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An Analytical Study of Health Insurance Schemes Offered by the Central and State Governments of India: A Comprehensive Review

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Abstract
In India, the federal and state governments' provision of public health insurance is a vital step in the direction of universal health coverage and the removal of financial obstacles to accessing healthcare. The primary state-specific models and significant government-sponsored health insurance programs like PMJAY, CGHS, and ESIS are thoroughly analyzed using secondary data in this study. The study assesses coverage trends, financial protection outcomes, service utilization, and significant operational issues using information from government reports, national surveys, scholarly studies, and publications from international agencies. The results show notable improvements in enrolment and service accessibility, but they also point to enduring problems like inadequate financial risk protection, unequal access in rural areas, and restricted outpatient coverage. In order to ensure more efficient and equitable healthcare delivery, the study ends by suggesting policy changes that improve scheme design, beneficiary awareness, and system accountability.

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1. Introduction

1.1 Background

World-class postsecondary institutions combine with severe deficiencies in primary and preventive healthcare, creating a paradoxical healthcare environment in India. When compared to other nations with comparable economic status, health outcomes are still below ideal despite notable economic advancements (World Bank, 2020).

High Out-of-Pocket Expenditure (OOPE), which as of 2018 accounted for 48.2% of India's total health expenditures, has been one of the main causes of poor health outcomes (National Health Accounts, 2020). Government-sponsored health insurance programs have been envisioned as financial safeguards that guarantee fair access to healthcare in order to counteract this. These programs seek to lower the prevalence of medical expense-driven poverty and pay for hospital stays.

Beginning with initiatives like the Employees' State Insurance Scheme (ESIS) in 1952, the journey subsequently broadened to encompass more comprehensive programs like the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PMJAY) (2018) and Rashtriya Swasthya Bima Yojana (RSBY) (2008). At the same time, different state governments introduced programs that were specific to their socioeconomic environment.

1.2 Rationale of the Study

- Even with the abundance of initiatives, India still faces many obstacles:
- division between state and federal initiatives.
- Beneficiaries are not sufficiently aware.
- Access to high-quality medical services varies.

- difficulties in administration.

Therefore, in order to inform future policy frameworks, a thorough examination of the structural design, operational effectiveness, financial sustainability, and equity in access to health insurance systems is urgently needed.

1.3 Research Issues

- What are the main characteristics and coverage trends of the main state and federal health insurance programs?
- To what extent have these programs improved access to healthcare and decreased OOPE?
- What operational obstacles prevent these schemes from succeeding?
- What legislative actions can improve the structure of public health insurance?

2. Literature Review

2.1 The Development of Indian Public Health Insurance

- Historically, supply-side subsidies have been the main emphasis of India's health funding changes. However, demand-side funding through insurance emerged in the 2000s due to the constraints of a tax-funded system in reaching poor populations (La Forgia & Nagpal, 2012) [7].
- The first organized attempt to study industrial workers was ESIS (1952).
- CGHS (1954) was designed with government workers in mind.
- With cutting-edge features like smart cards and portability, RSBY (2008) extended coverage to BPL households (Reddy *et al*., 2011).
- By offering to insure 500 million people, or about 40% of India's population, under a government-funded insurance scheme, PMJAY (2018) marked a paradigm change (National Health Authority, 2022).

2.2 Empirical study review

- Numerous academics have assessed the results of these efforts:
- According to Prinja *et al*. (2017), public insurance programs had a minimal effect on OOPE reduction but have increased healthcare consumption.
- To guarantee that public insurance produces the intended health results, Fan, Mahal, and Glassman (2012) underlined the need of strategic purchasing.
- According to Karan *et al*. (2017) [6], substantial OOPE continued even with health insurance because outpatient services and medications were not covered.
- The Karnataka implementation of RSBY was critically evaluated by Rajasekhar *et al*. (2011), who noted low renewal rates and provider malpractices.

2.3 Critical Evaluations of Particular Plans

- PMJAY, or Ayushman Bharat: Although it was praised for its ambitious scope, Sundararaman and Muraleedharan (2015) critiqued it for having a lower penetration rate among underprivileged communities.
- According to Fan *et al*. (2012) [5], Aarogyasri (Andhra Pradesh) is credited with notable increases in hospital utilization, but it is also linked to heavy financial burdens and a preference for tertiary care over primary care.
- Jyotiba Phule, Mahatma Although service quality has fluctuated, Maharashtra's Jan Arogya Yojana (MJPJAY) has been somewhat successful in reaching low-income groups (Bhat & Jain, 2006).

2.4 Conceptual Structure

Using the Health System Strengthening Framework (WHO, 2010) [15], the study assesses the aspects of finance, governance, service delivery, and human resources.

3. Overview of Key Schemes

Table 1

Scheme	Launched	Coverage	Features
PMJAY	2018	₹5 lakh per family	Tertiary and secondary care, cashless service
ESIS	1952	Workers earning up to ₹21,000	Comprehensive medical and cash benefits
CGHS	1954	Central government employees	OPD, hospitalization, and AYUSH services
Aarogyasri	2007	BPL families in Andhra Pradesh	High-cost tertiary care
MJPJAY	2012	Low-income groups in Maharashtra	Coverage for major surgeries
BSKY	2018	Odisha families	₹5 lakh coverage; ₹10 lakh for women

4. Research Methodology

4.1 Research Design

The study uses only secondary data and employs a descriptive and analytical research design. The main objective is to assess the impact, performance, and structure of India's state and federally supported health insurance programs.

