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Out-of-Pocket Healthcare Expenditure and Financial Protection under Ayushman Bharat-PMJAY: A case study of Malappuram District of Kerala

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Abstract

Health insurance funded with public money is an effective tool in increasing access to hospitals and safeguarding households from costs of ailments. But enrollment and use of health services may not provide full financial protection because patients may still spend money on medicine, diagnosis and treatment. This article looks at OOPE and financial protection for people covered by Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in Malappuram district of Kerala. The study is based on a cross-sectional survey of 250 people, of whom 175 have reported using health services covered by the scheme. The analysis serves to provide insights into the prevalence of residual OOPE, as well as the disparities among various selected treatment categories, how households cope with the situation, and their spending habits regarding both public and private hospitals. It has been noted that 62.9% of the surveyed users of health services said they did not incur any extra costs for the treatment in question. While 88.6% claimed that the scheme had significantly or somewhat reduced the financial burden they had to deal with, 8.6% also said they had to borrow money or sell their property to pay for medical services. Based on the statistics on expenses per disease, it is possible to discern differences in residual costs while treating cancer and cardiovascular diseases. Public and private spending figures are also different as people who had their treatment in private hospitals had to spend more money than those treated in public ones. The conclusion drawn is that AB-PMJAY should be evaluated not only in terms of hospitalization and claims but also based on any costs borne by the households during treatment.

Keywords: Ayushman Bharat; PM-JAY, Out-of-Pocket Expenditure (OoPE), financial protection; health insurance

Introduction

Affordable healthcare is crucial for the quality of life of people and equitable development. Disease can diminish not only the health status of the family members but also impose financial burden related to treatment. In settings where healthcare is paid for largely with out-of-pocket expenditures, people might delay treatment, take out a loan, sell property, or cut back on basic consumption to afford medical care. The effects of this situation are more serious for low-income families since they can hardly afford even minor healthcare expenses. Financial coverage is an important element of Universal Health Coverage (World Health Organization (WHO, 2010))

The elimination of household out-of-pocket expenses has proved to be a major roadblock in the advancement of healthcare in India. The estimates of the National Health Accounts reveal that the share of out-of-pocket expenditure in total health expenditure was 43.4 per cent in 2022–23, a reduction from 62.6 per cent in 2014-15 (National Health Systems Resource Centre (NHSRC, 2026)). A continuous decrease in the percentage of out-of-pocket expense signifies an increase in public financing in healthcare; however, the ongoing presence of household expenses indicates that financial protection is still an important area of concern in this field. Such recognition is also expressed in the National Health Policy 2017 (Ministry of Health and Family Welfare (MoHFW, 2017)).

Government sponsored health insurance has emerged as a significant element of India's approach to address its current issue. The Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana which was introduced in 2018, aims to create better access to secondary and tertiary hospital care for households of the economically backward classes. The scheme covers health insurance amounts of up to ₹5 lakh per annum for eligible families for various forms of hospitalisation in both public and private hospitals that have been empanelled (National Health Authority (NHA,

2021)). The basic structure of scheme is aimed at reducing the financial burden of hospitalisation and improving government's role in purchasing of health services.

Even though having some form of assurance will not always mean that families are safe from expenditures incurred relating to the disorder, the genuine financial safety of clients/beneficiaries will depend on the benefit set, drug and diagnostic options, assistance technologies and treatment continuity as well as access to medical facilities and services. In case hospitalization is covered, the family will still have to spend money before and after hospitalization and also for services not covered by the treatment plan. Therefore, it is essential to analyze the remaining costs for consumers.

The significance of financial risk protection in healthcare has been highlighted in several studies including one by Xu et al (2003) where the authors articulated how families can suffer immeasurable losses if they utilise their resources to obtain healthcare services. Furthermore, the health capital theory, which was first introduced by Grossman (1972), also serves to illustrate this point by regarding health as unique type of capital important for the people's welfare and capacity to work. Expenses that become substantial due to illness can lead to even bigger losses than those observed immediately in the form of hospital payments because they impose strict limits on personal savings and consumption behaviour including future possibilities to make some profit.

Malappuram district serves as an excellent case study of the influence of such factors. The population consists of both urban and rural residents, and the healthcare system consists of public and private services. The elements such as access to healthcare facilities, organizational capacity, availability of specialized treatments, and healthcare utilization are likely to be responsible for FRP.

