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From vision to reality: Dissecting Ayushman Bharat's role in Indian healthcare

Kunika Sharma [1,*], Nanthini Subbiah [2] and Aanchal Pancholi [3]

[1] *Institute of Health Management Research, IIHMR University, Jaipur, India.*
[2] *Department of Community Health Administration, The National Institute of Health and Family Welfare, India.*
[3] *Mahatma Gandhi Physiotherapy College, Mahatma Gandhi University of Medical Sciences and Technology, India.*

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Abstract

India's Ayushman Bharat initiative, inaugurated in 2018, is a cornerstone in the nation's healthcare reform, aiming to secure Universal Health Coverage. This ambitious program is structured around two fundamental components: the Health and Wellness Centers (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY). The HWCs are tasked with transforming existing health facilities into comprehensive primary healthcare hubs that provide a wide range of services, including preventive, promotive, curative, rehabilitative, and palliative care, focusing on addressing non-communicable diseases, mental health issues, and the needs of the elderly. As of mid-2024, the successful operationalization of more than 1.73 lakh HWCs has greatly improved access to primary healthcare services and on the other hand, PM-JAY stands as the most extensive health insurance program globally, offering financial coverage to over 50 crore individuals from economically disadvantaged backgrounds, enabling cashless treatment across a network of empaneled hospitals for secondary and tertiary care. Despite its wide-ranging and ambitious scope, the program grapples with challenges such as infrastructural deficits, limited public awareness, and uneven distribution of services. This review delineates the initiative's progress and persisting obstacles, underscoring the imperative need for augmented investment, infrastructural fortification, and enhanced public awareness to actualize the envisioned Universal Health Coverage (UHC) in India.

Keywords: Universal Health Coverage; Ayushman Bharat; HWCs; PMJAY; India's healthcare system

1. Introduction

Health has been officially recognized as an essential entitlement of every human being, as well as a fundamental component of human capital development [1]. Recognizing the right to health is an essential first step in striving to enhance public health and achieve the utmost level of physical and mental well-being for individuals [2]. The World Health Organization launched Universal Health Coverage (UHC) in 2013 intending to advocate the right to health and have the greatest influence on global health. Like every other country globally, India has also pledged to achieve this goal by the designated year of 2030 [3]. This review article intends to illustrate the evolution of health care in India through Ayushman Bharat and its key components, highlighting its successes and ongoing challenges.

India, with only 16% of the worldwide population, experiences 18 percent of global deaths & 20 percent of global illnesses. However, India allocates only just one percent of the total world health spending [4]. According to the nation's 2019 National Health Accounts, the total expenditure on Health during the 2016–17 fiscal year was Rs. 4,381 (in US dollars 58) per person, or 3.8% of GDP, or Rs. 581,023 ten million (in US dollars 767.7 trillion). The largest contributor to THE is out-of-pocket expenses (58.7%) [5]. This disparity is particularly evident in the contrasting urban & rural health systems. Nearly 70 percent of the total Indian populace resides in remote regions and they suffer from a dearth of amenities and specialized healthcare.

