

Why Traditional Medicine Remains Outside Public Health Insurance: Financing Architecture, Institutional Path Dependence, and Lessons for India's AB-PMJAY

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Abstract

Background

India's health system is characterised by medical pluralism, with Ayush systems contributing substantially to preventive care, chronic disease management, and wellness-oriented health practices. Although recent policy initiatives have promoted integrative healthcare and expanded Ayush services within public facilities, financing mechanisms have not evolved in parallel. India's flagship publicly financed health insurance scheme, Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), continues to focus primarily on biomedical inpatient services, excluding most Ayush interventions. This review examines the exclusion of Ayush from AB-PMJAY and situates India's experience within global patterns of public insurance coverage for traditional medicine, with particular attention to insurance design, institutional arrangements, and evidence requirements.

Methods

A narrative policy review with systematic search elements was conducted using an integrative health systems perspective. Literature was identified through PubMed, Scopus, Web of Science, Google Scholar, and grey literature sources, including the WHO, World Bank, Government of India ministries, and Health Technology Assessment India (HTAI). Following PRISMA-informed screening, approximately 55 documents were included in the synthesis. Findings were analysed narratively using three complementary frameworks: universal health coverage (UHC), health systems political economy, and health technology assessment (HTA).

Results

AB-PMJAY prioritises secondary and tertiary inpatient care under a catastrophic expenditure protection model, structurally excluding outpatient, preventive, and promotive services characteristic of Ayush practice. Ayush financing remains programme-based through the National Ayush Mission rather than insurance-driven. Internationally, only selected East and Southeast Asian countries routinely include traditional medicine within public insurance through selective, standardised coverage.

Conclusion

The exclusion of Ayush from AB-PMJAY reflects insurance design, institutional path dependence, and evidentiary standards rather than a lack of policy recognition.

Introduction

India sustains a pluralistic health system in which multiple medical knowledge traditions coexist and interact within formal and informal care settings. Ayurveda, Yoga and Naturopathy, Unani, Siddha, Homoeopathy, and Sowa Rigpa (Ayush) contribute substantially to preventive care, chronic disease management, and wellness-oriented health practices across the country[1, 2]. These systems operate through epistemologies, therapeutic logics, and care pathways that differ fundamentally from biomedicine, yet patients often navigate them concurrently rather than sequentially.

In recent years, policy discourse in India has increasingly emphasised integrative healthcare, recognising the potential complementarities between biomedical and traditional systems. The establishment of the Ministry of Ayush and the expansion of Ayush services within primary healthcare settings signal this shift. However, financing mechanisms have not evolved at the same pace. Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). India's flagship publicly

financed health insurance scheme continues to restrict coverage largely to biomedical inpatient services, thereby excluding most Ayush interventions[3] ,[4].

This exclusion reflects more than a policy oversight. Health insurance schemes shape clinical practice, institutional legitimacy, and patterns of evidence generation. By privileging hospitalisation-based biomedical care, AB-PMJAY implicitly defines what constitutes essential and insurable healthcare. Such definitions carry important implications for integrative health systems, particularly in contexts where traditional medicine emphasises longitudinal, individualised, and preventive care rather than episodic intervention.

Several countries with long-standing traditional medicine systems have addressed similar tensions by incorporating traditional medicine into public insurance through adaptive governance and evidence appraisal mechanisms. Examining these experiences offers an opportunity to reflect on how India might align its aspirations for integrative health with its financing architecture. This narrative review examines the exclusion of Ayush from AB-PMJAY through the analytical lenses of health technology assessment (HTA), institutional political economy, and integrative health systems theory. It seeks to explain why Ayush remains outside India's publicly financed insurance architecture despite sustained policy recognition, and to compare this position with international coverage for traditional medicine. By situating India's experience within global models, the review identifies the structural design features, institutional trajectories, and evidentiary norms that shape the insurance inclusion of traditional medicine in pluralistic health systems.

