Is the Implementation of Centrally Sponsored Schemes Affected by a Diverging Local Engine?

A Case Study of the Pradhan Mantri Jan Arogya Yojna

Introduction

In the past few years, significant media coverage in India has been given to the “double engine hypothesis”: the hypothesis that a common ruling party between the centre and the state favours economic growth through increased efficiency in the execution of central policies. This claim has formed a key promise in election campaigns too. The claim has been the subject of debate: while to some, it is logically coherent, to others it is simplistic and ignores nuances local needs (Kumar, 2019) (Leivon & Deb, 2022) (Tewari, 2025).

An example of a recent, and important, central scheme is the Ayushmaan Bharat - Pradhan Mantri Jan Arogya Yojna (henceforth referred to as the AB-PMJAY or PMJAY scheme) (National Health Authority of India, 2025). Health insurance policies such as this present an ideal case study. These are political big-tickets whose execution is highly dependent on higher-level funding allocation and approvals, as well as on-the-ground outreach and execution.

The author came across this issue based on interviews of volunteers who help senior citizens register for the scheme. A large number of those volunteers independently pointed to the single engine challenge: they claimed that citizens from a state whose government was from a different party than the ruling party at the center, faced various bureaucratic hurdles that directly or indirectly undermined the central government’s promises of universally accessible health insurance (source: survey performed by author).

The topic of the double engine, and central-local relations, have also been of interest in research circles. Sushma Yadav (2010) studies weak policy implementation in India and points out the role of the bureaucracy, legislature, and the judiciary in executing policies, all for the purpose of explaining the reasons for the gaps between policy design and delivery. She further says that the comparison of top-down, bottom-up, and behavioral models shows that over-centralization and fragmentation of administrative powers are the main problems, and these indicate the need for reform and capacity building for successful policy outcomes. Anita Rath (2013) looks into the centralization of social sector policies in India through the lens of centralized sponsored schemes, pointing out

the wall that the government's control creates around the state's financial autonomy and flexibility in implementation. The problems that have been identified by her — poor fund flow, duplication, and inefficient spending — lead her to the recommendation for schemes to be attuned, fund structures to be reformed, and state flexibility to be improved.

Genia Kostka (2014) examines the factors limiting the implementation of local environmental policy in China, identifying scarce local capacity, low incentives, and strict national targets as major problems. The target-based system leads to inflexible, short-term, and poor actions, with non-government actors having limited and inconsistent influence, according to her. One of her recommendations is to increase local capacity and adjust incentives accordingly. Linda Chelan Li (2010) focuses on China's central-local relations concerning the economic and administrative decentralization and sees the actors as co-agents not in a strict hierarchy. She says that the problems of coordination, not compliance failure, characterize the implementation. G. W. Jones and J. D. Stewart (1982) criticize the UK local authorities for being pointed at the wrong end of the stick and being held responsible for stumbling blocks in the implementation which led to centralization. The authors highlight the local strengths in community representation and democratic checks; meanwhile, they warn that centralization will cut down on public participation and local democracy and hence, they call for bottom-up public accountability.

This paper aims to evaluate the validity of the double engine hypothesis through the case study of the AB-PMJAY scheme. The paper comes at a time when adequacy of healthcare coverage is a key issue for India. There is an implementation gap, as reported by the aforementioned volunteers, between scheme announcements from the centre and their use by citizens at the local levels. This gap warrants research as to why. The paper assesses the performance of the states and union territories of India on various scheme-related metrics, comparing states with matching or non-matching ruling parties with the centre. It arrives at conclusions based on statistical analysis and recommends a few steps to improve the outcomes from the scheme.

Methodology

This particular study was done to compare the implementation of macro-economic policies when the political party varies between the state and the central government. It takes on the case study of the AB-PMJAY health insurance scheme. The scheme was launched in 2018, and its scope was majorly expanded in 2024, making it a highly relevant point of discussion (National Health Authority, 2025).

All data for this study was sourced through the Open Government Data (OGD) Platform of India, from official National Health Authority of India reports, and responses to parliamentary inquiries. The scope of this study is 2022-2024, as this was the most recent data available that had complete reports from all states and union territories.

Government-reported figures were sourced for their authenticity. The OGD Platform was scraped to find all relevant figures, and a dataset was compiled, adding card registration, hospital empanelment, hospital admission, claims submission and claims pending, and funds release data state-wise.States, and their corresponding data in figures, were categorised as matching (i.e. same ruling party as the party running the central government during the period under consideration), or non-matching (i.e. different ruling party from the party at the centre). Population figures were also added for normalisation. This compiled dataset was used for comparative quantitative analysis.