In this respect, the current investigation looks into the expenses incurred by patients in Malappuram under the AB-PMJAY program. This will involve the study of residual incidence, such

aspects as distribution, differences in treatment types, as well as common coping strategies and financial behavior in both private and public healthcare facilities.

Conceptual Framework and Review of Literature

Universal Health Coverage and Financial Protection

The provision of Universal Health Coverage (UHC) imposes an obligation on individuals to access any health care service needed without encountering any financial distress. Therefore, UHC embodies two interrelated objectives: provision of the necessary health care services as well as protection against financial distress as a result of using health care services. WHO recognizes financial protection as an essential element of UHC and measures it using indicators concerning expenditures on health by households regarding total household expenditure or income (WHO, 2010).

Payments made directly by households for health care services, whether they be health products or any service that needs to be paid for directly by the household without the reimbursement from another party are called out-of-pocket expenditure. Out-of-pocket expenditure includes medicines, diagnostics, consultation services, hospitalization fees and any other cost related to health care. The level of financial distress caused by out-of-pocket expenditure is determined not only by the total spending incurred by the household, but also by the level of household income and consumption, treatment needs and frequency of use of health care services.

The term 'catastrophic health expenditure (CHE)' refers to a situation where out-of-pocket payments for healthcare create significant challenges for households concerning their economic capacities. The Sustainable Development Goals indicator 3.8.2 uses two levels of out-of-pocket payments that characterize financial difficulties: payments that exceed 10% and 25% of the household's overall consumption. These measures reflect two types of financial burden, as the 25% measure indicates the highest level of financial difficulty (World Health Organization (2025)). In

this research, the rate of catastrophic health expenditure is calculated based on the annual income of each household.

Publicly Financed Health Insurance and PM-JAY

Health insurance funded by the government aims to reduce the investors' contribution to the overhead expenses incurred when receiving health services. By buying different health-related services for the eligible citizens, the government may allow the recipients of health services to access medical services and minimize treatment expenditures. However, the success of the program will depend on the definition of eligibility criteria, benefit package, participation of health establishments, reimbursement rules, and the actual implementation of the program in hospitals.

According to this program, the eligible citizens receive 5 lakhs in coverage for different procedures and operations performed in secondary and tertiary care facilities, and the plan prescribes the beneficiaries to receive cashless operations in both public and private healthcare facilities (National Health Authority, 2021). Thus, the goal of the program is to provide its patients with financial protection from expenses relating to medical treatment and make the implementation of the hospital packages effective. Nevertheless, a patient may receive benefits under PMJAY but still continue to incur cost on medicines, diagnostics, transports, or follow up treatments. Thus, the assessment of PM-JAY must consider the wider treatment pathway and not only the cost of the hospital admission.

Empirical Evidence on Health Insurance and Financial Protection in India

Research conducted in India demonstrates that the existence of the government funded health insurance does not influence financial protection in the same way. Parmar and his colleagues (2023) carried out a survey of 57000 respondents living in several states and reached the conclusion that the PM-JAY scheme reduced out-of-pocket and catastrophic medical expenses.

Nevertheless, Garg and co-authors (2024), studying the same program four years after its implementation in Chhattisgarh, indicated that access to health care services and service quality posed problems. Therefore, it is possible to conclude that the existence of public health insurance does not necessarily translate into favorable financial outcomes.

Lessons learned from past health insurance schemes in Kerala indicate that mere coverage is not enough to avoid out-of-pocket expenses. For example, Phillip et al. (2016) found that families with insurance under the Comprehensive Health Insurance Scheme used hospital care more than their counterparts. However, a large portion of their hospital bill was not paid back by the health scheme, thus exposing the limitations of utilizing insurance coverage performance in gauging health insurance performance. Research done by Ravindran et al. (2020) regarding insurance coverage and OOPE at the public sector hospitals in Kerala underscores the need for examining what patients spend in order to assess health insurance performance.

By carrying out a study on the implementation of Ayushman Bharat in the states of Kerala and Tamil Nadu, (Pillai & Obasanjo, 2023) highlighted low rates of reimbursements, poor participation of private hospitals and outdated criteria for eligibility are major challenges of implementation. In a similar vein Sharma et al. (2023) after conducting research on four districts of Kerala found that although the coverage of health insurance programme financed by public authorities is mainly among poorer households, nevertheless the issue of high out of pocket expenses remains an issue for the insured ones using private medical services.