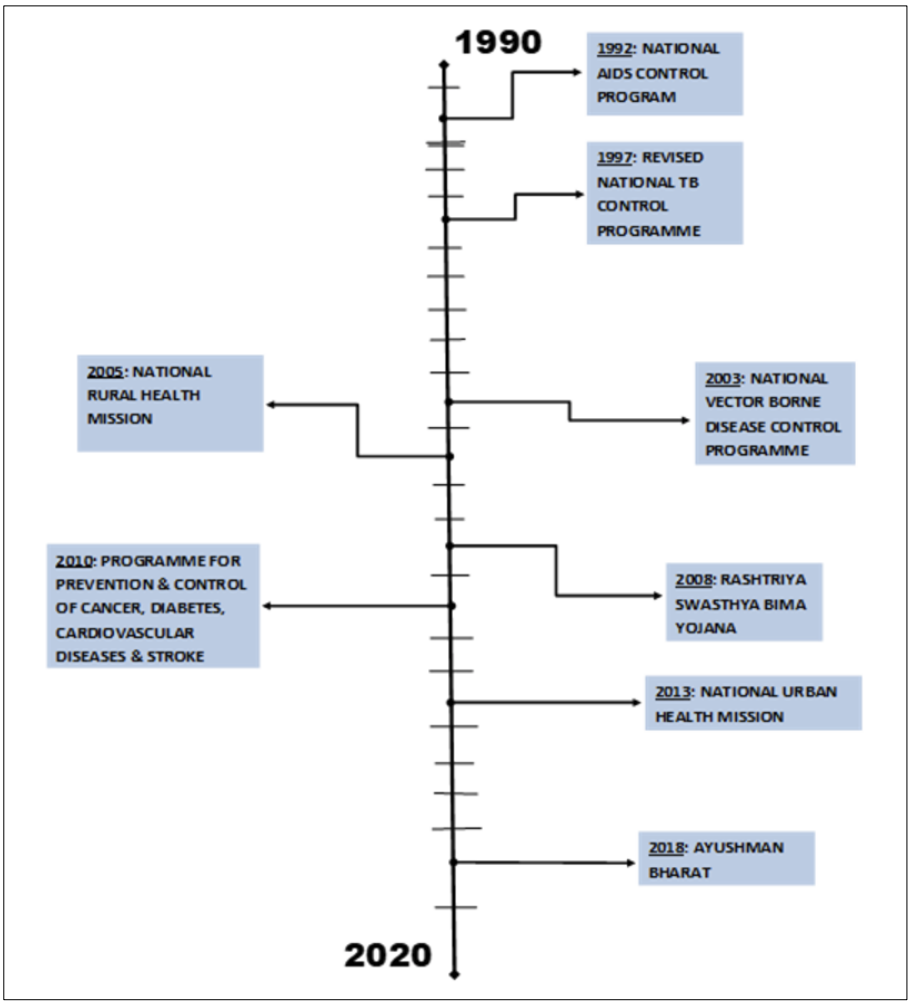
* Corresponding author: Kunika Sharma

In 2015, as the MDG era concluded, the UN General Assembly overwhelmingly recognized health as a fundamental component of the 2030 Agenda for Sustainable Development, which aims at advancing the general well-being of people at every stage of life [4]. Universal health care, or universal coverage, aims to guarantee that all individuals have access to essential healthcare services without facing financial hardships in affording them. This notion highlights the financial constraint individuals have while seeking healthcare and therefore proposes that Universal Health Coverage (UHC) should seek to mitigate the hardships suffered by individuals in accessing healthcare services owing to financial limitations [2].

In the twelfth 5-year plan, the Indian government recognizes the importance of Universal Health Coverage, or UHC, and proposes a strategic strategy to accomplish UHC across the country's population of 1.3 billion. Recently, the Indian government carried out several measures to tackle healthcare disparities in the country. In the year 2005, the entire public health system underwent a revision and was reorganized under the name of the National Rural Health Mission. Subsequently, in the year 2013, it transformed and became the National Health Mission. Projects such as Janani Suraksha Yojana and public-funded health coverage programs like the Rashtriya Swasthya Bima Yojana (called RSBY) were also initiated [1] in 2007, to provide coverage for hospital expenditures up to the amount of 30,000 rupees (about the United States $420) for families residing below the poverty threshold [6]. Although several governments implemented the RSBY scheme, others devised their own iterations of the program, either under various names or as an enhanced iteration of RSBY. India has implemented approximately 33 government-funded health Insurance (GFHI) plans in different states [7]. In addition to the national level, some states have also implemented health insurance schemes, including the Vajpayee Arogyashree Scheme of Karnataka, the Comprehensive Health Insurance Scheme of Kerela, and the Chief Minister Health Insurance Scheme of Tamil Nadu [1]. Approximately 37 crores of the general population were covered under these initiatives in the year 2014, a nearly one-fourth increase from the nearly 5.5 crores in the year 2003-2004 [10].

Despite the lofty mandates that have accompanied these programs along with comparable initiatives, their impact on safeguarding against financial risk has frequently been constrained by insufficient resources and voids in coverage [6]. Critics argue that an excessive emphasis on Reproductive and Child Health has diverted attention away from the prevention of tuberculosis and malaria in the country [9]. India constitutes 17 percent of the total world annual child mortality rate. It is also responsible for 22 percent of the total global impact of nutritional, maternal, prenatal, and communicable disorders. India has the second-lowest life expectancy in the WHO South-East Asia Region, at 68.3 years. Additionally, around 26.2 percent of premature deaths in the country are now caused by non-communicable diseases (NCDs) and traumas. In addition, there are persistent and extensive health inequities among different states. Approximately 1.2% of the GDP (gross domestic product) is allocated to public health spending by the Indian government. This is equivalent to US $18 (or Indian ₹1042) per capita. Furthermore, this kind of spending comprises approximately 30% of the worldwide health expenditure, making it the 17th lowest internationally. Each year, over 63 million individuals are forced into destitution due to the monetary strain of healthcare expenses, as they lack sufficient financial protections to meet their healthcare needs. Approximately 64.2% of India's total health spending is funded directly by individuals.

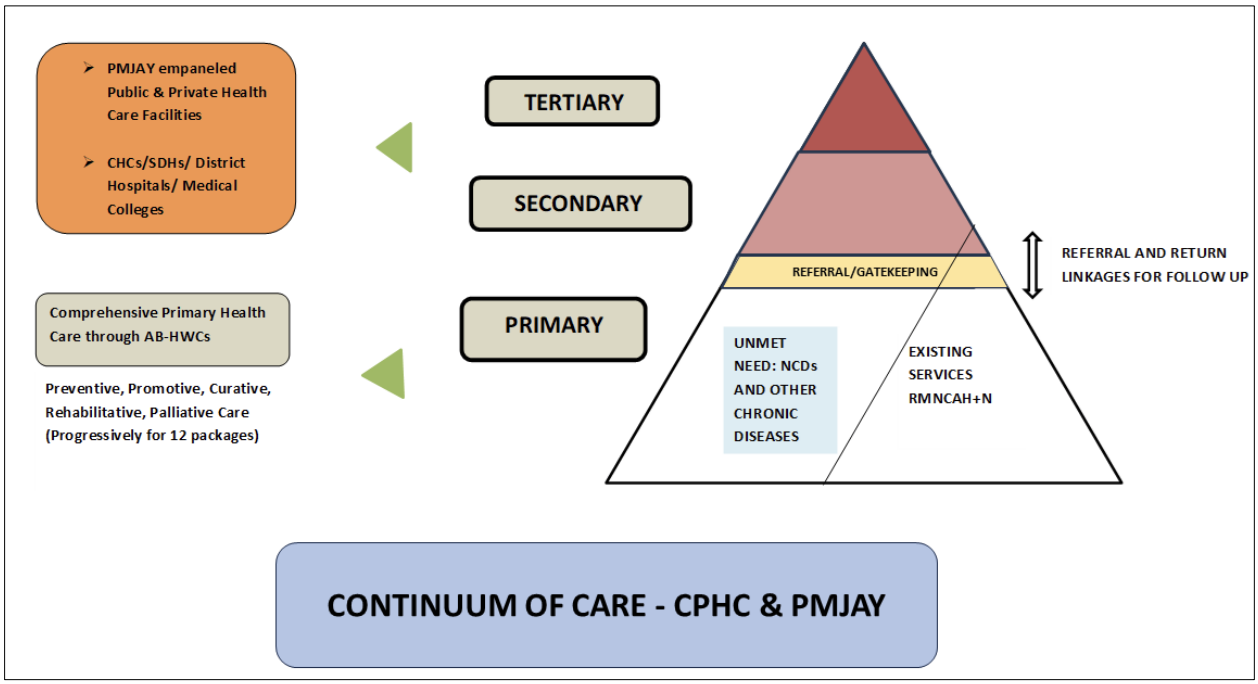
In response to the current health issues, the Indian government has implemented substantial policy-level measures in the past few years, especially since the introduction of the Sustainable Development Goals (SDGs). Notable actions that demonstrate the government's proactive approach include the implementation of the National Health Policy 2017 (NHP) [8]. The National Health Policy, which was unveiled in March 2017, was released exactly 14 years following the last National Health Policy [10] by the Ministry of Health and Family Welfare, acknowledges the evolving healthcare needs of the country, & establishes the goals to attain UHC (Universal Health Coverage). The strategy pledges to guarantee sufficient financial resources and suggests a rise in healthcare expenditure from 1% to a desired level of 2.5% of GDP by 2025. This strategy recognizes that the main way to raise health spending is by improving the use of public funds, but it also highlights the significance of working together with other industry sectors, particularly those that are private. The implied aim is to utilize India's extensive private health sector to advance Universal Health Coverage (UHC) by expanding service delivery, particularly in distant rural areas, and addressing crucial deficiencies in state healthcare systems [11]. As a move in this approach, the Union Budget [12] 2018-19, the 'Ayushman Bharat' initiative was launched for a healthy India [10] by the esteemed Prime Minister of India, Narendra Modi, as a component of the NHP-2017. Its objective is to achieve universal coverage for health care. Ayushman Bharat is an initiative that is designed to transform the healthcare delivery system from a fragmented & segmented approach to a comprehensive and demand-driven service [13].



Note: Adapted from "Early Experiences of Pradhan Mantri Jan Arogya Yojana (PM-JAY) in India: A Narrative Review" March 2021

Figure 1 The historical development of national health initiatives in India [36].

The Indian government has implemented two substantial initiatives in the health sector as part of Ayushman Bharat. These initiatives are designed to bring about groundbreaking solutions that comprehensively address health in all three levels of healthcare systems. They encompass both health promotion and preventive measures [10].



Note: Adapted from "AYUSHMAN BHARAT HEALTH AND WELLNESS CENTRES" Booklet 2019
https://abhwc.nhp.gov.in/assets/hwcpdf/Reforms_Booklet_HWC_English_updated_14th_Sep_2021.pdf

Figure 2 Continuum of Care under Ayushman Bharat [32]

1.1. Health and Wellness Centres

The initial pillar of the Ayushman Bharat scheme, "Health and Wellness Centres" (HWCs), [10] recently renamed Ayushman Arogya Mandirs [14] is expected to be modernized to provide Comprehensive Primary Healthcare to 1,50,000 extant Sub Health Centres & Primary Health Centres [10] with a time to care principle of not exceeding 30 minutes [14]. This is equivalent to nearly one HWC per 8,500 individuals [15]. The fundamental aim of this initiative was to address the lack of infrastructure in public health, specifically in primary care and essential services, in both rural as well as urban areas [16]. On April 14, 2018, the inaugural HWCs were established in Jangla village, which is situated in the Bhairamgarh tehsil of Bijapur district in the state of Chhattisgarh, India [17].

Two distinct kinds of Health and Wellness Centres (HWC) are proposed for the Sub-Centre and Primary Health Centre levels. A team of versatile personnel, both male and female, as well as a new category of healthcare personnel known as Mid-level Healthcare Providers, will staff the Health and Wellness Centre at the sub-centre level. The MLHPs may be a community health officer with a Bachelor of Science in Community Health, a nurse with a Bachelor of Science or General Nursing and Midwifery degree, or an AYUSH practitioner [15]. Health and Wellness centres (HWCs) are anticipated to provide 12 service packages [18]. The service package encompasses all fundamental services provided by the existing primary health care (PHC) system, with the notable inclusion of preventive measures, screening, and treatment for illnesses that are not transmissible, mental illness, prevalent eye, as well as ear problems, basic oral health services, elderly along with palliative health services [15], yoga [19] as well as emergency medical services, providing services in a life cycle approach from conception to tomb [14].

The HWC program's primary components for enhancing primary health care (PHC) are (1) versatile financial transfers to states and (2) structural adjustments to reorganize care closer to communities by primary health care teams. (3) Technology-enabled delivery of services and monitoring, which includes performance-driven reimbursements to personnel. (4) The provision of services at the domestic and community levels (outreach) (5) The maintenance of the continuum of care via referral linkages as well as follow-up care loops with higher-level institutions, as well as (6) telemedicine services at 80,000 HWCs, facilitate technology-enabled connectivity and timely referral. Health facilities are supplied with inputs, including medications and diagnostics, as commodities through the Free Drugs and Diagnostics services [18].

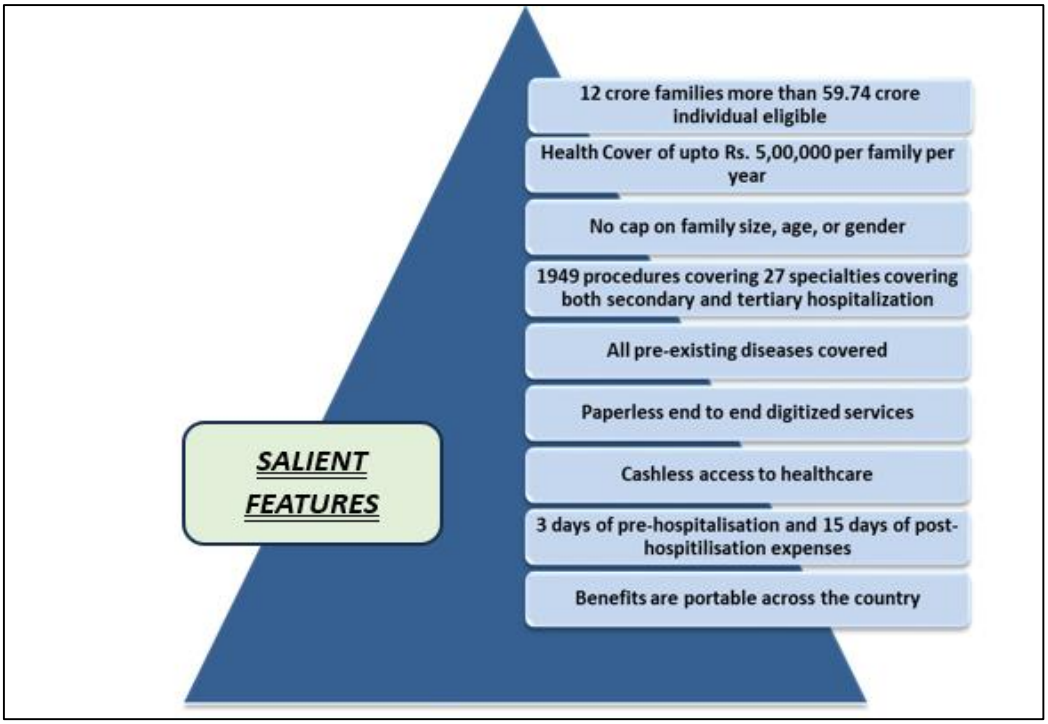
As of 6th June 2024, a total of 1,73,274 AB-HWCs have been operationalized throughout the nation. Of these, 1,27,468 are SHC-HWCs, 23,870 are PHC-HWCs, 5,086 are UPHC-HWCs, 11,770 are AYUSH-HWCs and 5,080 are UHWC [20].

1.2. Ayushman Bharat Pradhan Mantri Jan Arogya Yojna

The second pillar of Ayushman Bharat, AB-PMJAY, was initiated on September 23, 2018 [10], in Ranchi, Jharkhand [21]. PMJAY, initially introduced as the National Health Protection Scheme during the 2018 Union Budget by the Finance Minister, Arun Jaitley, has undergone significant changes in its design and nomenclature [22]. However, the objectives remain unchanged: to offer health insurance to more than 100 million impoverished and vulnerable households (about 500 million beneficiaries), offering coverage of up to INR 500,000 per family annually for both secondary and tertiary hospitalization [10] without anybody experiencing financial adversity. The scheme aims to decrease outside-of-pocket costs (OOPE) and catastrophic expenditures on healthcare by involving the private sector alongside the current network of public hospitals [15]. It is the world's largest publicly financed health assurance program [23].

The AB-PMJAY has incorporated centrally funded initiatives, including the Rashtriya Swasthya Bima Yojana (the RSBY) & the Senior Citizen Health Insurance Scheme (the SCHIS) [10] In addition to numerous other health insurance programs financed by state governments [22]. PMJAY offers recipients the ability to access services without the need for cash or paper documentation at the service location. The selection of households is determined by the criteria of deprivation and occupation as outlined in the Socio-Economic Caste Census 2011 (SECC-2011) for both urban and rural settings, respectively. This statistic also encompasses households enrolled in the RSBY but is not included in the SECC-2011 database. Although PMJAY uses the SECC as the basis for assessing household eligibility, many states have already initiated the implementation of their health insurance systems. The States have been given the authority to use their database for PMJAY. Nevertheless, the states must guarantee the inclusion of all eligible families as per the SECC database [24]. There will be no restriction on the number of family members eligible for inclusion, and the benefits will eventually extend to all of India (contingent upon the participation of every single state and union territory in the program). It also means that a recipient will have the entitlement to receive advantages without the requirement of payment from any public or authorized private healthcare facility across the entire country [6]. Due to India's population growth of around 11.7% since the year 2011, the Union Cabinet has approved the expansion of the beneficiary pool of AB PM-JAY. The expansion will include an additional 12 crore SECC families, increasing the total from the current 10.74 crore families. In addition to providing benefits to SECC families, states have also extended benefits to other families, with the funding for these benefits coming from the states themselves. This has resulted in a total coverage of 15.25 crore households, which is equivalent to 59.74 crore beneficiaries [26].

The implementation of the program was initiated through the utilization of the health benefit package master, consisting of 1393 packages, in Health Benefit Package-1.0. Subsequently, HBP-2.0 was introduced in December 2019. Currently, there are 1949 operations available across 27 different specialties as of April 2022 [24].



Note: Source from "NHA Annual Report 2022-2023,"; (https://abdm.gov.in:8081/uploads/NHA_Annual_Report_2022_23_6ac916792b.pdf)

Figure 3 Salient Features of PMJAY [26]

The implementation mechanism of PMJAY is hierarchical, with the National Health Authority (also known as NHA) serving as the highest authority in charge of executing it via State Health Agencies (SHAs). Every participating state has a Single Health Authority (SHA) that selects and includes both public and private institutions within its authority. Each SHA has the option to select from three different types of implementations - a) The insurance model of SHA involves the selection of an insurance company to oversee the management of PMJAY. b) The trust model of PMJAY involves the direct payment of compensation to providers by the state government, without the need for an insurance carrier. c) Mixed/Hybrid model - Claim settlements are jointly managed by both the state and the insurance provider. The SHA establishes a District Implementation Unit (DIU) to offer assistance for the implementation process in every district.

States have the autonomy to determine their participation in PMJAY. States have the option to maintain their current Government-funded Health Insurance Schemes (GFHIS) while collaborating to different extents with the Pradhan Mantri Jan Arogya Yojana (PMJAY). Some states that have chosen this approach include the states of Andhra Pradesh, Kerala, Madhya Pradesh, Karnataka, Meghalaya, Punjab, Rajasthan, Tamil Nadu & Telangana. As of April 2022, the Pradhan Mantri Jan Arogya Yojana has been successfully implemented in 33 states & union territories (UTs), except Delhi, West Bengal, and Odisha [25] of which 23 states/UTs are operating in Trust mode, 3 in Hybrid mode and 7 in Insurance modes [26]. The program's expenditure would be divided between the central and state governments in a predetermined proportion established by legal agreements and based on the relative wealth of every state. The Indian government will provide financial coverage ranging from 60% to 100% of the expenses [6].

As of January 15, 2024, almost 6.22 crore hospital admissions, valued at Rs. 79,174 crores, have been approved under the scheme [27] and a total of 27,742 hospitals, including 11,973 private hospitals, have been enlisted in the program to offer healthcare services to beneficiaries of the scheme [28]. Approximately 6.19 crore claims have been submitted by the empanelled hospitals for the treatment provided under the scheme, out of which 5.78 crore claims have been settled [27]. The Ayushman Bharat Pradhan Mantri - Jan Arogya Yojana (AB PM-JAY) achieved the significant accomplishment of issuing over 30 crore Ayushman cards on January 12, 2024 [29].

2. Methodology

This review article was conducted to study the evolution of healthcare in India through Ayushman Bharat and its key components, highlighting its successes and ongoing challenges. The data for this study was reviewed from the websites of the National Health Authority and Ayushman Arogya Mandir. Additional documented evidence was obtained from official government records, organizational reports, and the Press Information Bureau. Also, electronic databases such as PubMed and Google Scholar were searched for.

2.1. Advancements Through Ayushman Bharat: Milestones and Roadblocks

According to the Annual Economic Survey 2020-21, states that implemented PMJAY experienced elevated levels of healthcare coverage, reduced rates of child and infant mortality, improved accessibility to and utilization of birth control services, and enhanced awareness of AIDS and HIV in comparison to states that failed to implement PMJAY. The Survey notes the following: 1) The percentage of households with at least one regular person protected by health care insurance as well as a reimbursement scheme grew by 54 percent between NFHS 4 and NFHS 5. Conversely, it had a 10 percent decline in the states that opted out of PMJAY. This demonstrates the efficacy of PMJAY in improving comprehensive medical insurance coverage. 2) The mortality rate for infants also decreased by 20 percent in states that implemented PMJAY, compared to a decrease of 12% in states that did not implement PMJAY. This is an 8% difference in favor of states who adopted PMJAY. 3) The prevalence of individuals practicing family planning increased in all states among the two surveys, with a particularly notable rise observed in the regions that implemented PMJAY, suggesting its efficacy. The implementation of the PM-JAY resulted in a 31% reduction in the proportion of females who did not have their family planning needs fulfilled. In contrast, states that did not adopt PMJAY only saw a 10% decrease. 4) Though there has been an upsurge in the number of cesarean births, the states that implemented the PMJAY program have shown a greater rise in cesarean births as opposed to the states that declined to participate in the PMJAY, except for cesarean births in private healthcare organizations. 5) The proportion of women with a thorough understanding of the HIV/AIDS virus experienced a substantial rise of 13 percent in the PM-JAY states, while there was only a moderate gain of 2% in the non-PM-JAY states. Within all PMJAY states, there was a significant 9% gain in the statistics for men. However, in the non-PMJAY states, there was a notable decline of 39% in the data for men [30].

In addition, as reported by the National Health Authority, PM-JAY also offered financial security to around 23 million people during the COVID-19 pandemic. This coverage encompassed more than 160 thousand admissions directly attributed to COVID-19. As a result, beneficiaries and their families saved more than 1,800 crore Indian National Rupee (INR), which is equivalent to over 260 million US dollars. PM-JAY also offers emergency transport facilities with the

National Ambulance Service (NAS), that has over three thousand ambulances across the country. In March 2021, more than 150,000 emergency transport services were provided under PM-JAY [31].

Furthermore, AB-HWCs on the other hand, have broadened their range of services to encompass chronic illness conditions and non-communicable [32]. These centers were established in India to facilitate convenient healthcare access for the citizens. Since the inception of HWCs, the program has accomplished a significant amount. There were around 86.90 crore screenings conducted for non-transmissible diseases. A total of around 9.3 crore teleconsultations were given. A total of approximately 135 crore people have visited. There have been around 1.60 crore wellness sessions conducted at Health and Wellness Centers (HWCs). From August 2020 to December 2022, a significant increase was observed in the frequency of screenings for non-communicable diseases (NCDs) over 25 months. While the total number of screenings climbed by 510 percent, there was a notable spike in screenings specifically for Mouth Cancer, which saw a rise of 148 million (a 570 percent increase) [33]. Also, the facilities have alleviated the economic strain on individuals and families by providing complimentary critical medications and diagnostic services [32].

Despite the numerous advantages that Ayushman Bharat has brought us, it nevertheless faces a range of challenges. One of the major obstacles was the lack of beneficiary awareness regarding their eligibility & benefits [34]. The National Health Authority has established guidelines and conducted outreach initiatives to provide beneficiaries with a comprehensive understanding of the PM-JAY. For instance, the community outreach project called "Ayushman Bharat Diwas" reached out to three hundred thousand communities throughout the country. Additionally, in May 2020, an official WhatsApp chatbot and a Hindi web page promoting PM-JAY were also launched.

However, despite the substantial endeavors of educating households regarding the initiative, there remains a deficiency in comprehension in numerous states [35].

Presently, PM-JAY fails to reach a significant portion of its intended benefit population due to excessively stringent qualifying criteria and inadequate enrollment [35]. In Report No. 11, of 2023 on the Performance Audit of PMJAY, the comptroller and auditor general of India (CAG) emphasized that the SECC database used to assess eligibility for the plan was nearly seven years old at the time of commencement. Due to economic growth and job prospects, some households may no longer meet the requirements for participation, whereas others might now qualify to participate in the Socio-Economic Caste Census according to the current norms. An examination of the Beneficiary Identification System (BIS) database uncovered multiple discrepancies within the SECC database [23]. In addition, the process of registering beneficiaries can be time-consuming, requiring numerous hours of work which serves as an additional obstacle to accessing the service [35].

The PM-JAY has had varied outcomes in terms of providing enough financial security against risks. It should be emphasized that the PM-JAY does not cover outpatient care, which made up over 60% of India's out-of-pocket expenditure in 2016. While providing extensive coverage for inpatient care is beneficial, it may not adequately alleviate the burden of OOPE and may not be the most effective approach to encouraging preventative care [35]. Additionally, while public health insurance programs saw a quarter of India’s population enrolled in 2015-2016, with state coverage ranging from 6% in Uttar Pradesh to 75% in Andhra Pradesh (including Telangana), the PMJAY, with its intended recipients being approximately 40% of households, has the potential to somewhat enhance the extent of coverage in certain states but, it fails to provide coverage for a significant portion of the population referred to as the “missing middle” [25], leaving them vulnerable to the potential financial burden of severe healthcare costs [15].

Besides, the selection and distribution of hospitals, both public and private, vary significantly among different states and regions. More precisely, states that have higher rates of poverty & disease burdens have a somewhat lower number of public and private hospitals being established for every 100,000 qualified residents. More than 72% of the private hospitals participating in the PM-JAY program reside in only 7 states [35] and, roughly 65 percent private healthcare facilities in this nation possess a bed capacity ranging from 11 to 50 total beds, and this would significantly limit the hospital's capacity to function as just a tertiary care facility [15]. Furthermore, there are occurrences of a delay in the approval process for the empanelment of hospitals. at times the delays exceeded the specified 30-day period, ranging from 1 day to 44 months, which presents an additional obstacle [23].

The PMJAY scheme is being implemented either through consolidation or in conjunction with the State Government plans. There are fears that throughout the implementation of PMJAY, the primary funding agency, it may be overshadowed by State initiatives [23]. Several populous states, notably Uttar Pradesh, Bihar, and MP, lack experience in establishing a health insurance plan of this magnitude. Similar to prior centrally backed schemes, this system has the potential to further exacerbate interstate disparities in its effectiveness [15].

Further, the Central Government has allocated around Rs. 17,000 crores towards PMJAY over the past five years, from 2018-2019 to 2022-2023. Out of this, Rs. 6,180 crores were disbursed in the previous financial year, which is significantly lower for 33 states and territories [23]. If just five percent of the households eligible for an insurance claim 20 percent of the total sum (i.e., five lakh), the anticipated annual expenses would amount to a total of Rs. 50,000 crores, without including the operational costs of the system [15].

Additional issues that must be tackled include fraudulent practices, such as overbilling and superfluous processes, which can put a financial burden on the program and undermine its objectives. Avoiding and detecting fraud is a major apprehension [23]. Insufficient or delayed payments lead to reimbursement concerns, which in turn discourage private institutes from engaging. Insurance officials' unreasonable refusals to honor claims might lead to lengthy and laborious battles. Furthermore, there is a disparity between the availability of resources and the level of demand, which has led to a rise in government expenditure on healthcare [31].

The Health and Wellness Centre component of Ayushman Bharat is designed to meet the need for comprehensive primary healthcare [35] The initiative plans to establish and enhance 1.5 lakh HWC centers to meet the medical treatment needs of its centres. An allocation of 1200 crores has been made for the plan. The allocated funds are significantly insufficient for the planned number of centres, [13], and the implementation of these facilities has been progressing at a glacial pace.

As of September 17, 2019, just 21,000 were operational despite 52,744 being approved [35].

They are currently facing substantial difficulties. The Health Sub-Centre and Primary Health Centre levels are facing a deficiency of well-educated human resources [36], even on the national level, there is a significant shortage of auxiliary health staff, ranging from 47 percent to 66 percent among several categories. 10% of primary health centers lack a physician [37] which is impeding the provision of services. Also, there is a lack of accessible necessary medications and diagnostic tools that impair the delivery of a comprehensive primary healthcare package.

Several AB-HWCs function in leased structures or deteriorated circumstances [36], and 56% of SCs lack restroom amenities for their workforce. Approximately 73% of SCs lack gender-segregated restroom facilities. 36% of Primary Health Centers lack gender-segregated restroom facilities [37], requiring immediate infrastructure improvements and the development of new facilities by regulations.

The primary healthcare team frequently lacks the requisite knowledge and expertise to provide a broader array of services and the current IT system is insufficient for effectively enrolling the people served by AB-HWCs, organizing family folders, and coordinating referrals, screenings, diagnoses, treatments, and follow-ups. Also, advanced facilities lack the necessary resources to handle referrals from AB-HWCs which presents further obstacles [36].

2.2. Way Forward

A comprehensive strategy is crucial for properly addressing the shortcomings of the Ayushman Bharat initiative. This involves increasing beneficiary awareness through radio, TV, and social media advertising [31], as well as by sharing tales of success to promote word-of-mouth influence in successful behavioral shifts [23]. States/Union Territories should conduct a nationwide campaign to examine and validate the BIS database thoroughly. Implementing validation checks is necessary to enhance the precision and dependability of the data, as well as to broaden the scope to encompass outpatient care [23]. The Government of India can speed up the implementation of Health and Wellness Centers, which will ultimately offer outpatient treatment for minor ailments, to minimize expenditures out of pocket [35]. NITI Aayog report "Health Insurance for India's Missing Middle" suggests that states failing to meet the target of covering the population under the PMJAY scheme should consider including additional categories to ensure 100% coverage under the scheme. This can be done by identifying beneficiaries using the SECC database and other electronic databases readily accessible to the states. Moreover, the extension of health insurance coverage is an essential measure to attain Universal Health Coverage [23]. Furthermore, it is essential to establish equitable and prompt reimbursement systems, as well as engage clinicians in the process of evaluating claims [31]. Financial oversight could be strengthened through the augmentation of budget allocations and the implementation of anti-fraud actions, and Executives and stakeholders at all levels, including medical personnel, should participate in capacity-building initiatives focused on IT and data handling [23].

On the other hand, there is a need to speed up the implementation of Health and Wellness Centers by providing sufficient funds and developing human resources. This should be accompanied by enhancements in infrastructure and the availability of necessary pharmaceuticals and diagnostic equipment. Implementing upgrades to the IT systems will

enhance the efficiency as well as effectiveness of the service provided and the handling of beneficiary information [36]. Collectively, these measures will propel Ayushman Bharat towards achieving its objective of providing health for all.

3. Conclusion

The Ayushman Bharat scheme has significantly transformed the landscape of healthcare in India, particularly by improving accessibility and affordability for millions of underprivileged citizens. Through its dual pillars of the Health and Wellness Centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY), the initiative has made substantial progress in bridging healthcare gaps, reducing out-of-pocket expenditures, and enhancing the overall quality of life of marginalized populations. However, the success of Ayushman Bharat hinges on its ability to evolve with the changing healthcare needs of the population. Moving forward, it is essential to strengthen the infrastructure of HWCs, ensure sustainable financing models, and foster robust public-private partnerships. Continuous monitoring, policy adjustments, and community engagement will be crucial to maintaining the momentum and ensuring that Ayushman Bharat can continue to serve as a model for universal healthcare in developing nations.

Compliance with ethical standards

Disclosure of conflict of interest

There are no conflicts of interest.

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