Methods

Study design and approach

The authors designed this study as a narrative policy review with systematic search elements. It adopted an integrative health systems perspective to examine how financing architecture, institutional arrangements, and evidentiary standards shape the inclusion or exclusion of traditional medicine within publicly financed insurance schemes. Narrative policy reviews are a recognised and legitimate approach for examining policy-relevant questions that are explanatory and contextual, with the objective of generating conceptually grounded understanding rather than estimating intervention effects[5, 6]. While the review did not aim to conduct a quantitative aggregation or meta-analysis, it followed the PRISMA-ScR (PRISMA extension for Scoping Reviews) transparency principles to guide literature identification, selection, and synthesis, thereby enhancing methodological accountability[7].

Data sources and search strategy

The authors conducted a comprehensive literature search from September to November 2025 (with no lower date limit, seeking to capture historically relevant policy and institutional developments) across PubMed, Scopus, Web of Science, and Google Scholar. An illustrative core search string used for PubMed was: ("Ayush" OR "Ayurveda" OR "traditional medicine" OR "complementary medicine" OR "integrative medicine") AND ("public health insurance" OR "health financing" OR "benefit package" OR "universal health coverage") AND ("governance" OR "health technology assessment" OR "reimbursement"). Equivalent searches were conducted in other databases with appropriate syntax adjustments. Country-specific terms including "traditional Chinese medicine", "Korean medicine", "Kampo", and "Thai traditional medicine" were included in the base strings for regional comparisons.

The authors complemented database searches with a systematic review of grey literature from the WHO, the World Bank, the Ministry of Health and Family Welfare (Government of India), the Ministry of Ayush, the National Health Authority (NHA), and Health Technology Assessment India (HTAI). Citation tracking of key articles was conducted to identify additional relevant literature.

Note on supplementary search methods: The authors utilised publicly available large language model (LLM)-based platforms as a supplementary aid to identify dispersed policy documents and regulatory texts, particularly in regions with fragmented institutional documentation. Specifically, the authors used LLMs to generate candidate document titles and URLs, which they subsequently retrieved and independently verified against the original institutional sources. No document was included in the synthesis solely based on LLM-generated summaries; all included documents were independently located, read, and assessed against the eligibility criteria described below. This approach is disclosed in the interest of full transparency.

Eligibility criteria and study selection

The table below (Table 1) summarises the formal inclusion and exclusion criteria the authors applied during the screening process.

Table 1
Article Screening Criteria

Inclusion criteria	Exclusion criteria
Studies, reports, or policy documents addressing financing mechanisms, insurance coverage, governance structures, or economic evaluation of traditional medicine.	Studies focused exclusively on the clinical efficacy of traditional medicine interventions, with no relevance to health policy, financing, or system-level integration.
Health system analyses describing the institutional arrangements for traditional medicine within publicly financed healthcare.	Duplicate records across databases (retained in the database where first identified)
National and international policy documents, WHO reports, government guidelines, and grey literature related to traditional medicine and public insurance	Documents without sufficient detail on financing mechanisms, benefit package design, or insurance governance
Documents in English (primary) or with available English-language translations or summaries	Conference abstracts, editorials, and opinion pieces without empirical or policy analytical content.
Literature covering any country or region where traditional medicine intersects with public insurance or health financing policy	

After removing duplicates, the authors screened titles and abstracts for relevance. The authors retrieved and assessed full-text documents where titles or abstracts indicated relevance to financing mechanisms, insurance coverage, governance structures, or economic evaluation of traditional medicine. The first and second authors (BJM, NMS) conducted title/abstract screening; the third and fourth authors (NEP, JKP) independently reviewed a random 20% subsample each, with disagreements resolved through discussion. Citation tracking of key articles identified additional relevant literature.

