OPEN ACCESS

Manuscript ID:
ECO-2023-11046382

Volume: 11

Issue: 4

Month: September

Year: 2023

P-ISSN: 2319-961X

E-ISSN: 2582-0192

Received: 10.07.2023

Accepted: 28.08.2023

Published: 01.09.2023

Citation:
Ramya, S.S., and Rebecca Devaprasad. "An Investigation into the Implementation Approaches of the Pradhan Mantri Jan Arogya Yojana in Four South Indian States." *Shanlax International Journal of Economics*, vol. 11, no. 4, 2023, pp. 1–9.

DOI:
https://doi.org/10.34293/economics.v11i4.6382

An Investigation into the Implementation Approaches of the Pradhan Mantri Jan Arogya Yojana in Four South Indian States

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Abstract
The majority of India's overall health expenses are incurred through out-of-pocket spending, and the country's national health policies are aimed at reducing out-of-pocket expenditure in order to achieve universal health coverage and provide access to healthcare services for all. In such context, Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana, the largest health insurance programme, was launched in 2018 with theview of providing healthcare coverage of Rs.5,00,000 per household per year. The financial support for secondary and tertiary healthcare services offered by both public and private empaneled providers is supplied to India's underprivileged households. There are three different models used for implementing the scheme, and the states choose a model with their own state insurance schemes to execute PM-JAY. In order to monitor the implementation in each state, State Health Agencies (SHA) have been set up and have been assigned to monitor all the operations related to the scheme. Funds for the scheme are distributed to the SHAs jointly by the central and state governments. The present study aims to analyse the mode of implementation by the share of private and public hospitals empaneled in Andhra Pradesh, Karnataka, Kerala and Tamil Nadu by using secondary data sources from government websites, reports, and data repositories.

Key Words: Healthcare Service, Health Insurance, Pradhan Mantri - Jan Arogya Yojana (PMJAY), State Health Agency (SHA) and Hospitals Empanelled

Introduction

Health insurance plays a significant role in ensuring adequate public health coverage. Hence, state health insurance schemes are an essential part of a health policy (Turcotte). There has been active debate about the merits of various methods of providing health insurance (Barrientos). National or Universal Health Insurance schemes are quite prevalent in developing countries where policies and schemes of this sort help in nation building towards economic growth and development.

In India, the Government of India's Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PM-JAY) scheme was formally introduced in September 2018 with the goal of giving hospitalisation services to the underprivileged population. PM-JAY is preceded by Rashtriya Swasthya Bima Yojana (RSBY), for which beneficiaries now have access to various healthcare services up to five lakh rupees per enrolled family per year without a cap on the number of family members. According to the Niti Aayog Report on the Health System for a New India in 2019, 62% of healthcare expenditure in India is financed by households and PM-JAY envisages at reducing this out -of-pocket expenditure of households.

Under PM-JAY, State Health Agencies (SHA) have been established with personnel dedicated to the operation of the system. The Central and State governments jointly transfer funds for the programme to the SHAs. SHAs are entrusted with managing all activities involved in the execution of schemes. SHA is primarily in charge of enrolling beneficiaries, negotiating with providers, and resolving grievances. States and Union Territories can choose to administer the programme directly through the Trust or Society, through an insurance provider, or by using an integrated model. In such a context, PM-JAY is implemented through three different modes such as the trust mode, insurance mode and the hybrid or mixed mode which integrates the former two modes. The objective of the study is to identify the mode of implementation and gauge the effectiveness of the modes by determining the share of private and public hospitals empaneled in the four southern Indian states of Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu.

Review of Literature

India's financial assistance for the health sector is still insufficient. Total health expenditure was recorded in the country's 2019 National Health Accounts at 3.8% of GDP. Overall health expenses are greatly influenced by out-of-pocket costs. The country's high level of revenue fragmentation and weak risk pooling mechanisms led to substantial out-of-pocket expenses, especially among the poor (62% of expenditures come solely from households) (Joseph et al., 2021).

The national health policies are framed with the objective of achieving Universal Health Coverage by developing institutional frameworks to broaden coverage and access to healthcare services. The National Health Policy of 2017 reaffirmed the government's intention to raise health spending from 1.15 to 2.5 percent of GDP by 2025. Ayushman Bharat Yojana also known as Modicare, was introduced in 2018, and aims to provide continuum of care. It addresses the population's primary, secondary, and tertiary level health needs cohesively (Joseph et al., 2021). Under this ambit, the Pradhan Mantri Jan Arogya Yojana was initiated, it was an extensive government funded scheme having a target of 500 million people as beneficiaries who are under Below Poverty Line (BPL) (Nirula et al., 2019).

