



# Implementation And Utilization Of Ayushman Bharat In Villages Of Faridkot District

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## Introduction

An important factor in a nation's socioeconomic progress is its healthcare system. By lowering the burden of sickness and boosting productivity, access to high-quality healthcare services not only improves people's quality of life but also makes a substantial contribution to economic growth <sup>1</sup>. Achieving universal health coverage (UHC) has proven to be a recurring challenge in a nation as diverse and populated as India <sup>2</sup>.

To address this issue, the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) was introduced in 2018 as a flagship health insurance program with the goal of shielding low-income families from unaffordable medical bills. The Pradhan Mantri Jan Arogya Yojana (PM-JAY) and Health and Wellness Centres (HWCs) are the two primary pillars upon which the Ayushman Bharat scheme is based <sup>3</sup>. While HWCs focus on strengthening primary healthcare services, PM-JAY aims to provide secondary and tertiary care to the economically weaker sections of society. Together, these components strive to create a comprehensive and inclusive healthcare ecosystem in India. With over 10 crore families targeted under PM-JAY, the scheme represents one of the largest health insurance initiatives globally <sup>4,5</sup>.

Health expenditures are estimated to contribute to 3.6% and 2.9% of rural and urban poverty, respectively <sup>6</sup>. Annually, an estimated 60 to 80 million people in India either falls into poverty or get deeper into poverty (if already below poverty line) due to health-related expenditures <sup>7,8</sup>. Clearly, the health expenditures undermine poverty alleviation efforts by the union and state governments in India <sup>7,9,10</sup>.

The PM-JAY is being implemented by the National Health Authority (NHA) which is responsible for 'the overall vision and stewardship for design, roll-out, implementation and management of PM-JAY across the country'. This involves 'formulation of PM-JAY policies, development of operational

guidelines, implementation mechanisms, coordination with state governments, monitoring and oversight of PM-JAY<sup>11</sup>. In addition, State Health Agencies (SHAs) have been set up across states of India with full operational autonomy for implementing this scheme under the guidance of the NHA<sup>11</sup>. The implementation of the Ayushman Bharat scheme in various states has shown mixed results, influenced by local governance, healthcare infrastructure, and socio-economic factors. Punjab, a state known for its relatively better healthcare indicators, presents an interesting case for studying the scheme's impact. Within Punjab, Faridkot district has emerged as a focal point due to its unique demographic and healthcare dynamics. The present study focused on the implementation and utilization of the Ayushman Bharat Scheme in nine different villages of the Faridkot district.

## Materials and Methods

The present cross-sectional study employed a mixed-methods research design, blending both quantitative and qualitative approaches to thoroughly evaluate how the Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) was being implemented and its effects in Faridkot District, Punjab. The present research took place across the nine different villages of three blocks falling under the Faridkot district of Punjab naming Faridkot: Machaki Mal Singh, Chahal and Bhana; Kotkapura: Sandhwan, Dawariana and Dhimanwali; Bagapurana: Smalsar, Rajiana and Panj Grain Khurd. A total of 400 individuals were divided into two distinct groups including beneficiaries (households identified through the Socio-Economic Caste Census (SECC) database and enrolled in the Ayushman Bharat program) and healthcare providers (doctors, nurses, administrators, and hospital staff from both government and private hospitals in Faridkot). The ethical clearance was taken from the Institutional Ethics Committee. Informed consent was obtained from all participants, with consent forms available in both English and Punjabi. The data was collected from the beneficiaries and healthcare providers by help of interviews conducted during camp set ups in the different villages. The answers were collected according to the pre-designed proformas. A detailed questionnaire for beneficiaries including demographic data (name, age, gender, address, educational qualification, occupation), Ayushman Bharat awareness questions, utilization of the scheme done till date in any circumstances (if the answer was yes, then full details of medical records were extracted), questions regarding the challenges they faced during the implementation of the scheme, perceived impact and the suggestions were taken. For healthcare workers the questionnaire included demographic data, job profile, name of the hospital (name and district), years of working experience, questions regarding awareness and training of Ayushman Bharat scheme, questions regarding challenges in patient registration and service delivery under Ayushman Bharat scheme, challenges in hospital infrastructure and support, observations and impact and their recommendations.

## RESULTS AND DISCUSSION

### Beneficiaries

#### 1. Demographic data

The beneficiaries' ages ranged from 20 to 72 years. There were 200 males and 150 females in the survey. The maximum number of males had higher secondary education (28.5%), and the maximum number of females also had higher secondary education (28.0%). The farming occupation was opted by the maximum number of males (34.5%) and females were also involved in farming in major numbers (29.3%). Approximately 31.5% of the males had annual income between 50,000/- to 1,00,000/- and approximately 30.7% of the females had annual income of this slab.