Volunteers who, in 2023, helped senior citizens get access to the AB-PMJAY scheme in Chennai, Tamil Nadu, were interviewed prior to the study, and their responses noted; however, these survey answers were only used for context-setting and did not inform the data analysis.

Results and Discussion

Firstly, key data about the states and union territories was compiled, namely: state or union territory status (‘State/UT’); whether the ruling party of the state matched the ruling party of the country (‘Matching: Y/N?’); and the most recently available population data (‘population’). State or union territory status, and their respective ruling parties, are as of the relevant time period.

STATE/UT	State/UT?	Matching: Y/N?	POPULATION
Andaman and Nikobar Islands	UT	Y	380,581
Andra Pradesh	State	N	49,577,103
Arunachal Pradesh	State	Y	1,383,727
Assam	State	Y	31,205,576
Bihar	State	N	104,099,452
Chandigarh	UT	Y	1,055,450
Chhatisgarh	State	Y	25,545,198
Dadra and Nagar Haveli and Daman and Diu	UT	Y	585,764
Delhi	UT	Y	16,787,941

Goa	State	Y	1,458,545
Gujarat	State	Y	60,439,692
Haryana	State	Y	25,351,462
Himachal Pradesh	State	N	6,864,602
Jammu and Kashmir	UT	N	12,267,032
Jharkand	State	N	32,988,134
Karnataka	State	N	61,095,297
Kerala	State	N	33,406,061
Ladakh	UT	Y	274,000
Lakshadweep	UT	Y	64,473
Madhya Pradesh	State	Y	72,626,809
Maharashtra	State	Y	112,374,333
Manipur	State	Y	2,570,390
Meghalaya	State	N	2,966,889
Mizoram	State	N	1,097,206
Nagaland	State	N	1,978,502
Odisha	State	Y	41,974,219
Puducherry	UT	N	1,247,953
Punjab	State	N	27,743,338
Rajasthan	State	Y	68,548,437
Sikkim	State	N	610,577
Tamil Nadu	State	N	72,147,030
Telangana	State	N	35,003,674
Tripura	State	Y	3,673,917
Uttar Pradesh	State	Y	199,812,341
Uttarakhand	State	Y	10,086,292
West Bengal	State	N	91,276,115

Table. 1: Name, status, ruling party, and population data of the states and union territories of India.
Source:Compiled by the author using Indian Census 2011.

Controlling for population was a key step in ensuring a normalised comparison of the efficacy of the PMJAY scheme across variables.

The key comparison drawn throughout this study was the performance of different states on the implementation of the AB-PMJAY, depending on whether they were **matching**– i.e., if the ruling party of the state was the same as the central government– or whether they were **non-matching.** This performance is judged through **various metrics of efficacy.** These were: (a) the number of AB-PMJAY cards issued, which registers new citizens for the scheme and allows them to access the provided health insurance; (b) the number of hospital admissions recorded through the PMJAY scheme, for the years 2022-23 and 2023-24; (c) the claims submitted, paid and pending. These variables represent the complete process of availing PMJAY: registration as an eligible citizen, hospital admission for any medical needs, and insurance approval through claims.

Number of Cards Issued per capita

First, the number of cards issued by state/union territory are graphed below. The raw count of cards registered is normalised by population, and calculated as cards issued per 1000 people, to allow for a fair comparison. Non-matching states are shown in orange, while matching states are shown in dark blue:

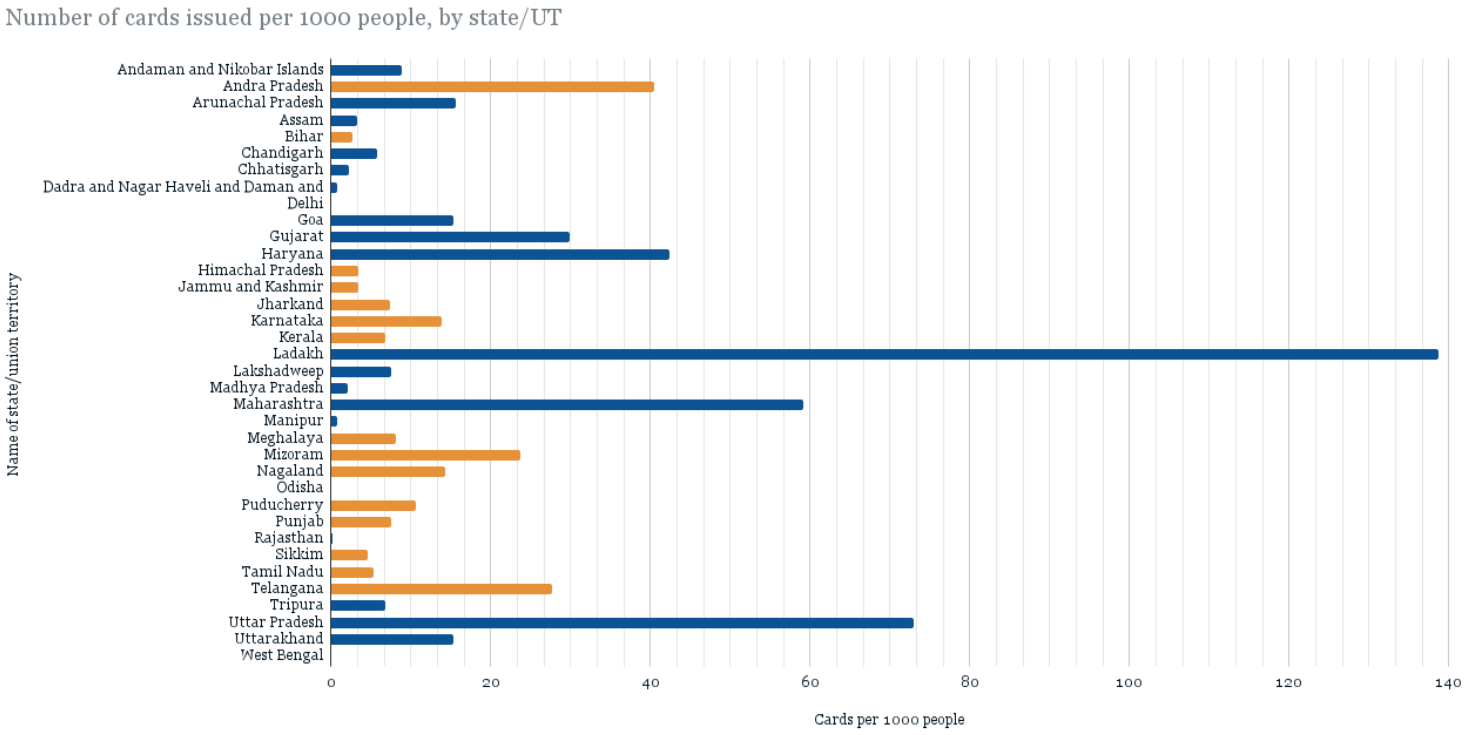


*Fig. 1: Bar chart depicting AB-PMJAY cards issued, per 1000 people in the population. States where ruling parties are **matching** are shown with **dark blue** bars, while **non-matching** governments are shown with **orange** bars. '0' data (in the states of Delhi, Odisha, and West Bengal) is due to no reported cards issued, likely due to non-participation in the scheme. Source: Compiled by the author using a report from OGD Platform of India,(2024).*

A comparison of the non-matching and matching states/union territories clearly demonstrates that matching regions have a significantly higher number of cards issued. Four out of the top five states in this metric are all in the matching category. Meanwhile, four out of the lowest performing five states are all non-matching (Table 2).

	Highest 5 performers	Lowest 5 performers
Matching	Uttar Pradesh, Maharashtra, Haryana, Ladakh	Bihar*
Non-Matching	Andhra Pradesh	Himachal Pradesh, Jammu and Kashmir, Sikkim, Tamil Nadu

Table 2: A comparison of the top and bottom five performers in the number of PMJAY cards issued per 1000 people in the population. Source: Compiled by author from OGD Platform of India (2024).
**For analytical purposes, Bihar can be considered a matching state due to the close alliance between its ruling party and the centre.*

Hospital Admissions per capita

Next, the hospital admissions per 1000 people, for the years 2022-23 and 2023-24 are graphed below. As with Fig. 1, non-matching states are shown in orange, while matching states are shown in dark blue:

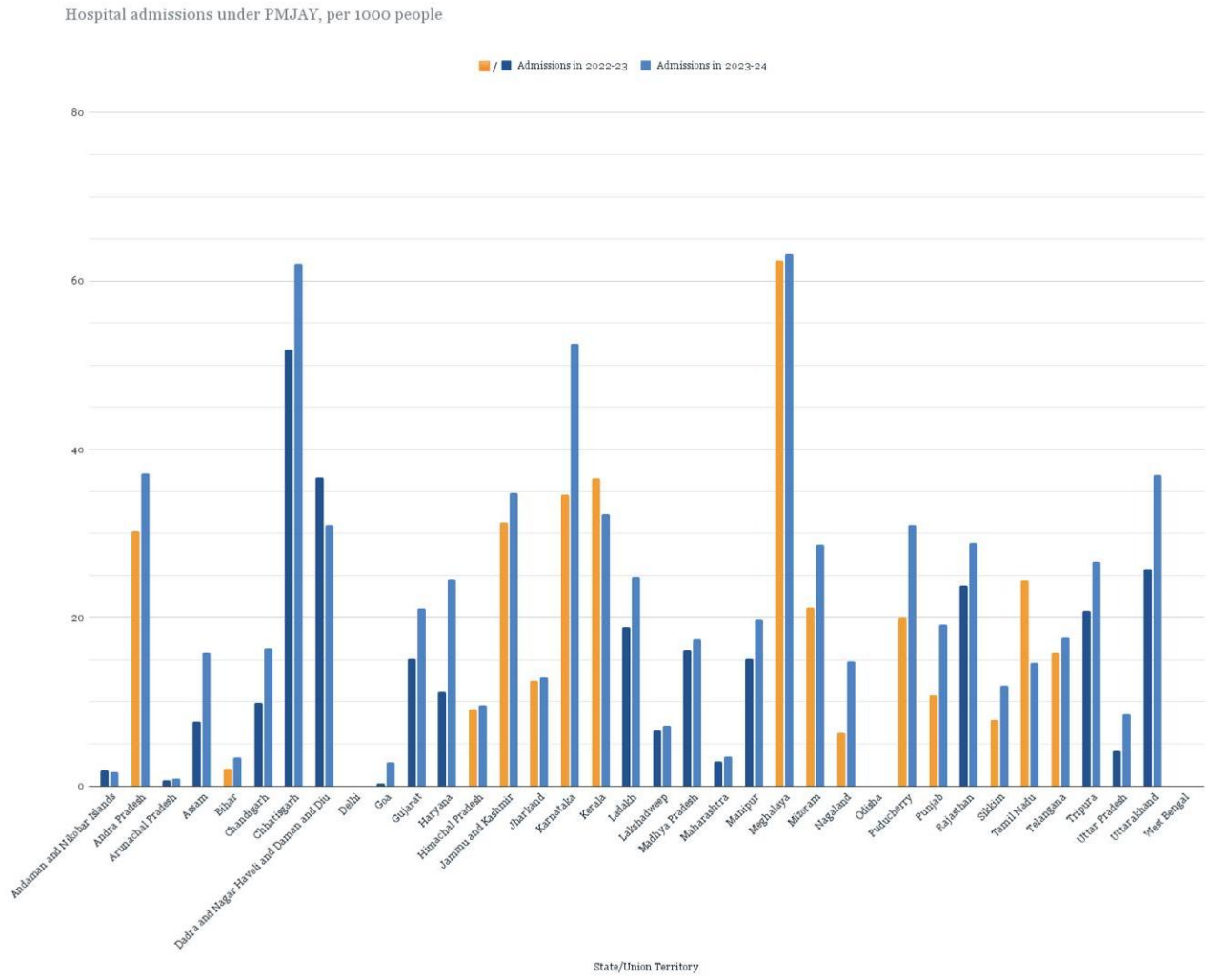


*Fig. 2: Bar chart depicting hospital admissions under the AB-PMJAY scheme, per 1000 people in the population. States where ruling parties are **matching** are shown with **dark blue** bars in the 2022-23 category, while **non-matching** governments are shown with **orange** bars in the 2022-23 category. '0' data (in the states of Delhi, Odisha, and West Bengal) is due to no reported cards issued, likely due to non-participation in the scheme. Source: compiled by author from a report from OGD Platform of India, (2025).*

Hospital admissions had mixed performance. Firstly, for the majority of states and union territories, the numbers in 2023-24 were higher in 2022-23, indicating an increased adoption of the scheme across most states.