Research Gap

Current literature has explored the use and financial coverage aspects of PM-JAY at the national and state levels. Past work has been done in Kerala that looked at old public health insurance schemes. Nevertheless, it is possible that a person's financial experiences will differ by district as a consequence of facility infrastructure and availability of service, health care provider

participation, geographic distribution, and the availability of treatment options. Thus, it is important to study whether expenditures in different treatment categories are distributed evenly. It is worth mentioning that costly and recurrent treatments may impose financial burden that cannot be captured with the help of aggregate OOPE values. Moreover, the use of the services in public versus private hospitals can make a difference for beneficiaries.

Therefore, the study provides descriptive findings from the Malappuram district with respect to the residual OOPE, residual treatment-related expenses, rural household coping strategies and public/private differential spending patterns. The contribution of the study is that it documents the financial experience of PM-JAY service users.

Objectives and Research Questions

The main goal of this research is to evaluate the amount of money spent out of pocket for healthcare and the level of financial protection enjoyed by beneficiaries of AB-PMJAY in Malappuram district, Kerala.

The specific aims of the study include:

1. To assess the incidence and distribution of OOPE among respondents who used PM-JAY services. 2. To investigate the reported differences in residual OOPE among selected treatment types.
2. To compare the reported savings in OOPE in public versus private hospitals.
3. To identify implementation gaps that limit the effectiveness of PM-JAY in providing financial protection.

The questions of research formulated in this research consist of:

1. To what extent do the beneficiaries appear to have incurred OOPE post PM-JAY treatment?
2. Are there any differences in terms of residual expenditure incurred by various treatments?
3. What coping strategies have been resorted to by patients?

4. Have there been any distinctions in OOPE incurred by beneficiaries of public sector hospitals and those in private hospitals?
5. What reforms would you propose in order to improve financial safety provided by the program?

Methodology

Study Design and Study Area

The research uses a cross-sectional format and is based on a beneficiary survey performed in Malappuram district in Kerala. The study is restricted to Malappuram, which is among the most populated districts in Kerala. Malappuram is special because of the large rural population as well as the existence of numerous socially disadvantaged communities. Moreover, the Ministry of Health and Family Welfare has declared the district to be a High-Priority District (HPD), which denotes that it suffers from serious healthcare problems that need to be addressed immediately. Focusing on the specific problem of Malappuram, the study aims to draw conclusions that can be applied to other similar districts and provide helpful insights for improvement of healthcare access and financial protection in the area in question.

Sampling Design and Sample Size

This study utilized a method of non-probability convenience sampling. In this context, five of the 15 blocks in the district were chosen based on geographical spread and rural-urban dichotomy (See Table 1). The selection of the blocks and the 10 hospitals, which have been empaneled under the PM-JAY scheme (four government hospitals along with four private hospitals and the remaining being quasi-government), was made largely based on the knowledge of the researcher regarding the study area and its healthcare system. This was done to ensure variability in healthcare delivery settings and the collection of respondents from diverse geographical and socio-economic backgrounds.

Table 1.

Representative Sample Distribution

Cluster (Block)	Hospitals Selected	Benefeciaries Sampled	Total Participants
Perintalmanna (Semi-Urban)	District (Govt.) Hospital, Perinthalmanna	25	50
	EMS Hospital, Perinthalamanna	25	
Nilambur Block (Rural)	District (Govt.) Hospital, Nilambur	25	100
	Medical College, Manjeri	25	
	Korambayil Hospital, Manjeri	25	
	Metro Malabar Cardiac Centre, Manjeri	25	
Total	10 Hospitals	250 Beneficiaries	250 participants

The study covered a total of 250 individuals (140 participants from the rural areas and 110 from the cities). The chosen size of the sample was decided based on convenience in terms of conducting field studies as well as the time and money required for the data gathering process. Some hospitals where the respondents were subjected to the survey also made answering the survey questions easier due to the presence of respondents. As per the data there were 175 respondents who said they availed services from the healthcare system under PM-JAY scheme. Therefore, conclusions from the survey can be mainly based on the group of 175 respondents.