#### 2. Awareness of the scheme

During the survey of 350 beneficiaries, it was found that the majority were aware of the scheme, reflecting successful outreach, particularly in Punjab where government campaigns, health workers, and community networks have been effective. In the present study, overall awareness of the Ayushman Bharat scheme among beneficiaries was high, with 88% reporting that they had heard about the scheme. Machaki Mal Singh and Sandhwan reported the highest awareness levels due to effective local political mobilization and active block officials. Rajiana and Panj Grain Khurd lagged behind in enrollment despite significant healthcare needs, reflecting disparities in outreach and administrative engagement.

#### 3. Utilization of the scheme

A total of 78.6% of the surveyed beneficiaries availed services (275 out of 350). Health scheme utilization was higher among females (83.3%) compared to males (75%). This difference is suggestive of more healthcare needs among women, particularly related to maternal and reproductive services. The majority utilized the scheme for medical treatment (45.5%), followed by surgeries (32.7%). Maternity care was exclusively utilized by females (36% of female beneficiaries, 16.4% overall). Diagnostic tests accounted for 27.3% across both genders. Males showed slightly higher preference for surgical and diagnostic services, whereas females predominantly availed maternity and other supportive services (Table 1).

Table 1: Table represents the number of male and female and the type of service they utilized from the scheme

Type of Service	Male (n=150)	Female (n=125)	Total (n=275)
Surgery	55 (36.7%)	35 (28.0%)	90 (32.7%)
Medical treatment	70 (46.7%)	55 (44.0%)	125 (45.5%)
Maternity care	0 (0.0%)	45 (36.0%)	45 (16.4%)
Diagnostic tests	45 (30.0%)	30 (24.0%)	75 (27.3%)
Others	10 (6.7%)	15 (12.0%)	25 (9.1%)

#### 4. Implementation of the scheme among different blocks

Across the three surveyed blocks, approximately 47% of eligible households had at least one member who accessed services under AB-PMJAY within the last year. Among the villages, utilization rates were slightly higher in Kotkapura block (51%), moderate in Faridkot block (45%), and comparatively lower in Bagapurana block (42%). The majority of claims were related to secondary care services, especially surgeries (cardiac, orthopedic, and gynecological), followed by medical emergencies such as dialysis and critical care support. Around two-thirds of beneficiaries (67.3%) reported receiving treatment that was fully cashless. A significant fraction (21.8%) had to bear partial costs. Female beneficiaries reported slightly better access to cashless services compared to males. The use of government hospitals (54.5%) was slightly more common than that of private, empanelled hospitals (45.5%). However, females were more likely than males to utilise private facilities, possibly reflecting demand for maternity and specialised care.

#### 5. Financial protection during utilization of the scheme

A significant reduction in out-of-pocket expenditure (OOPE) was observed. Among beneficiary households, the average savings per hospitalisation episode were estimated at ₹8,000 compared with non-beneficiaries in the same region. Nearly 62% of beneficiaries reported avoiding distress financing (such as loans or sale of assets) due to coverage under the scheme. However, 18% of those who attempted to

avail of the scheme reported having to pay for medicines or diagnostic tests unavailable within empaneled hospitals, indicating that partial OOPE remained.

Households reported improved access to both private and public facilities without discrimination, reducing dependency on informal healers or delayed treatment. Around 36% of respondents indicated that the scheme positively impacted their capacity to maintain household consumption patterns during health crises. Employment opportunities were indirectly stimulated, as local empaneled private hospitals hired additional paramedical staff to handle increased patient load. More males reported improved access (approximately 65%) compared to females (around 52%), while females were more likely to respond “Can’t say”.

## Healthcare workers

### 1. Demographic details

A total of 50 healthcare providers were surveyed to collect the data. Out of 50 participants, majority doctors followed by nurses and hospital administrators. Government hospitals make up the majority, reflecting the nationwide prevalence of Ayushman Bharat in public healthcare facilities. Significant participation from those with over 5 years of experience indicates that feedback reflects the views of seasoned professionals. Most respondents are actively involved in the implementation or oversight of Ayushman Bharat services, emphasizing the survey's validity for program assessment.

### 2. Formal training for the implementation of the scheme

Healthcare providers were asked for the formal training they received or not for implementation, processing and technical issues of Ayushman Bharat scheme. The answers from all the respondents were recorded. Majority (around 70-80%) across designations reported receiving formal training, with Government hospital staff significantly more likely to have received training. Those involved in PM-JAY were much more likely to have formal training (89%) compared to uninformed (33%), highly significant. Feeling fully informed about guidelines is moderate (~30-40%), with most respondents feeling partially informed.