Secondly, given below is the tabular comparison on hospitalisation rate in matching and non-matching states:

Large states	High hospitalization rate (>20)	Low hospitalization rate (<20)

Matching	Gujarat, Rajasthan, Haryana, Chhatisgarh, Uttarakhand (5)	Uttar Pradesh, Madhya Pradesh, Maharashtra, Assam, Goa, Manipur, Bihar* (7)
Non-matching	Kerala, Karnataka, Andhra Pradesh, Tripura, Jammu and Kashmir, Meghalaya, Mizoram (7)	Jharkhand, Punjab, Telangana, Tamil Nadu, Sikkim, Himachal Pradesh, Nagaland (7)

Table 3: A comparison of hospitalisation rates between matching and non-matching states. A 'high' rate is deemed to be 20 or more hospitalisations per 1000 people. Source: Compiled by author from OGD Platform of India,(2025).

**For analytical purposes, Bihar can be considered a matching state due to the close alliance between its ruling party and the centre.*

Here, matching or non-matching status is not a reliable indicator of hospitalisation rate, with plenty of states in all four quadrants. The split between high and low hospitalisation is approximately equal for both the matching and non-matching categories. The other drivers of this categorisation, such as existing infrastructure and typical state-wise economic profiles, remain an interesting avenue for further study.

Claims Data

The final step in the PMJAY process is the submission, and payment, of an insurance claim by the registered patient. Claims data– the count submitted, paid, and pending– is visualised in the figure below:

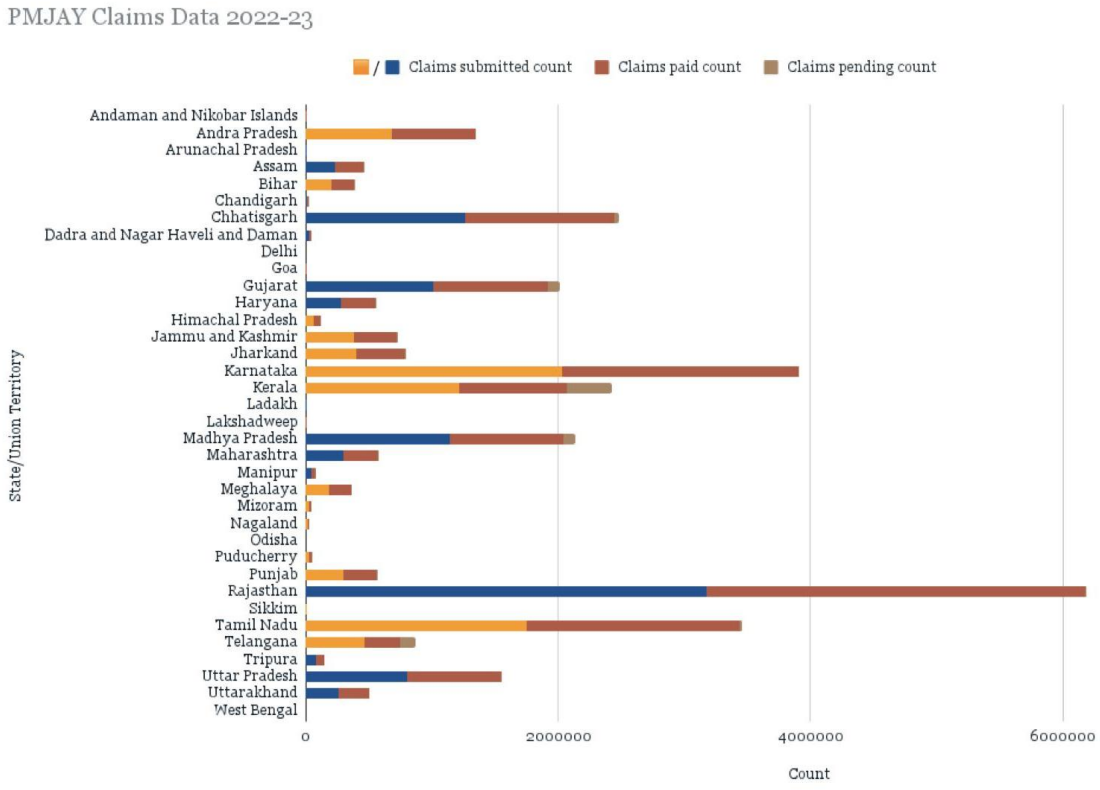


*Fig. 3: Stacked bar chart depicting claims data for the year 2022-23, per state or union territory. The first bar, shown in **blue (matching) or orange (non-matching)**, visualises the number of claims submitted. The second bar, shown in red, shows the number of claims paid. The final bar, shown in brown, shows the number of claims pending. Source: Compiled by author from a report from OGD Platform of India, (2024).*