Data extraction and synthesis

The authors applied a structured data extraction template to all included documents. For each document, the following items were extracted: country context, traditional medicine system covered; type of insurance or financing mechanism; scope of coverage; governance and institutional arrangements; approaches to HTA or evidence appraisal; and key policy outcomes. The first author (BJM) conducted primary data extraction; a second author (NMS) independently extracted data from a 20% subsample to check consistency. Discrepancies were resolved by discussion and reference to the original source. Given the heterogeneity of study designs, data sources, and analytical approaches across the included literature, the authors adopted a narrative synthesis approach[8]. Extracted data were organised thematically and interpreted using three analytical frameworks.

Analytical frameworks

The authors interpreted findings using three complementary analytical frameworks. First, they applied a universal health coverage (UHC) framework, drawing on the WHO's conceptualisation of UHC as encompassing service coverage, financial protection, and equity, to analyse how benefit package design under AB-PMJAY defines essential services and shapes the position of traditional medicine within publicly financed systems[9, 10]. Second, they applied a health systems political economy framework to examine how historical financing arrangements, institutional norms, and governance structures influence the inclusion or exclusion of traditional medicine within insurance schemes, with particular attention to path dependence, institutional incentives, and policy implementation dynamics[11–13]. Third, they employed an HTA framework to analyse how evidence hierarchies, methodological standards, and priority-setting processes affect the eligibility of Ayush interventions for insurance coverage, drawing on HTA principles articulated by the WHO and HTAIn[14–16].

Methodological considerations

The authors did not assess the methodological quality or risk of bias of individual studies, consistent with the objectives of a narrative policy review. They aimed to synthesise policy-relevant insights about the structural determinants rather than to estimate intervention effects. Limitations include reliance on secondary literature and policy documents, which represent official positions rather than implementation realities; potential publication bias toward English-language sources; the absence of stakeholder or provider perspectives; and the possibility that some grey literature documents may not reflect the most current policy status. The authors discuss these limitations further in the discussion section.

Results

A total of 55 articles were included for the final review. The PRISMA-informed flow of literature identification and selection is presented below (Fig. 1).

Positioning of Ayush within AB- PMJAY

Policy documents describe AB-PMJAY as a tax-funded public health insurance scheme providing cashless coverage of secondary and tertiary inpatient care through predefined procedure-based packages in empanelled hospitals[3]. The benefit packages focus on biomedical interventions delivered during hospitalisation and exclude outpatient, preventive, or promotive services[3].

Sources consistently show that Ayush services operate predominantly in outpatient and primary care settings, emphasising preventive care, chronic disease management, and wellness-oriented interventions [1, 2]. National survey data continued utilisation of traditional medicine alongside persistent out-of-pocket expenditures, as public insurance schemes do not reimburse Ayush services [17]. Programme reports note the expansion of Ayush services within public health facilities, particularly through co-location at Ayushman Arogya Mandirs (AAMs); however, reviewed sources do not document routine reimbursement of Ayush under AB-PMJAY[18, 19]. Earlier publicly financed insurance schemes in India, including RSBY, similarly restricted coverage to inpatient biomedical services[20]. No reviewed source documents systematically include Ayush services within publicly financed insurance schemes in India.

This represents a significant null finding: despite explicit government policy recognising Ayush's role in primary healthcare, there is no reimbursement pathway for Ayush services within AB-PMJAY's benefit package. This absence is not incidental but reflects the scheme's structural features, as discussed in the analysis below.

HTA and evidence requirements

Documents describing HTA processes in India reported that national HTA frameworks prioritise randomised controlled trials, standardised outcome measures, and economic evaluation methods such as cost-utility analysis[15, 16]. The HTA methodological guidelines reviewed in this study did not describe specific approaches for evaluating traditional medicine or integrative interventions[15].

The reviewed literature reported limited availability of published economic evaluations and HTA studies focusing on Ayush interventions[14]. Studies describing Ayush research practices reported the use of individualised treatment protocols and multimodal therapeutic approaches[2, 14]. Policy documents reviewed did not report inclusion of Ayush interventions in formal HTA-based priority-setting exercises linked to AB- PMJAY benefit package design[15, 16].