Moreover, India would have a national scheme for health protection that would increase the quality of healthcare services which would give medical support to many poor and vulnerable households, and enhance the scope of establishing health and wellness centres. In this context, the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) was launched in September 2018 (Sharma, 2018).

The "Rashtriya Swasthya Bima Yojana" (RSBY), a plan of a similar nature, was introduced in 2008 with a healthcare benefit of only Rs. 30,000 per household per year. Hospital admissions did rise by 59% as a result of RSBY, but there was no discernible decline in out-of-pocket expenses. Notwithstanding the RSBY, patients who are under the below poverty line continued to pay more for healthcare services due lack of proper insurance coverage and most importantly, a lack of coverage for outpatient expenses. According to 2016 Brookings analysis, 65.3% of out-of-pocket expenses were for the cost of outpatient care, which the financially vulnerable prefer to hospitalisation (Nirula et al., 2019). And so, in order to bridge the gaps in the preceding programme, AB PM-JAY was launched.

It is significant to note that because health is a state subject in India, the PM-JAY implementation model differs throughout the nation and uses the idea of cooperative federalism. Under this model, elements of programme design, execution, and funding at the federal and state levels are influenced by the flexibility offered by the scheme as well as the state context and prior experience with implementing public insurance. Research on this regard suggests that the primary design of PM-JAY may not be sufficient to meet the criteria of the financial risk protection envisioned by universal health coverage due to the likelihood that these design alterations may have a varied operationalizing impact (Joseph et al., 2021).

In this regard, Furtado et al., 2022, conducted a study to comprehend the institutional agencies involved in the implementation of the scheme and the performance of the trust and insurance models in Uttar Pradesh and Jharkhand, where the former had followed the trust mode and the

latter had implemented the scheme through the insurance mode. In both models, the insurance company had little or no influence over the state's ultimate authority on empanelment decisions. The preponderance of empaneled providers in both states were private hospitals. Both states had to assess hospitals again and de-panel those that did not satisfy requirements in the early stages of the programme due to the necessity of finishing empanelment. In comparison to the insurance model, the trust mode of implementation has demonstrated better monitoring of that which concerns the procedures related to claims and the queries that are being submitted. In both states, it was difficult for support organisations to evaluate the medical choices made by hospitals.

Further, Sriee et al., 2021 conducted a cross-sectional study in the rural region of Mappedu in Thiruvallur district, Tamil Nadu, and found that only 42.33 percent of the 300 homes were part of the AB PM-JAY, and only 1/10th of the beneficiaries who have availed of the scheme had additional expenditure for healthcare services in the year 2019–20. Approximately 39.88% of households without access to the Ayushman Bharat programme have experienced financial hardship due to medical expenses.

In brief, it is necessary to make efforts to improve distribution and guarantee the standard of care in hospitals with empanelled status. To assist hospitals and implementing organisations in better claim handling, consistent treatment recommendations must be adopted (Furtado et al., 2022). Further research is necessary to understand the causes of these empanelment trends as well as how empanelment affects population health, service access, and utilisation. The public sector's participation is still crucial, especially in India's underserved areas, even though the inclusion and regulation of the private sector is a goal that may be achieved through empanelment (Joseph et al., 2021).

The Three Modes of Implementing Pm-Jay

The core principle of Ayushman Bharat is cooperative federalism where the states are entrusted with the implementation of the scheme and also given the flexibility to choose their mode of implementation. The following are the three alternative modes that states can choose from viz. the trust mode, insurance mode and hybrid mode which is a mix of both trust and insurance modes.

Moreover, the hospitals are enrolled through an online IT platform known as the Hospital Empanelment Module (HEM). Hospitals empanelment requires decision making by all the tiers of government agencies. The states have varying policies regarding the empanelment of healthcare professionals, depending on their public health infrastructure and ability to handle patients in various specialties. And, also, the mode of implementation has been adopted accordingly.