Rajasthan stands out as an exception with the highest count of claims submitted and paid. It has matching center-state governments. Other than that, many large states with non-matching governments are high on this metric, such as Tamil Nadu, Kerala, Karnataka and Andhra. In large states with matching governments and a high count of claims submitted and paid, there are: Madhya Pradesh, Gujarat and Chhattisgarh. Overall, while there is a mixed pattern of claims submitted and paid across matching and non-matching states, non-matching states emerge as doing slightly better.

A key metric in evaluating claims data is the **settlement ratio**:

$$\textit{number of claims paid} \,/\, \textit{number of claims submitted}$$

This shows the proportion of successful cases of an insurance policy such as AB-PMJAY.

Given below is a radar chart depicting the settlement ratio across states and union territories:

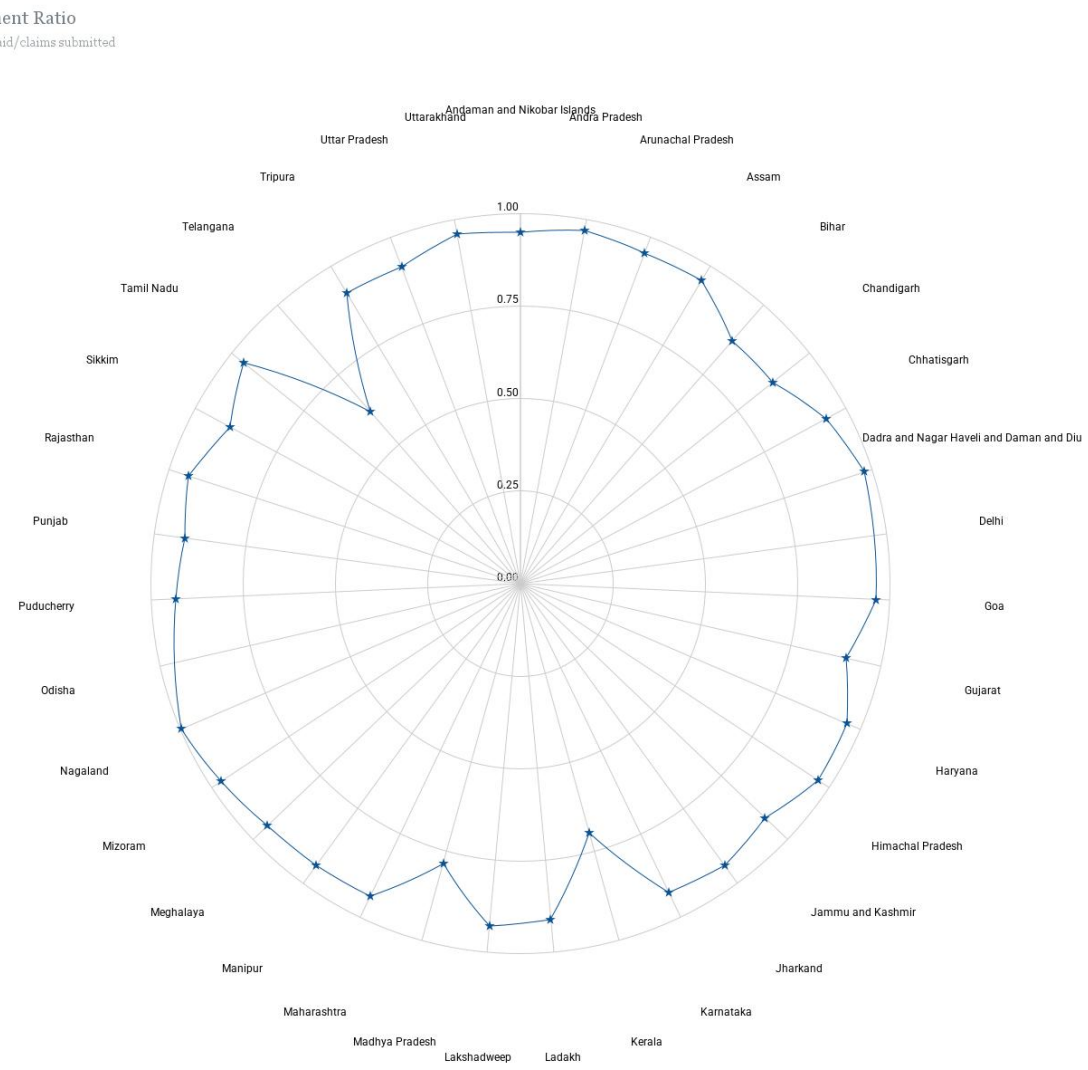


Fig. 4: Radar, or spider, chart depicting the settlement ratio for each state and union territory. The central circle is divided into four quadrants: 0.0+, 0.25+, 0.50+, and 0.75+. Labels arranged clockwise. Source: Ratio compiled by author from a report from OGD Platform of India,(2024)

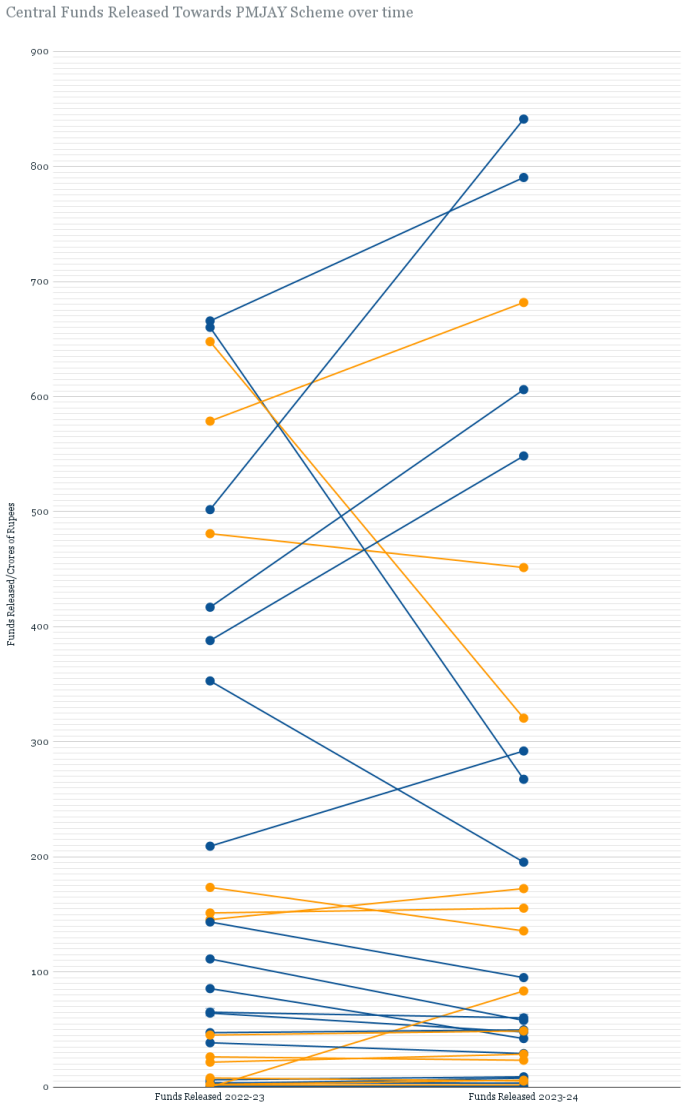
As can be seen, the AB-PMJAY scheme has a consistently impressive settlement ratio, with almost all states and union territories being in the top quadrant. The only two regions with a radio below 0.75 are Kerala and Telangana: both **non-matching**.

Another aspect of interest is the comparison of union territories and states. Union territories are governed directly by the central government– arguably a greater degree of 'matching' than even states, which may have a matching ruling party but do function independently. This begs the question of whether an even greater execution efficiency can be seen in the union territories. Table 1 shows the average of all matching states,

non-matching states, and union territories on the chosen performance metrics of interest. Union territories outperform the states on all metrics. When comparing non-matching and matching states, while non-matching states have a greater average number of cards issued per 1000 people, matching states have a consistently greater average number of hospital admissions per 1000 people.