International sources included in the review reported the use of pragmatic trials, observational studies, and real-world evidence in the assessment of traditional medicine interventions in selected countries[21]. These documents describe reimbursement decisions for traditional medicine based on defined service categories, standardised therapies, or approved formulations, suggesting integration[22, 23].

Institutional and financing arrangements

The reviewed literature shows that India's public health insurance system has historically been oriented toward hospital-based biomedical care financed through package-based reimbursement mechanisms[20, 24]. Policy analyses show that insurance purchasing arrangements emphasise standardisation, predefined pricing, and facility-based service delivery[3, 24].

Sources show that Ayush services receive public financing primarily through separate budgetary allocations and national programmes, such as the National Ayush Mission (NAM), rather than through insurance-based purchasing[25, 26]. The literature described distinct administrative, regulatory, and financing arrangements for Ayush and biomedical services within the public health system[26]. None of the reviewed policy documents describes established mechanisms for the empanelment of Ayush providers or for pricing Ayush interventions within AB-PMJAY[3, 25].

International Models: East and Southeast Asia

The reviewed international literature identifies several countries that include traditional medicine within public insurance systems through varied financing mechanisms. China includes Traditional Chinese Medicine (TCM) within the national social health insurance schemes, covering both inpatient and outpatient services, with TCM's institutional embedding in state-supported health systems dating to the 1950s[22, 27]. South Korea's National Health Insurance system reimburses selected Korean Medicine procedures and medicines under a social insurance model, with systematic expansion from the late 1980s onwards[22]. Japan's universal health insurance reimburses Kampo medicine, with coverage restricted to standardised formulations approved for reimbursement since 1967 [28]. Thailand's Universal Coverage Scheme, established in 2002, covers Thai Traditional Medicine primarily at the primary care level[29].

Across the reviewed literature, no country reports unrestricted equivalence between traditional medicine and biomedical services in public health insurance coverage. Instead, sources describe selective inclusion based on defined services, standardised interventions, or specific levels of care. Crucially, in each East Asian case, governments had institutionally embedded traditional medicine in state-supported health systems prior to insurance consolidation, a sequence pattern that appears to have been a precondition for subsequent insurance inclusion.

International Models: Europe

European literature documents selective and limited coverage of complementary medicine within statutory health insurance systems. In Germany, some statutory funds cover selected naturopathic and homoeopathic therapies, though coverage is variable and has undergone periodic reform[30].

International Models: Africa and Latin America

The reviewed literature documents widespread use of traditional medicine across African Countries, where it often serves as a primary source of care. WHO reports and country-level studies documented that African traditional medicine remains largely financed through out-of-pocket payments and informal arrangements rather than public insurance mechanisms [31, 32]. Although several countries like Ghana, Nigeria, South Africa, and Tanzania have established regulatory frameworks recognising traditional medicine practitioners, none of the reviewed sources documents routine reimbursement for African traditional medicine within national health insurance benefit packages [31–33]. Ghana’s National Health Insurance Scheme, one of the most established insurance systems in Sub-Saharan Africa, does not reimburse traditional medicine services despite the formal recognition of traditional medicine practice[33].

The literature from Latin America describes the recognition of indigenous and traditional medicine within national health policies and intercultural health frameworks in countries such as Peru, Bolivia, and Mexico. However, the reviewed sources show that public insurance schemes in these countries do not routinely reimburse traditional medicine services, which remain largely financed through household payments or community-based arrangements [34, 35].

These patterns indicate that policy recognition of traditional medicine does not automatically translate into financial risk protection or inclusion. The absence of standardised service definitions, cost data, and formal evaluative frameworks constrains the eligibility of traditional medicine interventions in these settings.

International Models: Australia and Oceania

The reviewed literature shows that Australia's tax-funded Medicare system recognises Aboriginal and Torres Strait Islander traditional healing practices within cultural, social, and primary healthcare frameworks; however, no reviewed source documents routine reimbursement of Indigenous traditional medicine through Medicare[36–38]. Traditional healing services operate primarily through Aboriginal Community Controlled Health Organisations, which governments fund through targeted programmes and block grants rather than insurance-based reimbursement.