In that regard, the first type of mode is the trust mode, which denotes that a trust registered with the government, sometimes known as the State Health Agencies (SHA), makes direct service purchases from empaneled suppliers. To assist the state with its administrative functions under the trust mode, third-party administrators (TPAs), also known as Implementation Support Agencies (ISAs), can be hired. In order to increase registration rates and claim processing effectiveness, SHAs will utilise ISA resources. For example, Madhya Pradesh implements PM-JAY in a trust model where the role of SHA is prevalent. SHA monitors the third-party administrators and the empaneled Health Care Provider (EHCP). Further, SHA provides the necessary details for the empanelment of hospitals with the National Health Authority which is done through the Hospital Empanelment Module.

Further, in the Insurance mode, the State Health Agency plays a vital role in hiring the insurance companies and pays them a set premium for each family that is to be covered by the scheme. In this case, insurers are in charge of approving medical procedures, handling insurance claims, and paying healthcare providers. As a result, the insurance firm manages total financial risk and detects malpractice. SHAs' monitoring and assistance through upholding open and responsive communication channels plays an essential role in ensuring implementation issues faced by hospitals and insurance companies do not adversely affect scheme outcomes. For example, Pondicherry, in its first year of implementation, followed the insurance mode with Star Health and Allied Insurance Company Limited.

The third alternative mode is known as the hybrid mode, also known as the mixed mode, in which one part of the implementation is by the insurance mode and the other part by the trust mode. In this mode, responsibility of relying on insurance firms is partly transferred to handle claims to a state-run trust. For instance, Maharashtra follows a hybrid model for the implementation of PM-JAY, for which the United India Insurance Company, which is a Public Sector undertaking, undertakes the task of providing health insurance coverage under the insurance mode and the State Health Assurance Society, which is the State Health Agency (SHA), is under the trust mode. Here, the SHA pays a premium to the insurance company for each eligible family. This scheme in Maharashtra is an integration of the state-run scheme Mahatma Jyotirao Phule Jan Arogya Yojana with Ayushman Bharath—PM Jan Arogya Yojana.

In this regard, National Health Authority in a report on assessment of trust and insurance models of AB PM-JAY implementation stated that states' prior experiences with state insurance programmes implemented prior to PM-JAY and the number of human resources required to administer PM-JAY, both had an impact on the model they ultimately chose to adopt. States indicated that a Trust-run programme or the trust model would need additional human resources, on one hand and on the other, the State would have fewer requirements when dealing with insurance companies. In comparison to states which follow an insurance model, states which implement PM-JAY in a trust mode of implementation have substantial levels of human resources and greater levels of SHAs. Yet, because they were also influenced by other factors, the scheme outputs were not always higher.

The largest SHA among Trust states was found in Haryana, which does not hire an Implementation Support Agency (ISA). Meghalaya and Haryana had lower claim rejection rates, however, both states had different modes of implementation, such that Meghalaya implemented PM-JAY in insurance mode and Haryana in trust mode. Under such a pretext, it is to be noted that under both the models the states were able to have lower claim rejection rates.

Moreover, from the report, it was also noted that smaller states (such as HP, which follows the trust mode, and Meghalaya, which follows the insurance mode) were shown to have a better understanding and more cooperative working between SHAs and involved stakeholders, regardless of the involvement of Implementation Support Agencies (ISA). In brief, NHA report had stated that the total registration rates among qualified beneficiaries were higher in insurance states and also, National Health Portal states that the hybrid model of implementing PM-JAY has more number of claims submitted.

An Analysis of the Mode of Implementation in the Four Southern States

The present study focuses on the mode of implementation of the four states viz. Andhra Pradesh, Karnataka, Kerala and Tamil Nadu and Table 1 shows the state schemes and State Health Agencies present in each state.