	Cards/ 1000 ppl	**2022-23 admissions/ 1000 ppl**	**2023-24 admissions/ 1000 ppl**	**Settlement Ratio (=claims paid/ claims submitted)**
Average in UTs	17.299	17.089	21.097	0.924
Average in Non-Matching States	17.105	16.949	20.926	0.913
Average in Matching States	16.914	17.059	21.069	0.913

Table 5: Average number of cards issued, hospital admissions, and settlement ratios as grouped by Union Territory, Matching State, or Non-Matching State status. Rounded to 3 d.p. Source:Compiled by author form Report from OGD Platform of India(2024).



It is worth noting that union territories often have significantly smaller populations, and unique socioeconomic behaviour, that may also play a part in this difference; however, given the consistent trend this may be an interesting avenue for further studies.

Finally, in the interest of looking into causative factors, here are the central fund allocation data across states:

*< Fig. 5: Central funds allocated to various states towards the implementation of the PMJAY scheme, over 2022-2024 period. **Matching** states are shown in **dark blue,** while **non-matching** states are shown in orange. Source: Compiled by author from a report from OGD Platform of India,(2025)*

The top 15 states (in terms of fund allocation) are also the largest in terms of population. Analysing these, it is observed that the highest funds allocated, and greatest increase, have both been in matching states. Of the top fifteen group, four out of five highest paid states are matching, while four out of five of the lowest paid are non-matching. Additionally, funds are more likely to have reduced in the second year if the state is non-matching, while most matching states have seen an increase in funds.

Conclusion

In the case of the Ayushmaan Bharat- Pradhan Mantri Jan Arogya Yojna (PMJAY), there are multiple points of evidence indicating improved performance on efficiency metrics where the state and central government are matching. To start with, when it comes to PMJAY cards issued, a clear difference is seen between matching and non-matching regions, with matching states performing exceptionally well in the cohort. This shows that states with matching ruling party have been more enthusiastic in registering members into the scheme and issuing cards. States with non-matching ruling parties would have probably focused on the state run health insurance schemes.

However, when it comes to hospital admissions and the number claims submitted, performance in both matching and non-matching states is comparable. This is an indicator of the healthcare needs in people's lives and the health infrastructure in the state, more than the efficacy of health insurance schemes. Some states have historically performed better on health indicators and they seem to be continuing to do so.

When it comes to settlement ratio, all significantly underperforming states are non-matching. This might indicate compliance challenges or bureaucratic hurdles in running a centrally sponsored scheme in such states.

One more factor evidenced in the analysis is the allocation of central funds, which both trends higher and is more likely to increase in matching states.

Union territories, who have a greater degree of congruence with the centre than all states, outperform on all the measured metrics.

Considering all the above, we can conclude that there is a correlation between matching or non-matching governments and the health insurance outcomes (the double engine theory), though it matters only in some parts of the process, most notably coverage of the central scheme, claims settlement ratio and central funds allocation.

However, it is important to keep in mind that existing healthcare infrastructure in the states and socio-political tensions can be additional factors that can impact the health outcome indicators.

As pointed out in the literature, it would be a mistake to characterise the conclusions from the analysis as being caused by simple non-cooperation from the states. While taking a mean value for a category, such as in Table 3, tends to flatten data somewhat, the visualisations of statewise data show the variation within these, which are representative of the variation in local conditions and needs. The more ambiguous results, such as in Figures 2 and 3, show that the media-driven or political messaging of a double engine that promotes centralisation may not be the road towards increased efficiency.

Recommendations

A **shared administrative drive** can materially improve the government-sponsored benefits received by the public. Literature around central-local relations points out the bottom-up approach, where the centre designs policies with local resources and challenges in mind, as opposed to expecting state governments to uphold central hierarchies.

Greater transparency is needed in the institutional mechanisms behind healthcare fund allocation. Decision making should evolve into an objective, data-driven exercise, as opposed to a politically-influenced one.

Finally, health insurance is a consumer benefit with positive externalities. Above state or central politics is adoption of the scheme at a family level. The author has three recommendations stemming from this perspective, as well as insights from on-ground volunteers. Firstly, **portability** between various schemes offered by all levels of government is key to reducing confusion amongst citizens. This will also contribute to the shared drive towards healthcare for all, regardless of the specific governing body. Secondly, **extensibility**, i.e. the use of the same card outside of the citizen's domicile state, reduces bureaucracy and provides care as and when needed, particularly considering increasing migration nation-wide. Finally, increasing **public awareness** of such schemes heightens the people's own desire for improved healthcare. As a democratic nation, governments of all levels are inclined to follow public will, creating the perfect motive for a smooth provision of universal health insurance.

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