New Zealand’s government supports its formal recognition of Rongoa Māori through direct public funding and contractual arrangements rather than insurance-based reimbursement [39]. No reviewed document reported inclusion of Rongoa Māori within insurance benefit packages.

Reports from Pacific Island countries described widespread use of traditional medicine, largely financed through out-of-pocket or informal arrangements, with no identified national insurance scheme providing systematic reimbursement[40].

These cases suggest that cultural recognition and even dedicated funding do not necessarily translate into financial risk protection through insurance inclusion. Traditional healing systems in Australia and New Zealand remain situated within parallel or community-governed financing structures rather than within core insurance purchasing arrangements.

Comparative overview

Table 2 presents a comparative summary of public insurance coverage for traditional medicine systems across selected countries, including the type of insurance mechanism and the scope of coverage[3, 22, 27, 28, 41] [42].

Table 2
Comparative Overview of Public Insurance Coverage for Traditional Medicine Systems Across Selected Countries[3, 22, 27, 28, 41] [42]

SI No	Country	Traditional medicine system	Public insurance coverage	Type of insurance mechanism	Scope of coverage
1	China	Traditional Chinese Medicine	Yes	Social health insurance (Bismarckian)	Inpatient and outpatient services
2	South Korea	Korean Medicine	Yes	National health insurance (Bismarckian)	Selected procedures and medicines
3	Japan	Kampo Medicine	Yes	Universal health insurance (social insurance)	Standardized formulations
4	Thailand	Thai Traditional Medicine	Yes	Tax-funded universal coverage (Beveridge-type)	Primary care and preventive services
5	Germany	Naturopathy, Homoeopathy	Partial	Statutory health insurance (Bismarckian)	Selected therapies
6	Ghana	African Traditional Medicine	No	National Health Insurance	No routine reimbursement
7	South Africa	African Traditional Medicine	No	Tax-funded public health system	No insurance coverage
8	Peru	Indigenous traditional medicine	No	Social health insurance	Policy recognition only
9	Australia	Aboriginal traditional medicine	No	Tax-funded public health system (Medicare)	Programmatic funding only
10	New Zealand	Rongoa Māori	No	Tax-funded public health system	Direct government funding
11	India	Ayush systems	No	Tax-funded public insurance	Limited pilots; no routine reimbursements

Discussion

This review examined why Ayush remains outside India’s flagship publicly financed health insurance scheme, AB-PMJAY, despite sustained policy recognition, and compared this position with international patterns of traditional medicine coverage. The findings suggest that exclusion reflects three interacting structural dimensions: hospital-centric benefit package design, institutional path dependence in purchasing architecture, and evidentiary norms aligned with biomedical models. These dimensions collectively shape which forms of care are considered insurable within publicly financed systems. A cross-cutting implication of insurance-based UHC is that it can simultaneously expand financial protection while narrowing therapeutic pluralism, as the comparative analysis reveals and is developed across the sub-sections below.

Benefit Package Design and the Scope of Coverage

A central finding is the structural misalignment between the scope of services covered under AB-PAY and the modes through which Ayush delivers care. AB-PMJAY focuses on secondary and tertiary inpatient care, reflecting a catastrophic expenditure protection model[11, 24]. Ayush systems, however, predominantly deliver outpatient, preventive, and chronic disease-oriented services. This structural incompatibility limits the eligibility of Ayush interventions within the scheme’s benefit package design.

The international comparison reinforces this observation. Countries such as China, South Korea, and Thailand extend insurance coverage beyond hospitalisation to outpatient and primary care services[22, 29], thereby creating institutional

space for the inclusion of traditional medicine. In contrast, in Africa, Latin America, Australia, and New Zealand, traditional or indigenous medicine is finally recognised but financed primarily through programmatic funding or out-of-pocket payments [23, 34, 36]. These patterns indicate that inclusion depends less on cultural recognition and more on how insurance systems define and prioritise covered services.

This finding has a critical normative implication: insurance-based UHC expansion can simultaneously narrow therapeutic pluralism if benefit packages remain hospital-centric. Patients who rely on Ayush for preventive care and chronic disease management gain no financial protection under AB-PMJAY, even as the scheme expands population coverage. The UHC agenda, if pursued through narrow benefit package design, may paradoxically exclude care modalities that serve large segments of the population.

Institutional Path Dependence and Purchasing Architecture

Institutional trajectories further shape these outcomes. India's publicly financed insurance evolved around biomedical hospitals, standardised procedures, and package-based reimbursement- a trajectory traceable from RSBY through PMJAY[20, 24]. AB-PMJAY continues this purchasing architecture. Such continuity reflects path dependence: earlier design choices, particularly the hospitalisation focus from RSBY, constrained subsequent policy options by creating entrenched provider networks, pricing frameworks, and administrative processes oriented exclusively towards biomedical care[12, 13].

Strategic purchasing under AB-PMJAY relies on clearly defined service packages, standardised pricing, and measurable outputs. Biomedical procedures align readily with this logic. Many Ayush interventions, by contrast, involve individualised consultations, multimodal therapies, and longitudinal management that policymakers cannot easily codify into discrete reimbursement units. This structural incompatibility limits integration within existing purchasing arrangements without deliberate reform.

Sequencing appears critical in the comparative analysis. In East Asian contexts, traditional medicine was historically embedded in state-supported health systems prior to insurance consolidation [27]. China's formalisation of TCM within state healthcare structures in the 1950s, Korea's dual-track medical licensing system, and Japan's early integration of Kampo within medical mainstream all preceded insurance expansion. This institutional embedding facilitated later incorporation into insurance purchasing. In India and most African and Latin American settings, policymakers expanded insurance within a biomedical-dominated architecture, leaving traditional medicine institutionally parallel rather than integrated. These differences underscore how the timing and institutional positioning of traditional systems, their political economy dynamics, shape contemporary insurance inclusion.

Evidentiary Norms and Reimbursement Eligibility

Evidentiary standards constitute the third determinant. India's HTA processes emphasise randomised controlled trials (RCTs), standardised outcome measures, and cost-utility analysis to inform benefit package decisions [15, 16]. While these approaches support transparency and efficiency, they align more readily with pharmaceuticals and discrete biomedical interventions than with traditional medicine, which often involves individualised, multimodal, and long-term therapeutic approaches. Reviews of traditional medicine research consistently identify limited availability of economic evaluations and HTA studies that meet conventional reimbursement standards[14, 43].

Traditional medicine systems, including Ayush, often involve individualised, multimodal, and context-sensitive interventions[26, 43]. Reviews indicate limited availability of economic evaluations meeting conventional reimbursement standards[14]. The resulting gap reflects not necessarily an absence of evidence but a divergence between dominant evaluative paradigms and therapeutic models.

International experience suggests adaptation is possible. Japan restricts coverage to standardised Kampo formulations amenable to existing pricing frameworks[28]

Evidentiary requirements associated with insurance inclusion further influence these patterns. In India, HTA processes emphasise randomised controlled trials, standardised outcome measures, and cost-utility analysis to inform benefit package decisions[15]. While these approaches support transparency and efficiency, they align more readily with pharmaceuticals and discrete biomedical interventions than with traditional medicine, which often involves individualised, multimodal, and long-term therapeutic approaches. Reviews of traditional medicine research have consistently reported limited availability of economic evaluations and HTA studies that meet conventional reimbursement standards, including Ayush interventions[14, 43].

International experience indicates that some health systems have addressed this challenge by adapting evidence appraisal processes rather than excluding traditional medicine. Japan restricts insurance coverage to standardised Kampo formulations, enabling evaluation within existing pricing and reimbursement frameworks[28]. China and South Korea supplement conventional clinical trials with pragmatic studies and real-world evidence to inform reimbursement decisions [22]. These examples demonstrate that insurance inclusion does not require abandoning methodological flexibility to evaluate complex interventions. The gap in Ayush evidence reflects not an absence of therapeutic value but a divergence between dominant evaluative paradigms and the therapeutic models that traditional medicine employs.

Implications for Policy

Taken together, the findings show that hospital-centric benefit design, purchasing mechanisms optimised for standardised procedures, and evidentiary frameworks aligned with biomedical models interact to produce Ayush's exclusion from AB-PMJAY. India's experience more closely resembles global patterns observed in Africa, Latin America, and Oceania than the East Asian models often cited as exemplars of integration. Three broad policy pathways emerge from comparative analysis:

- Selective and standardised inclusion: Coverage of a defined subset of Ayush interventions amenable to standardisation and existing pricing frameworks, analogous to Japan's Kampo model, would represent the most administratively feasible near-term step.
- Outpatient purchasing mechanisms: Development of outpatient-oriented purchasing arrangements suited to preventive and chronic care services would be a precondition for meaningful Ayush inclusion, as the current inpatient-only benefit package structurally excludes Ayush services.
- HTA methodology adaptation: Incorporation of pragmatic trial designs, real-world evidence, and patient-reported outcome measures into HTA frameworks would expand the evidence base available to support reimbursement decisions for complex Ayush interventions.

Importantly, insurance inclusion may also reshape traditional medicine by incentivising codification, standardisation, and proceduralization. The individualised and relational dimensions of Ayush practice may be compressed under reimbursement-driven standardisation pressures. Thus, integration should not be viewed as inherently neutral or universally desirable: the design of any inclusion pathway requires deliberate attention to preserving therapeutic integrity alongside financial access.

Strengths, Limitations, and Future Research

This review contributes to debates on pluralistic health systems by explicitly linking financing architecture to epistemic legitimacy within publicly financed insurance. Its strengths include global comparative scope, structured analysis across three complementary analytical frameworks, and explicit methodological transparency. The observation that insurance-based UHC can narrow therapeutic pluralism, even as it expands financial protection, is an analytically important contribution to UHC theory.

Limitations include reliance on secondary literature and policy documents, which represent official positions rather than implementation realities; potential publication bias toward English-language sources; absence of empirical fiscal or utilisation analysis; and the absence of stakeholder or provider perspectives, which would be essential for implementation-

focused research. The use of LLMs as supplementary search aids, while disclosed and independently verified, may introduce retrieval biases that structured database searches would avoid. Future research should include empirical fiscal analysis of the costs and coverage implications of selective Ayush inclusion with AB-PMJAY, qualitative studies of provider and patient perspectives on Ayush financing, and evaluations of existing state-level pilots of Ayush integration.

Conclusion

Structural features of the insurance architecture, hospital-centric benefit design, standardised purchasing mechanisms, and biomedically aligned evidentiary frameworks, rather than a lack of policy recognition, drive the exclusion of Ayush from AB-PMJAY. These structural dimensions interact with and reinforce one another, creating a system in which traditional medicine remains institutionally parallel to, rather than integrated within, publicly financed insurance. Public insurance systems define not only financial entitlements but also the forms of care they consider insurable and, by extension, epistemically legitimate.

Integrating Ayush, therefore, requires policymakers to reconsider the design of benefit packages, purchasing mechanisms, and evaluative frameworks simultaneously. More broadly, advancing UHC in pluralistic health systems requires negotiating the institutional and epistemic boundaries of publicly financed care, a negotiation in which the benefit package is never merely technical but always also political.

Declarations

Data Availability

Data sharing is not applicable to this article as no new primary datasets were created or analysed during this study. All sources of information and literature reviewed in this study are explicitly cited within the manuscript and available through the referenced public databases and institutional repositories.

Funding Statement

This work has not received any funding.

Ethics statement

This study used official documents available in the open source. No human participants involved. So, ethics, consent to participate, and consent to publication are not applicable.

Author Contributions Statement

BJM and NMS contributed to the conceptualisation and design of the study. NMS performed the literature search across PubMed, Scopus, and grey literature sources. BJM conducted the comparative analysis of international insurance models. BJM and NMS drafted the first version of the manuscript. NEP and JKP critically revised the work for important intellectual content and provided final approval for the version to be published.

Declaration of competing interests

The authors declare that there are no competing financial/ non-financial interests in relation to this work.

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Figures

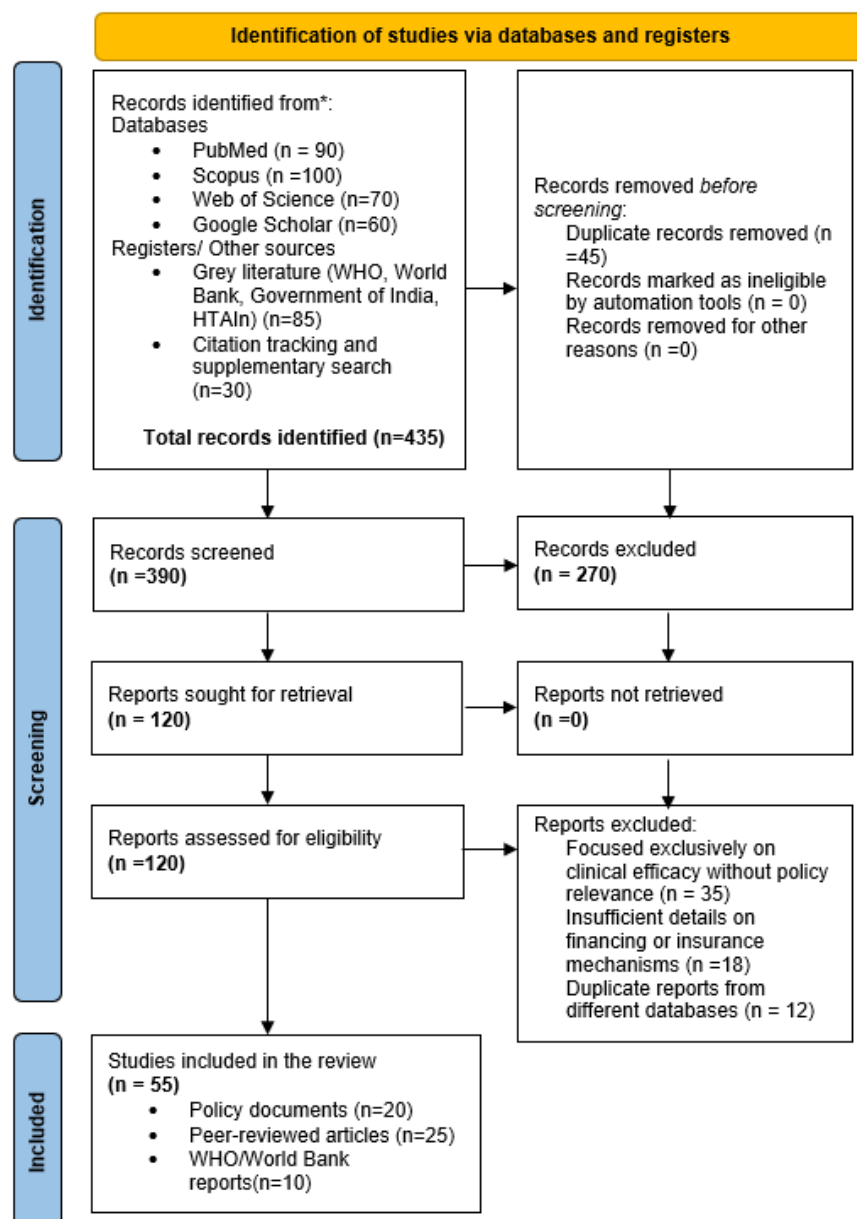


Figure 1

Legend not included with this version.