Table 1 Mode of Implementation of Four States

State	Mode of Implementation	Name of the Scheme	State Health Agency (SHA)
Andhra Pradesh	Trust	Ayushman Bharat - Dr.YSR Arogyasri Healthcare Scheme	Dr. YSR Arogyashri Healthcare Trust
Karnataka	Trust	Ayushman Bharat - Arogya Karnataka	Suvarna Arogya Suraksha Trust
Kerala	Trust	Pradhan Mantri Jan Arogya Yojana – Karunya Arogya Suraksha Paddhati	State Health Agency, Kerala
Tamil Nadu	Hybrid	Pradhan Mantri Jan Arogya Yojana-Chief Minister's Comprehensive Health Insurance Scheme	Tamil Nadu Health System Project

Source: National Health Authority Report on Ayushman Bharat Best Practices – 2019

Andhra Pradesh following the trust mode in the implementation of PM-JAY has a healthcare trust run by the government of Andhra Pradesh known as Dr. YSR Arogyasri Health Care Trust through which the beneficiaries can avail the insurance provided under the ambit of PM-JAY. The Trust directly implements the programme by signing contracts with network hospitals. A Chief Executive Officer oversees the Trust's operations. The trust manages the programme after consulting with experts in the fields of insurance and healthcare.

Further, Karnataka under trust mode, with the Suvarna Arogya Suraksha Trust, has been implementing different healthcare services for the benefit of the state's Below Poverty Line population. The recipients are required to enrol in the "Arogya Karnataka '' system in order to receive the benefits of the scheme. Enrolment staff will register the patient on the enrolment portal created for "Arogya Karnataka'' and create an individual identity card called "AB-ArKID." An individual's Aadhar Card number serves as the basis for enrolment and verification along with biometric authentication.

In Kerala, the Comprehensive Health Insurance Scheme (CHIS), Senior Citizen Health Insurance Scheme (SCHIS), Karunya Benevolent Fund (KBF) and AB PM-JAY have all been combined and formulated as the Karunya Arogya Suraksha Padhathi (KASP). The State of Kerala and the NHA entered into an agreement, and the State Health Agency (SHA) was established to carry out the scheme. Third-party administrators (TPAs) will handle the claims of Private Empanelled Healthcare Providers and the state-chosen TPA is Vidal Health TPA Services Private Limited.

Moreover, Tamil Nadu is one amongst the very few states that follows the hybrid mode in the implementation of PM-JAY. The state in collaboration with its own scheme known as the Chief Minister's Comprehensive Health Insurance Scheme (CM-CHIS) which was launched as an independent scheme in 2009. With the launch of PM-JAY, the state scheme now is implemented through the United India Insurance Company, as the scheme is partly undertaken in the insurance mode. The programme has made sure that beneficiaries who weren't covered under CMCHIS are presently covered under the integrated PM-JAY-CMCHIS.

The share of public and private hospitals plays an essential role in implementing PM-JAY and it is influenced by several factors, but one major factor can be the mode of implementation that has been adopted by each state. Effectively, a comparison of the data from 2019 and 2021 for the share of public and private hospitals will lead to an understanding of which mode of implementation has yielded a higher number of beneficiaries admitted and hospitals empaneled.

Table 2 represents the data of state-wise implementation of modes and the details of the beneficiaries admitted and the hospitals empaneled in 2019. It is observed that about 40% of claims have been submitted among the 13, 69, 447 beneficiaries admitted to 6,179 hospitals overall in all four states. Further, out of 6,179 hospitals empaneled, 35% are private hospitals and 65% are public hospitals, so it should be noted that the enrolment of public hospitals is much higher than that of private hospitals overall in the four states. The ratio of the number of beneficiaries admitted to the number of hospitals empaneled shows that, on average, 222 beneficiaries are admitted to one hospital that is being empaneled in all four states in different modes.

Table 2 State Wise Distribution of PM-JAY Empanelment by Mode of Implementation in 2019

States	No. of beneficiaries admitted	No. of claims submitted	No. of private hospitals	No. of public hospitals	Total No. of hospitals
Andhra Pradesh	5,29,493	92,982	467	225	692
Karnataka	85,299	65,172	427	2422	2849
Kerala	6,37,165	2,74,298	202	179	381
Tamil Nadu	1,17,490	1,10,835	1,087	1,170	2,257

Source: Compiled from Indiastat.com

In Andhra Pradesh, about 38.6 % of beneficiaries are admitted to about 11.19% of hospitals in the state, out of the total number of beneficiaries admitted and hospitals empaneled in all four states. Likewise, 6.23% of beneficiaries are admitted to about 46% of hospitals in Karnataka. And, 46.5% and 8.58% of beneficiaries are admitted to 6% and 36.5% of hospitals in Kerala and Tamil Nadu, respectively. It is observed that the states with a higher number of beneficiaries have fewer hospitals than those with a lower number of beneficiaries. The differences in hospital empanelment are due to variations in the mode of implementation in each state.

Table 3 represents the share of private and public hospitals in the four states. States that follow the trust mode are Andhra Pradesh, Karnataka, and Kerala, which have 32.5%, 85%, and 46.98% of public hospitals and 68%, 14.5%, and 53% of private hospitals, respectively. In this regard, it is noted that Karnataka has a larger share of public hospitals, while Andhra Pradesh and Kerala have a higher share of private hospitals as compared to Karnataka under the same mode of implementation. Further, Tamil Nadu, which implements the hybrid mode, has 51.83% of public hospitals, which is relatively higher as compared to private hospitals in the state. However, the empanelment of private hospitals was also seen as prevalent in Tamil Nadu under the hybrid mode.

Table 3 Percentage of Private and Public Hospitals Empaneled in 2019 Across the Four States

States	Private hospitals (percentage)	Public hospitals (percentage)
Andhra Pradesh	68%	32.50%
Karnataka	14.90%	85%
Kerala	53%	46.98%
Tamil Nadu	48.16%	51.83%

Source: Calculated Values/ Data

From Table 4, it is observed that Kerala has a higher number of beneficiaries admitted to one hospital, which means that more beneficiaries are admitted to one hospital because there are fewer hospitals empaneled as opposed to the total number of beneficiaries admitted in Kerala, and so, each hospital admits more beneficiaries. Similarly, Karnataka has a lower number of beneficiaries admitted to one hospital because there are more hospitals empaneled as opposed to the total number of beneficiaries admitted in the entire state, and so, each hospital intakes fewer beneficiaries (see Table 2).

Table 4 Percentage of Claims Submitted Relative to the Beneficiaries Admitted in 2019

States	No. of beneficiaries admitted in one hospital	Claims submitted (percentage)
Andhra Pradesh	765	17.50%
Karnataka	29	76.40%
Kerala	1672	43%
Tamil Nadu	52	94%

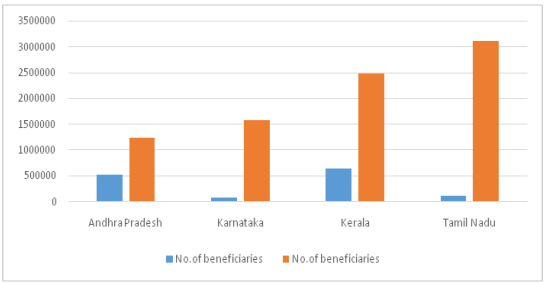
Source: Calculated Values/ Data

Further, percentage of claims submitted in the four states show that Tamil Nadu stands the highest in submitting the claims made by the beneficiaries admitted. In this regard, the hybrid model of implementation that Tamil Nadu has pursued has resulted in an increased number of claims submitted by the beneficiaries admitted to the hospital as compared to other states that followed the trust model.

State Wise Comparison in Performance of the Scheme Between 2019 and 2021

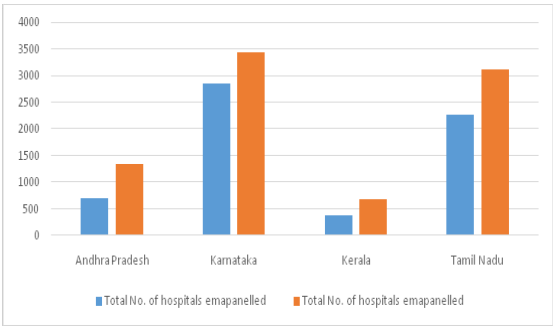
Figure 1 provides a distinction between the number of beneficiaries admitted in 2019 and 2021, which represents an increase in the number of beneficiaries admitted in 2021 when compared to 2019. It is observed that in 2019, Karnataka and Tamil Nadu had a lower number of beneficiaries than the other two states, but there has been a significant increase in 2021.

Figure 1 Number of Beneficiaries Admitted in 2019 and 2021



Similarly, Figure 2 shows a significant increase in the number of hospitals empanelled in all the four states in 2021 as compared to 2019. In 2019, the trust mode states, Andhra Pradesh and Kerala has less hospitals empanelled as compared to Karnataka which also follows trust mode. It is observed that Karnataka being a state which followed trust mode has more hospitals empanelled in both the years like Tamil Nadu which follows hybrid model.

Figure 2 Number of Hospitals Empanelled in 2019 and 2012



Moreover, Kerala has the highest number of beneficiaries when compared to other two trust model states (see Figure 1) and likewise, Karnataka has the highest number of hospitals empaneled (see Figure 2). In this regard, it is noted that Tamil Nadu, which follows a hybrid model, has a higher number of both beneficiaries and hospitals empaneled among other three states which implement the scheme in trust mode.

From Table 5, the trust model states such as Andhra Pradesh and Karnataka have a higher share of public hospitals than the other trust model state, Kerala. In this context, in 2019, Andhra Pradesh has a higher number of private hospitals than it is in 2021 (see Table 3). The state has increased the share of public hospitals covered by the trust mode in 2021. Further, Kerala has had a higher number of private hospitals empaneled in both years, but the share of private hospitals has further increased as compared to 2019 (see Table 3). Tamil Nadu's hybrid model has only a marginal difference in the share of private and public hospitals for both years.

Table 5 Percentage of Private and Public Hospitals Empaneled in 2021 Across the Four States

States	Private hospital (%)	Public hospital (%)
Andhra Pradesh	42.19%	57.80%
Karnataka	15.77%	84.22%
Kerala	76.69%	23.30%
Tamil Nadu	50.62%	49.37%

Source: Calcu1ated Values/ Data

Further, the study focuses on the mode of implementation and the hospitals empaneled in Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu. Three states are under trust mode: Andhra Pradesh, Karnataka, and Kerala. Tamil Nadu is one of the very few states under hybrid mode in India. For the study, data available for 2019 and 2021 for all four states has been used to make an inter-state comparison.

In 2019, the states had a higher share of public hospitals despite the mode of implementation. While comparing the states, Kerala had a higher number of beneficiaries as compared to other states in trust mode and also to the state that implemented PM-JAY in hybrid mode. However, Kerala has the lowest number of hospitals empaneled in the same year. Contrasting to that, Karnataka had more hospitals empaneled and a lower number of beneficiaries admitted compared to other states. In this case, although both the states, Kerala and Karnataka, implement PM-JAY under the same mode, there is a difference in the number of beneficiaries admitted and hospitals empaneled. And due to this, more beneficiaries were admitted to one hospital, or there were more hospitals for a smaller number of beneficiaries.

Further, in 2021, all four states had an increased number of beneficiaries and hospitals empaneled,

irrespective of the mode of implementation. In this case, the increase in hospitals empaneled had variations in the empanelment of private and public hospitals. In such a context, Andhra Pradesh had a higher number of public hospitals in 2021 when compared to 2019. Moreover, Tamil Nadu was the only state with a hybrid mode and had minimal differences in the share of public and private hospitals in the state.

Furthermore, in this regard, Furtado et al., conducted a study in which a significant finding with regard to provider contracting was that, regardless of the model, the State had final authority over whether to contract with hospitals. This was in contrast to the previous RSBY, where empanelment was essentially the responsibility of the insurance company (Furtado et al., 2022). Under such a pretext, this can also be referred to the four states that have been analysed, showing that although the mode of implementation was the same for three states, their outcomes were different from each other, and the state that followed the hybrid mode also had similar results in the number of beneficiaries and there was no difference in the outcomes due to mode of implementation, but it was the only state that had an almost equal share of both private and public hospitals.

Conclusion

The four southern states followed two modes of implementation, which are trust and hybrid. And, with reference to these four states chosen for the present study, there is no similarity in the outcome in terms of hospitals empaneled and number of beneficiaries admitted in the same models of implementation. The four states had varying results in both years, despite the fact that three states followed the same model. From the analysis in these states, it is observed that the difference that was identified between the trust mode and hybrid mode is that in hybrid mode, as in the case of Tamil Nadu, the share of public and private hospitals was almost equal. Moreover, Kerala was the only state that was to initially follow the insurance mode for the implementation of PM-JAY, but Kerala also changed to the trust mode, so the impact of the insurance mode is not stated in the present study. However, by implementation mode, the distribution of empanelment (private versus public) does not appear to differ significantly (as of trust, insurance or hybrid model) (Joseph et al., 2021). Studies on PM-JAY and data indicates that the modes of implementation are not linked to higher hospital care utilisation in the southern Indian states, nor is there a link to enrolment-related out-of-pocket expenditure (Joseph et al., 2021).

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