4.2 Data Sources

Secondary Information

Publications from the government (such as the Ministry of Health and Family Welfare and the National Health Authority Annual Reports).

Policy documents (such as PMJAY, Aarogyasri, CGHS, and ESIS program guidelines).

Research papers and scholarly pieces that have been published in reputable journals.

Information obtained from surveys conducted by the National Sample Survey Organization (NSSO).

Reports from global institutions, such as the UNDP, WHO, and World Bank.

NGO reports and working papers are examples of grey literature.

4.3 Data Gathering Instruments

Thorough analysis of the secondary sources that are available.

Gathering and evaluating data pertaining to the strategy.

Comparative evaluation of different insurance models' policies.

4.4 Method of Data Analysis

Article and report content analysis.

Trend analysis with secondary data.

Comparative analysis between states and schemes using important metrics such as hospitalization rates, OOPE reduction, claim settlement time, and enrollment rate.

5. Data Analysis

5.1 Trends in Coverage and Enrollment

By 2022, PMJAY alone had enrolled almost 540 million beneficiaries, according to the National Health Authority (2023). More than 80% of eligible households were enrolled in states with strong state-led insurance programs, such as Tamil Nadu (CMCHIS) and Andhra Pradesh (Dr. YSR Aarogyasri) (MoHFW, 2023).

Table 2

Scheme	Coverage (millions)	Year
PMJAY	540	2022
Aarogyasri	15	2022
MJPJAY	9	2022

5.2 Outcomes for Financial Protection

As per the World Bank Report (2022):

- Among participating families, PMJAY has resulted in a 13% reduction in catastrophic health expenses.
- According to Fan *et al.* (2012) [5], Aarogyasri beneficiaries in Andhra Pradesh saw a 21% decrease in OOPE when compared to non-beneficiaries.
- But according to NSSO (78th Round, 2022), families are still being forced into debt by outpatient and prescription charges that are mainly hidden by the insurance arrangements in place.

5.3 Use of Services

The PMJAY Annual Report (2022) data reveals:

- By 2022, more than 4.2 crore hospitalizations had been approved under PMJAY.
- Seventy percent of the claims were for tertiary care, including oncology and cardiology.
- Better hospital networks and proactive grievance redressal mechanisms in states like Tamil Nadu and Kerala resulted in greater service use rates (National Health Authority, 2022).

5.4 Difficulties Determined

- Common operational issues are revealed by secondary data:
- Some northern states, like Bihar and Uttar Pradesh, have low claim settlement rates.
- The distribution of empaneled hospitals exhibits urban bias (NHA, 2022).
- Disparities in service use by gender and region (Prinja *et al.*, 2020) [12].

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6. Findings

- Insurance Expansion: Public health insurance programs have considerably increased coverage, especially since PMJAY.
- Limited Financial Protection: Outpatient service OOPE is still high, and catastrophic expenditures have only slightly decreased.
- Operational Variability: States differ significantly in the quality of implementation.
- Access Inequities: Women's use rates are lower than men's, and rural beneficiaries encounter obstacles to hospital access.
- Awareness Deficit: According to several reports, a major obstacle is still a lack of beneficiary awareness (NITI Aayog, 2021) [9].

7. Suggestions

- Increase the Benefits package that includes pharmaceutical and outpatient services.
- Encourage hospitals in rural areas to join by forming public-private partnerships.
- Using e-claims management and digital health IDs, strengthen monitoring frameworks.
- Boost awareness campaigns, especially for women living in remote areas.
- Encourage State-Centre convergence to prevent administrative misunderstandings and duplication.

8. Conclusion

The government-sponsored health insurance programs in India are essential to improvements in the health system, according to a review of secondary data. However, issues including uneven access, insufficient financial protection, and scattered coverage still exist. To come closer to universal health coverage, the ecosystem must be strengthened through more focused IEC initiatives, improved provider networks, thorough coverage, and strong monitoring.

Table 3: Summary Table: Key Scheme Comparison

Scheme	Beneficiary Group	Sum Insured	Major Features	Challenges
PMJAY	500 million (bottom 40%)	₹5 lakh/family	Pan-India portability, cashless	Awareness gaps, outpatient costs
CGHS	Central govt employees	Comprehensive	OPD + IPD services	Quality variability
ESIS	Industrial workers	Full coverage	Medical + disability benefits	Private sector coverage gaps
Aarogyasri	BPL in AP	₹5 lakh	Tertiary care focus	Cost overruns
MJPJAY	Low-income Maharashtra	₹1.5 lakh (basic)	Cardiology, oncology focus	Rural access gaps
BSKY	Odisha residents	₹5 lakh (general), ₹10 lakh (women)	Smart card-based cashless	Infrastructure deficits

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