### 3. Implementation of the scheme in different hospitals

Government hospitals and experienced staff show significantly higher PM-JAY service volumes and cashless delivery compliance. Documentation and server issues are frequent eligibility-check challenges. Patient understanding remains moderate, signaling need for enhanced IEC (Information, Education, and Communication) efforts at the facility level. Involvement in PM-JAY consistently correlates with better operational knowledge and smoother service delivery (Table 2).

**Table 2:** Average Number of Patients Availing PM-JAY per Month

Feature	Category	0–10 (n,%)	11–30 (n,%)	31–50 (n,%)	>50 (n,%)
Designation	Doctor	4 (20%)	7 (35%)	6 (30%)	3 (15%)
	Nurse	1 (10%)	5 (50%)	3 (30%)	1 (10%)
	Hospital Administrator	1 (12%)	2 (25%)	3 (38%)	2 (25%)
	Medical Officer	2 (29%)	3 (43%)	1 (14%)	1 (14%)
	Other Staff	2 (40%)	2 (40%)	1 (20%)	0
	Type of Hospital	Government	4 (13%)	10 (33%)	10 (33%)
	Private (empanelled)	3 (15%)	9 (45%)	6 (30%)	2 (10%)
Involvement in PM-JAY	Yes	4 (10%)	16 (42%)	12 (32%)	6 (16%)
	No	3 (25%)	3 (25%)	4 (33%)	2 (17%)

## Discussion

India's 28 states and 8 Union Territories determine their participation in PM-JAY. When announced in February 2018, 20 states agreed to join. By September 2018, a few states and territories, including Maharashtra and Tamil Nadu, initially declined to participate due to their existing healthcare programs but later joined with tailored arrangements<sup>12</sup>. Kerala adopted the scheme in November 2019, while West Bengal and Telangana opted for regional programs<sup>13-17</sup>. Odisha had not joined as of January 2020, but Delhi announced participation in March 2020<sup>18,19</sup>.

The existing body of literature on health insurance schemes in India highlights the importance of equitable access, efficient governance, and robust infrastructure for the success of such initiatives. For instance, study by Karan et al. (2017) has emphasized the need for targeted outreach and community

engagement to improve the uptake of health insurance schemes<sup>2</sup>. In the context of Ayushman Bharat, research by Prinja et al. (2019) and Lahariya (2020) has provided initial assessments of its implementation, noting both successes and challenges<sup>3,20</sup>. Similarly, studies by Sengupta and Nundy (2020) underscore the importance of healthcare infrastructure and local governance, yet there is insufficient focus on their interplay at the district level<sup>21</sup>.

A study conducted by Srivastava (2023) explored the implementation of the Pradhan Mantri Jan Arogya Yojana (PM-JAY), a publicly funded health insurance scheme launched in September 2018 to provide financial access to healthcare services for India's economically disadvantaged populations<sup>22</sup>. PM-JAY's design incorporates flexibility to enable state-specific adaptations, thereby accommodating decentralized health governance structures.

Sanjay N. Mohanty and colleagues examined the impact of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY)—potentially the world's largest non-contributory public health insurance (NPHI) program—on extending health insurance coverage to India's marginalized populations. Their study emphasized the critical role of NPHI in advancing towards universal health coverage (UHC) and assessed PM-JAY's success in enhancing coverage for the poorest 40% of the population<sup>24</sup>.

By reducing financial barriers to healthcare, PM-JAY ensures equity and has the potential to enhance system efficiency by incorporating cost-effective interventions into its benefit package.

## CONCLUSION

PM-JAY has resulted in measurable increases in patient footfall, especially in government hospitals and among staff involved in the scheme. This aligns with national reports showing higher utilization rates as the scheme increases poor patients' access and encourages facility visits, especially where PM-JAY empanelment is widespread. Providers overwhelmingly report improved access, with "significant" improvements most common in government hospitals and among scheme-involved staff. National data confirm PM-JAY expanded service utilization and hospitalizations for the poorest, especially where hospitals are fully integrated. The PM-JAY scheme is widely viewed by healthcare providers as a catalyst for increased patient footfall, improved access to healthcare for poor families, enhanced quality of care standards in government facilities, and substantial reductions in financial burden for patients. However, disparities between government and private sectors and between involved/non-involved staff highlight ongoing operational challenges. Sustained investments and process improvements will be vital to further strengthening the scheme's impact across all settings.

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