans to set up 'YSR Rural Clinics' to take healthcare to doorstep of villagers. *Hindustan Times*. https://www.hindustantimes.com/india-news/andhra-govt-plans-to-set-up-ysr-rural-clinics-to-take-healthcare-to-doorstep-of-villagers-101633794996119.html.

India Review. (2005). *Banking on India's States: The Politics of World Bank Reform Programs in Andhra Pradesh and Karnataka*. Jason Kirk. https://www.tandfonline.com/doi/abs/10.1080/14736480500430984.

India Today. (2013). *Medicine Man*. https://www.indiatoday.in/prevention/story/medicine-man-155933-2013-03-11.

Jadhav, Abhijeet. (2020, February 26). How bike ambulances help patients in remote areas access hospitals. *Village Square*. https://www.villagesquare.in/how-bike-ambulances-help-patients-in-remote-areas-access-hospitals/.

Jain, Simran. (2021, August 25). Meet the Sahiyas empowering women to take control of their health in Rural Jharkhand. *The Bastion*. https://thebastion.co.in/politics-and/healthcare/meet-the-sahiyas-empowering-women-to-take-control-of-their-health-in-rural-jharkhand/.

Kalaiyarasan A. & Vijayabaskar M. (2020). *The Dravidian model: Interpreting the political economy of Tamil Nadu*. Cambridge University Press.

Kingdon, J. W. (2011). *Agendas, alternatives and public policy*. Longman.

Mahapatra, Prasanta. (1989). Secondary level hospital services: The Andhra Pradesh experiment. *Bulletin of Hospital Services*, *1*(1). https://www.researchgate.net/publication/261993065_Secondary_Level_Hospital_Services_The_Andhra_Pradesh_Experiment/citation/download.

Makkar, Sahil. (2015, September 11). Rajasthan plans universal health insurance; 45 million to benefit. *Business Standard*. https://www.business-standard.com/article/economy-policy/rajasthan-plans-universal-health-insurance-45-million-to-benefit-115091100035_1.html.

Mathew, S. & Mick Moore. (2011). State incapacity by design: Understanding the Bihar story. *IDS Working Papers*, *2011*(366), 1–31. https://doi.org/10.1111/j.2040-0209.2011.00366.x.

Mehrotra, S. (2006). Well-being and caste in Uttar Pradesh: Why UP is not like Tamil Nadu. *Economic & Political Weekly*, *41*(40), 4261–71.

Ministry of Health and Family Welfare. 2019. Chapter 3: Maternal and adolescent healthcare. In *Ministry of Health and Family Welfare Annual Report, 2017-2018*

National Family Health Survey. (1995). *National family health survey (NFHS-1) 1992-93*. Indian Institute for Population Sciences.

National Family Health Survey. (2000). *National family health survey (NFHS-2) 1998-99*. Indian Institute for Population Sciences.

National Family Health Survey. (2007). *National family health survey (NFHS-3) 2005-06*. Indian Institute for Population Sciences.

National Family Health Survey. (2017). *National family health survey (NFHS-4) 2015-16* Indian Institute for Population Sciences.

National Family Health Survey. (2019). *National family health survey (NFHS-5) 2019-21*.

National Statistical Office. (2019). *Key indicators of social consumption in India: Health, 2017-18.*

National Rural Health Mission. (2008). *Second common review mission report*. Ministry of Health & Family Welfare.

National Rural Health Mission. (n.d.) *Bihar state report*. Ministry of Health & Family Welfare. http://nhm.gov.in/images/pdf/nrhm-in-state/state-wise-information/bihar/bihar_report.pdf.

NITI Aayog. (2020). *NITI Aayog health index round 3*. http://social.niti.gov.in/hlt-ranking/?round=3.

Press Trust of India. (2014, December 28). Raghubar Das becomes first non-tribal chief minister of Jharkhand. *India Today*. https://www.indiatoday.in/assembly-elections-2015/jharkhand/story/raghubar-das-jharkhand-cm-non-tribal-cm-bjp-ajsu-modi-233110-2014-12-28.

Press Trust of India. (2022, March 17). J'khand medical health infra entity fails to utilise 88 pc of funds for drug procurement CAG. *The Week*. https://www.theweek.in/wire-updates/national/2022/03/17/cal32-jh-cag-health.html.

Press Information Bureau (2022, 25 March). Enhancement of healthcare workforce. Ministry of Health and Family Welfare. https://pib.gov.in/PressReleasePage.aspx?PRID=1809812, last accessed on 7 July 2022

Press Information Bureau (2021, 20 July). Initiatives to promote Indian health industry. Ministry of Health and Family Welfare. https://pib.gov.in/Pressreleaseshare.aspx?PRID=1737184, last accessed on 7 July 2022

Prakasamma, M. (2009). Maternal mortality-reduction programme in Andhra Pradesh. *Journal of Health, Population and Nutrition*, *27*(2), 220–34. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2761774/.

Registrar General of India (2022). *Special bulletin on maternal mortality in India 2017-19*.

Shiffman, J., & R. R. Ved. (2007). The state of political priority for safe motherhood in India. *BJOG: An International Journal of Obstetrics & Gynaecology*, *114*(7), 785–90.

Shiffman, J. (2009). A social explanation for the rise and fall of global health issues. *Bulletin of the World Health Organization*, *87*, 608–613.

Sparkes, S. P., Jesse B. Bump, Ece A. Özçelik, Joseph Kutzin, & Michael R. Reich. (2019). Political economy analysis for health financing reform. *Health Systems and Reform*, *5*(3), 183–194. https://doi.org/10.1080/23288604.2019.1633874.

Sunday Guardian Live. (2020). *Spurred by AAP win, Jagan goes for village clinics in AP*. https://www.sundayguardianlive.com/news/spurred-aap-win-jagan-goes-village-clinics-ap.

The Indian Express. (2019). *Explained: What causes AES? What makes Bihar so vulnerable?*. https://indianexpress.com/article/explained/acute-encephalitis-syndrome-low-blood-sugar-bihar-5785453/.

Times News Network. (2019, June 26). Rajasthan government's Right to Health to reduce patients' expenses. *The Times of India*. https://timesofindia.indiatimes.com/city/jaipur/state-govts-right-to-health-to-reduce-patients-expenses/articleshow/69950165.cms.

Venkateswaran, S., Shruti Slaria, & Sampriti Mukherjee. (2022). Political motivation as a key driver for universal health coverage. *Working Paper-32*. Centre for Social and Economic Progress. https://csep.org/wp-content/uploads/2022/07/POLITICAL-MOTIVATION-3.pdf.

Vyas, Kalpana. (2017). Enhancing access to essential medicines. Rajasthan Medical Services Cooperation. www.sihfwrajasthan.com/ppts/full/Enhancing%20Access%20to%20Essential%20Medicines.pdf.

Wadhwahan, Dev Ankur. (2019, August 29). Rajasthan: Gehlot govt to launch health scheme by combining Ayushman Bharat, Bhamashah schemes. *India Today*. https://www.indiatoday.in/india/story/rajasthan-gehlot-govt-launch-health-scheme-ayushman-bharat-bhamashah-1592838-2019-08-29.

World Bank. (2014). *Here is a model Indian States can implement to ensure smooth flow of medical supplies to health facilities* [Blog]. https://blogs.worldbank.org/governance/here-model-indian-states-can-implement-ensure-smooth-flow-medical-supplies-health-facilities.

World Bank. (2019, June 4). *World Bank signs $287 million loan to improve healthcare in Tamil Nadu* [Press release]. https://www.worldbank.org/en/news/press-release/2019/06/04/world-bankploan-healthcare-tamil-nadu-india.

World Health Organization, Lucy Gilson, Marsha Orgill, & Zubin Cyrus. (2018). *A health policy analysis reader: The politics of policy change in low-and middle-income countries*. World Health Organization. https://apps.who.int/iris/handle/10665/310886.

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6, Dr Jose P. Rizal Marg, Chanakyapuri, New Delhi - 110021, India

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