Data Collection

The observation got valid information through semi - structured surveys that has been constructed chiefly to get comprehensive information from those who receive the help in the program concerning their background awareness, application and experience about the program. The semi-structured surveys were divided into different sections aimed at collecting various information from beneficiaries of Ayushman Bharat i.e., demographic profile, awareness and registration, use of Ayushman Bharat health services, protection form financial losses and feedback about the program. The parameters discussed in the paper include, approximate value of the treatment provided, extra out of pocket expenditure (OOPE), borrowing or selling of assets, perceived diminishment of the financial burden, and costs related to the illness and discrepancies between public and private hospitals.

The analysis was performed in two phases, namely descriptive statistics and inferential statistics that used data obtained from the semi-structured questionnaires as well as interview details. The descriptive statistics techniques applied included frequency counts, percentages, means, medians and standard deviations which were used for data input.

Ethical Considerations

Participants in the survey were provided with details regarding the goals of the study and guaranteed an option to exit the survey and study. Another important note made in the study is regarding the confidentiality agreement. The current research paper provides only aggregate data and does not utilize data from any individual participants. The research was approved by the District Medical Officer of Malappuram for collecting data.

Limitations of the Methodology

There are some limitations in the study resulting from the research design that does not allow for establishing causality between the implementation of PM-JAY and the difference in household health expenditures. Due to a limited number of participants involved in the survey, which included only 250 respondents conveniently sourced from particular blocks and hospitals in Malappuram district, generalizability of the results is restricted to the PM-JAY population.

Results and Analysis

Overall Financial Protection among AB-PMJAY Service Users

The first dimension of financial protection examined here is extra spending done by beneficiaries after availing treatment from PM-JAY. The data is presented in Table 2 that shows the distribution of approximate treatment costs, remaining OOPE, borrowing or asset selling and reduction in financial burden as perceived by 175 beneficiaries.

Table 2.

Financial Protection Analysis (Section E) - AB-PMJAY Beneficiaries in Malappuram (N=175)

OoPE for Treatment	Response Options	Rural (n=98)	Urban (n=77)	Total (175)
Approximate cost of covered treatment	<₹50,000	55 (56.1%)	35 (45.5%)	90 (51.4%)
	₹50,000-₹1L	30 (30.6%)	25 (32.5%)	55 (31.4%)
	>₹1L	13 (13.3%)	17 (22.1%)	30 (17.1%)
Out-of-pocket expenditure	Nothing	60 (61.2%)	50 (64.9%)	110 (62.9%)
	<₹1,000	25 (25.5%)	15 (19.5%)	40 (22.9%)

	₹1,000-5,000	10 (10.2%)	8 (10.4%)	18 (10.3%)
	>₹5,000	3 (3.1%)	4 (5.2%)	7 (4%)
Borrowed/sold assets	Yes	10 (10.2%)	5 (6.5%)	15 (8.6%)
	No	88 (89.8%)	72 (93.5%)	160 (91.4%)
Financial burden reduction	Significantly	65 (66.3%)	55 (71.4%)	120 (68.6%)
	Moderately	20 (20.4%)	15 (19.5%)	35 (20%)
	No change	10 (10.2%)	5 (6.5%)	15 (8.6%)
	Increased	3 (3.1%)	2 (2.6%)	5 (2.9%)

Source: Primary data

According to the data in Table 2, majority of the service users (110 out of 175) reported zero additional OOPE for treatment. Such findings can be categorized as a positive outcome regarding financial protection objective of PM-JAY. It indicates that large number of beneficiaries surveyed has not reported any additional out of pocket expenditure.

Nevertheless, 65 people (37.1%) said that they had some additional costs. Of these, 40 people (22.9% of the number of people who took part in the survey) had expenses of less than ₹1,000, 18 of them (10.3%) had expenses between ₹1,000 and ₹5,000 and seven people (4.0%) had expenses of more than ₹5,000. But merely the actual amount does not at all show the economic force of the payments, it depends on the income of the family, consumption and type of the treatment. A small payment in this case can be challenging to pay even for the family with little money.

Rural vs urban distribution shows that 61.2% of rural respondents and 64.9% of urban respondents indicated that they did not do any additional spending. The people spending more than

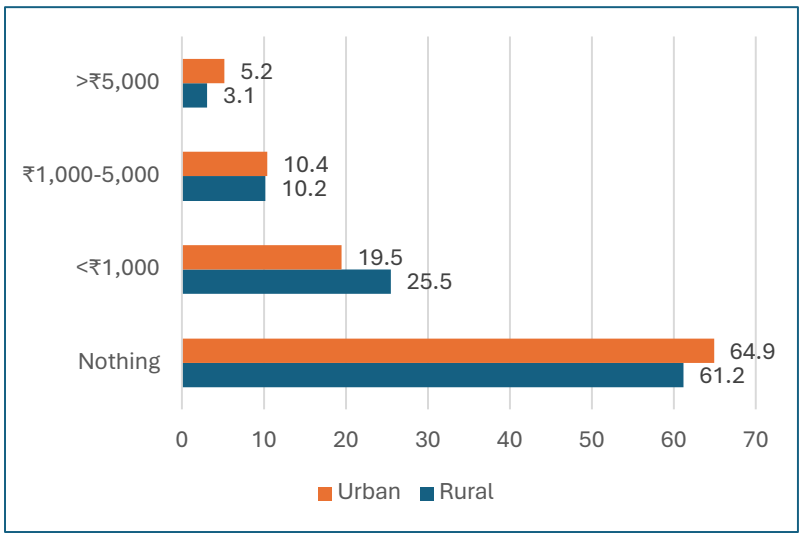
₹5,000 accounted for 3.1% in the rural segment while the same was 5.2% for the urban segment. For those spending in the ₹1,000-₹5,000 bracket, 10.2% of rural population stated that their spending was in this bracket while 10.4% stated the same among urban respondents

The approximate cost of treatment has thrown some light on the situation. More than 50% of the respondents said their treatment did not cross ₹50,000 while almost 17.1% said it was beyond ₹1 lakh. The percentage of respondents belonging to the upper limit in terms of costs stood at 22.1% in urban respondents and 13.3% in the case of rural respondents. This difference may reflect the types of services required for treatment.

Figure 1.

Out-of-Pocket Expenditure (OoPE) incurred by beneficiaries

(Source-Table 2)



The distress financing strategies utilized have an important role in measuring the financial vulnerability. Among the respondents, 15 people out of 175 respondents, or 8.6%, stated that they borrowed money or sold their assets in order to cover healthcare expenses. The proportion of rural respondents is somewhat higher, being 10.2% and that of urban respondents is lower, being 6.5%. The fact that while this measure does not signify the full extent of catastrophic health expenditure, it signifies the presence of the financial burden for a portion of beneficiaries. Perceptions of the

program were largely favorable as out of the 175 respondents 120 people (68.6%) indicated that PM-JAY improved their financial situation, while 35 individuals agreed that the relief was moderate. In total, 88.6% of those surveyed reported that they received at least moderate financial relief; however, it should be mentioned that 15 respondents (8.6%) specified that the change was marginal and five people stated that the burden increased.

The study showed that PM-JAY provided significant support in financial terms for a large number of users. It should be also mentioned that while receiving services under PM-JAY patients continue to spend and borrow money, which highlights that gaining access to medical services does not fully relieve patients of financial problems.

Disease-Specific Patterns of Out-of-Pocket Expenditure

The financial burden, which patients incur from their healthcare, differs with types of conditions. Specific medical conditions comprise specific hospitals or types of treatment involving different hospital stays, medicine, tests, procedures, and post-treatment care. Intensity of spending on patient care differs across treatment categories.

Table 3.

Disease-Specific Out-of-Pocket Expenditure among PM-JAY Beneficiaries

Disease/treatment category	*Average claim covered (₹)*	*Reported incidence of OOPE (%)*	*Reported average OOPE (₹)*
Cardiac care	1,80,000	38	6,200
Dialysis	65,000	12	850
Cancer care	2,10,000	65	4,850
Maternal health	42,000	18	1,200

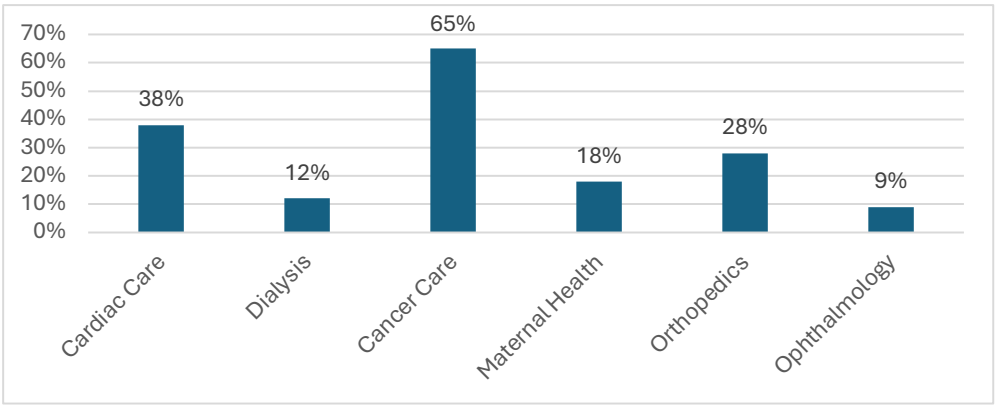
Orthopaedics	78,000	28	3,400
Ophthalmology	32,000	9	550

Source: Primary survey findings

The incidence of OOPE is most prevalent in cancer care, accounting for 65 per cent of cases, followed by cardiac care with 38 per cent, orthopaedics with 28 per cent and ophthalmology having the lowest incidence with 9 per cent. Cardiac care has the highest average OOPE at ₹6,200, followed by cancer care at ₹4,850 and orthopaedics at ₹3,400.

Figure 2.

Incidence of OoPE (Source-Table 3)



Several tests, drugs, doctors and the treatment process are part of cancer treatment, and therefore there are additional payments in addition to the hospital expenses.

Also, cardiology can be characterized by high out-of-pocket payment, as the average medical expenses paid by medical insurance amounts to ₹1.80 lakhs, while the additional expenses equal to ₹6,200 on the average. Treatment in cardiology requires surgeries, tests, drugs and follow up consultations. Regarding orthopedic surgeries, their out-of-pocket expenses equal 28% and average expense amounts to ₹3,400. Hidden costs in this area are due medication, tests, drugs, physiotherapy or rehabilitation.

With a relatively modest incidence of OOPE at 12 percent and a mean outlay of Rs 850, dialysis continues to incur expenses over time as it is a regular treatment. Given its low expenditure per visit, it is possible for the average OOPE to rise over a number of visits to become considerable.

In the case of maternal and eye health, the overall OOPE incidence remains substantially lower. It is found that maternal health has an OOPE incidence of 18 percent, while for eye health it is only 9 percent. Instances of such variation can be attributed to differences of type of treatments and the extent of coverage provided under the hospitalization treatment. In this respect, disease-specific data shows that aggregate indices of financial protection may be inaccurate due to masking disparities in costs of treatment options.

Out-of-Pocket Expenditure by Type of Healthcare Institution

The type of healthcare service provider will probably influence the level of difficulty that patients have to face regarding any financial hardship. Government and private hospitals may differ in terms of the availability of services, availabilities of medicines, availabilities of diagnostics, and PM-JAY scheme execution. A comparison between public and private healthcare providers has been given in Table 4.

Table 4.

Average OoPE and type of institution (Public vs Private)

Category	Public Hospitals	Private Hospitals	p-value
Mean OOPE per Admission (₹)	1,200	8,500	<0.001***

Category	Public Hospitals	Private Hospitals	p-value
Median OOPE (₹)	900	6,200	<0.001***
% Catastrophic OOPE	5%	32%	<0.001***
% Insured (PMJAY)	95%	65%	0.002**
Top OOPE Components	Medicines (60%)	Diagnostics (40%), Room Charges (30%)	—

Source: Primary Data

The average OOPE of private medical institutions (₹8,500 ± 1,200) was higher than that of public medical institutions (₹1,200 ± 300; t=28.4, df=173, p<0.001). This difference holds regardless of case mix and severity, where adjusted p<0.001. The incidence of catastrophic health expenditure, which is defined as the out-of-pocket health care expenditure exceeding 10 percent of the annual household income, among households utilizing private hospitals was 32 percent, while that among households utilizing public hospitals was only 5 percent. This suggests that households using private health care services face a greater financial burden; χ^2=86.3, p<0.001).

The costs incurred for diagnostics constituted a majority of the OOP costs, with an impact of 40% in the case of private hospitals and only 15% in that of public hospitals, with a χ^2 value of 64.2 at $p<0.001$. