Section: Miscellaneous

Review Article

AYUSHMAN BHARAT IN REDUCING THE HEALTH INEQUITY

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ABSTRACT

Background: India's healthcare system is marked by stark inequalities in access and affordability, disproportionately affecting underprivileged populations. The Ayushman Bharat initiative, launched in 2018, aims to bridge these disparities and move the nation closer to Universal Health Coverage (UHC). It comprises two main components: the establishment of Health and Wellness Centres (HWCs) for comprehensive primary care, and the Pradhan Mantri Jan Arogya Yojana (PM-JAY), the world's largest publicly funded health insurance scheme. Objectives: This review evaluates the effectiveness of Ayushman Bharat in addressing health inequities, especially for rural, economically vulnerable, and marginalized communities across India. **Materials and Methods:** The article synthesizes data from government reports, peer-reviewed literature, and implementation frameworks to assess the program's structure, reach, outcomes, and challenges.
Results: Ayushman Bharat has enrolled over 500 million beneficiaries and empaneled more than 30,000 hospitals. It has significantly reduced Out-of-Pocket Expenditure (OOPE) from 62.6% to 47.1% of total health expenditure. The scheme has strengthened rural health infrastructure and provided critical financial protection during crises like COVID-19. However, issues like limited outpatient coverage, disparities in state implementation, low public awareness, and infrastructural gaps persist.
Conclusion: Ayushman Bharat marks a transformative step toward equitable healthcare in India. While the initiative shows promise in reducing health inequity and enhancing financial protection, targeted reforms in preventive care, awareness, and infrastructural support are essential for its long-term sustainability and inclusivity.

Keywords: Ayushman Bharat, PM-JAY, Health Inequity, Universal Health Coverage, Public Health Insurance, India, Primary Healthcare

INTRODUCTION

The Government of India introduced the Ayushman Bharat initiative to address the diverse health care needs of India. In line with National Health Policy 2017 and Sustainable Development Goals (SDGs) of India, Ayushman Bharat aims to achieve healthcare availability and accessibility across rural and urban. India with its large and diverse population, continues to have uneven socioeconomic structure. The factors that affect the health of Indian population is also very diverse .Over 20% of the population lives in poverty and 34% of the population is aged between 15-35.[1] Also, there is a substantial economic growth in recent years, however it is still considered in lower middle income category, with unimpressive health indicators.[2]

India is in a transitive phase of having communicable diseases, a growing prevalence of non-communicable diseases, and injuries.1.4 billion people's health care needs to addressed adequately. In India 70% of healthcare needs are catered by private providers, this sector is unregulated, and concentrated in urban areas, leaving underprivileged populations without proper care.[1] Whereas the public sector health care facilities are often overburdened, lacking funds with poorly trained manpower and inconsistent drug and equipment supplies.[2]

The quality of the infrastructure of these health centers has significant interstate variation

It is seen that the better governed states doing better than the rest. States with larger health budgets might be better placed to handle increased spending requirements of on health care where as the poorer states may not be able to spend as much. Strong public health systems seem to be associated with lower levels of spending on publicly funded health insurances PFHIs.[6]

The government of India only spends 2.1% of the Gross Domestic Product (GDP) on health. In contrast United States of America spent 17.8% of its GDP on health care in 2021.[4]

A total of 47.1% of India's total healthcare expenditure is borne by the patients, this forces millions Indians into poverty annually. Previously, Secondary care hospitalization was supported by government-funded health insurance schemes such as Rashtriya Swasthya Bima Yojna (RSBY), however the primary healthcare was overlooked.[7]

To bridge this gap the Government of India launched the Ayushman Bharat initiative. This program aims to reduce disease burden and hospitalization, by providing better and specialized services in existing sub-centers and primary health centers will be converted to Health and Wellness Centres (HWCs), these HWCs are expected to deliver Comprehensive Primary Health Care.[7]

These health centers are mostly concentrated in the rural areas, where 65% of the population resides.[3] 35%of urban population utilizes public health care services from district hospitals and general hospitals. Over all , private health care sector caters to 70% of health care and the rest from the public health care system.[8] The program also introduced a second component, which is, Pradhan Mantri Jan Arogya Yojana (PM-JAY), it is the largest health assurance scheme in the world, providing financial protection for various secondary and tertiary care hospitalizations for nearly 120 million impoverished families (550 million Indians).[5]

PM-JAY is funded entirely by the Government and by increasing access to quality health care for marginal population, the program intents to bring down the catastrophic out-of-pocket health expenses. Rashtriya Swasthya Bima Yojana catered to the population of below poverty line (BPL) and the PM-JAY is an extension of it. The RSBY covered the family size of five and the cashless cover of Rs. 30,000 was given. A total of 34.64 crore Ayushman cards have been issued to the scheme beneficiaries, about 30,000 hospitals have been empanelled under PMJAY by various State/Union Territory Governments.[9]

The PMJAY scheme gives cashless cover is Rs. 500,000.[6] The services are provided across public and private impaneled hospitals. They essentially cover secondary and tertiary care hospitalization.[10] The scheme can be ported across the country. There is no cap on family size and no age bar. Preexisting conditions are covered from day 1. Costs of diagnostics and medicines are covered up to 3 days of prehospitalization and 15 days post hospitalization. Under this scheme about 1300 procedures are covered and preexisting conditions are also covered. In India, Out-of-pocket catastrophic health care expenditure prevalence in India varies from 19% to 30% across states. *****kamath

The National health accounts reports that the share of Out-of-Pocket Expenditure (OOPE) in total Health Expenditure (THE) declined from 62.6% to 47.1% in a span of five years.[11]

The continuous decline in the OOPE in the overall health spending show progress towards ensuring financial protection and Universal Health Coverage for citizens.

ELIGIBLE BENEFICIARIES

The PMJAY covers both rural and urban population, however, there are certain criteria which must be fulfilled, the Rural beneficiaries should at least fulfill one of six deprivation criteria, which are categorized as (D1 to D5 and D7) and the beneficiary are included if they full fill the criteria such as destitution, manual scavenging, tribal groups, and bonded labor etc.[1]

The six deprivation criteria are detailed as follows: D1 - only one room with kucha walls and kucha roof; D2 – no adult member between ages 16 to 59; D3 - households with no adult male member between ages 16 to 59; D4 - disabled member and no able-bodied adult member; D5 - Scheduled Castes and Scheduled Tribes (SC/ST) households; and D7 - landless households deriving a major part of their income from manual casual labor.[1]

Urban beneficiaries are eligible if they belong to one of the 11 occupational categories, including rag pickers, domestic workers, construction workers, and electricians.[1] PM-JAY aims to give access of secondary and tertiary care to 40% of India's poor and vulnerable population.[6] The utilization of the services depends on various factors such as active community engagement, increasing awareness, empowering communities, quality and regulation of services. The ranking of the households are done by Socioeconomic Caste Census SECC, they rank the households based on socioeconomic status, PM-JAY utilizes this database to identify targeted beneficiary families.PM-JAY has objectives of covering catastrophic illnesses comprehensively, to reduce the out-of-pocket expenses, improve the access to hospitalization increase the coverage of insurance. It aims to standardize health assurance systems and increase the portability of care.[6]

IMPLEMENTATION STRATEGIES

Implementation of any program in a country as diverse and large as India is mammoth task. For efficient implementation of the program the states can choose from implementation models under PM-JAY. Three implementation models viz. are available, which are: the assurance or the trust model, insurance model, and mixed model.[1]

The most commonly adopted model is the assurance or the trust model, here the State Health Agency handles all the operations with no role of any insurance company, here the financial risk is borne by the government agencies. The central agencies and the state government bear the risk with a 60:40 ratio.[5]

In insurance model the insurance companies are selected through tendering and company manages the program in that particular state, however the insurance company bears the financial risk. The mixed model combines both the trust and insurance models, making it more flexible.[6] Based on the cost of administration the models are divided into two categories, category A states here administrative cost is below 20% and category B states , here the cost of administration doesn't exceed 15% .In case of increase in claims settlement ratio, the excess amount is covered by the central government.

The insurance processing is also done according to the standard operating procedure, when a package is chosen for the patient, requisition is sent to the insurer. If all the conditions are met the request will be auto-approved per guidelines if not approved within six hours. The hospitals can register a patient up to five days after admission. The timeline for claims reimbursement is within fifteen days for claims within the same state, for interstate claims it is 30 days, however some relaxation in time frame is observed by states like Gujarat.[7]

The hospitals must satisfy the guidelines for them to be empanelled under PMJAY. The hospitals which provide non-specialized general medical and surgical care are grouped under one category and the hospitals which provide specialized clinical services are another category. The State and District Empanelment Committees are set to look over the procedure of hospital empanelment and also they review the applications submitted online, and recommend approving or rejecting them. The applications are processed within 15 working days, additional 30 days can be given to the health facility in case of any flaws or shortcomings.[6]

PM-JAY encourages the hospitals to improve the quality of their care and services by incentivizing them, accreditation by National Accreditation Board for Healthcare Providers (NABH) has additional benefits under the program. Some of the premiere institutes of the country have Memorandum of Understanding (MoU) to operate under this scheme.PM-JAY has enrolled over 30,174 hospitals and healthcare providers.[9] Furthermore, the Ayushman Bharat scheme has established over 12 lakh (~1.2 million) health and wellness centers to provide primary healthcare services to people residing in remote and rural areas.

PM-JAY was successful in providing financial protection to approximately 23 million individuals during the most challenging time of COVID-19 pandemic.[6] In May 2020 Covid 19 specific packages were introduced, that covered the costs of COVID-19 testing and treatment for beneficiaries, other charges such as hospitalization, nursing charges, Personal Protective Equipment (PPE) kits, doctor's fees were covered.

PM-JAY initiated the use of telemedicine in several areas services during the pandemic. In March 2021, more than 1.6 lakh teleconsultations were conducted in March 2021. eSanjeevani telemedicine platform was launched in April 2020, where close to 1.1 crore teleconsultations were done as of March 2021.[12] To provide essential health care in New Delhi and the state of Punjab Moholla clinics were introduced to provide essential health services and serve as the first point of contact, free of cost.[13]

One of the reasons for delay in seeking health care is limited resources and infrastructure this may dissuade patients from seeking early care altogether. This may also encourage the patients to seek care from unlicensed or unqualified health care providers, which may result in poor health outcomes. The collaboration between healthcare providers, policymakers, and the broader community need to unify their efforts to overcome these hurdles.[14] PM-JAY provides the much needed platform to address all these issues.

CHALLENGES AND WAYS FORWARD

The Ayushman Bharat Pradhan Mantri Jan Arogya scheme has progressed by leaps and bounds since its launch in September 2018 taking India towards Universal Health Coverage. However, in spite of the encouraging start, there have been challenges.

Although the start has been encouraging, there have been some challenges. During the covid-19 pandemic, it was very evident that India was not prepared for challenges like these. The gap and the imbalance in the healthcare demand and supply in terms of resources, manpower, training needs to be addressed. In spite of availability of quality medical care in urban areas, health care access may be difficult due to cost, distance, and dysfunctional systems. Thus, it is crucial to address the imbalance of doctor-patient ratio, especially in rural areas.[15]

As mentioned above, more than 50% of India's total healthcare expenditure is out-of-pocket expenses .Many of the families go into bankruptcy due to medical debt.[10]

The Indian health care system is influenced by multiple factors, considering the fact that the Ayushman scheme covers only inpatient illness and healthcare expenses incurred during the admission to hospital, the other expenses are not addressed. Most of the Indians have no regular healthcare access or there are no extensive measures to focus on health education, more proactive scheme is needed to reduce expenses and get better outcomes. Preventive aspect of health care has to be focused on, which will lead to prevention and early diagnosis of various diseases. Hence, the burden on the agencies to provide specialist care will be decreased. If this is done there will be substantial reduction of cost of healthcare. Inclusion criteria of the scheme can be broadened, by including coverage of the visits to physicians, outpatient tests, and

treatments. PMJAY can be integrated with other schemes that cover other areas of healthcare, which are currently lying outside the scope of Ayushman Yojna. Increasing coverage slabs for patients with no habits, those with regular good health record, optimal BMI, those undergoing preventive health examinations can be incentivized. Few of the states have their schemes and do not recognize the scheme of the central government. Centralized scheme for whole of India would streamline the health expenditure, implementation will be uniform and administration would be more efficient.

To assess the socio economic condition of a family, more scientific and a robust assessment should be developed, as people who may be unable to bear burden of specialist health care may be left out, for e.g. individuals or families with own vehicles or monthly salary is more than INR 10,000 may not receive full benefit of the scheme but they still need support from the government to handle major health care expense. Provision of inclusion of such families with capping of the benefits can be done.[16,17]

Some times in a bid to cut costs hospitals may use sub standard products. Robust quality control for the hospitals should be implemented to prevent use of substandard health care equipment or products which may lead to increased complications. Critical patients or bed ridden patients may be unable to enroll their biometric details under the scheme. Provisions for biometric enrolment of such patients should be facilitated. Prompt or automated settlement of the reimbursement will encourage private institutes from participating in the scheme; the reimbursement issues such as insufficient or delayed payments usually concern the management of private institutes.

Efficient mechanisms to solve claims refusals or disputes should be put in place for reasonable and timely reimbursement mechanisms; physicians involvement claim review can address these issues. The government and the agencies involved should advertise on various mass media and social media as significant portion of beneficiaries are unaware of the scheme.[13]

CONCLUSION

The Ayushman Bharath initiative has helped India to strive towards universal health coverage. This program will help India in combating the disparity of quality of health care, access, availability of health care in urban and rural areas. This program encourages infrastructure development for healthcare. This programs operational model can be a role model for equitable healthcare. Also the program has proved its worth providing financial protection to millions of individuals. With its impressive record, substantial challenges must also be overcome, which include the gap between the supply and demand of healthcare services, increased government expenditure on health, and underfunded rural health centers. Efforts and planning to raise public awareness and to maximize usage by its target beneficiaries has to be done. Ayushman Bharat can achieve its aim of offering equitable and cost-effective healthcare services for all Indians by overcoming these challenges and ultimately achieving the aim of universal health coverage which is the sustainable development goals.

REFERENCES

1. National Health Authority. National Health Authority GOI [Internet] Available from: https://nha.gov.in/PM-JAY Last Accessed on: 26/05/2024
2. Powell-Jackson T, Acharya A, Mills A. An assessment of the quality of primary health care in India. Economic and Political Weekly. 2013 May 11:53-61.
3. Kamath R, Brand H. A critical analysis of the world's largest publicly funded health insurance program: India's Ayushman Bharat. International Journal of Preventive Medicine. 2023 Feb 1;14(1):20.
4. Gunja MZ, Gumas ED, Williams II RD. U.S. Health care from a global perspective, 2022: Accelerating spending, worsening Outcomes [Internet]. The Commonwealth Fund 2023. Available from:
5. https://www.commonwealthfund.org/publications/issuebriefs/2023/jan/us-health-care-global-perspective-2022
6. Gopichandran V. Ayushman Bharat National health protection scheme: an ethical analysis. Asian bioethics review. 2019 Mar 31;11(1):69-80.
7. Joseph J, Sankar DH, Nambiar D. Empanelment of health care facilities under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) in India. PloS one. 2021 May 27;16(5):e0251814.
8. Saxena A, Trivedi M, Shroff ZC, Sharma M. Improving hospital-based processes for effective implementation of Government funded health insurance schemes: evidence from early implementation of PM-JAY in India. BMC Health Services Research. 2022 Dec; 22:1-3.
9. Ghuman BS, Mehta A. Health care services in India: Problems and prospects. International conference on the Asian social protection in comparative perspective. Singapore: National University of Singapore; 2009 Jan (pp. 7-9).
10. Ayushman Bharat Pradhan Mantri – Jan Arogya Yojana, [2024] Available from: https://dashboard.pmjay.gov.in/pmj/#/esic
11. Mohanty SK, Upadhyay AK, Maiti S, Mishra RS, Kämpfen F, Maurer J, O'Donnell O. Public health insurance coverage in India before and after PM-JAY: repeated cross-sectional analysis of nationally representative survey data. BMJ Global Health. 2023 Aug 1;8(8):e012725.
12. National Health Accounts Estimates for India (2019-20) released [Internet]. pib.gov.in. Available from: https://pib.gov.in/PressReleaseIframePage.aspx?PRID=1919582. Last accessed on 26/05/2024.
13. Ministry of Health and Family Welfare GOI [Internet]. main.mohfw.gov.in. Available from: https://main.mohfw.gov.in Last accessed on 06/11/2023
14. Prasad SS, Singh C, Naik BN, Pandey S, Rao R: Awareness of the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana in the rural community: a cross-sectional study in eastern India. Cureus. 2023, 15:e35901. 10.7759/cureus.35901
15. Lahariya C. Mohalla Clinics of Delhi, India: Could these become platform to strengthen primary healthcare?. Journal of family medicine and primary care. 2017 Jan 1;6(1):1-0.
16. Lahariya C: Access, utilization, perceived quality, and satisfaction with health services at Mohalla (Community) Clinics of Delhi, India. J Family Med Prim Care. 2020, 9:5872-80. 10.4103/jfmpc.jfmpc_1574_20
17. Kamath R, Brand H. A critical analysis of the world's largest publicly funded health insurance program: India's Ayushman Bharat. International Journal of Preventive Medicine. 2023 Feb 1;14(1):20.
18. Bhaduri SD. Ayushman Bharat and universal health coverage in India: is our approach ethical?. Indian J Med Ethics. 2021 Jul 1;6(3):1-7.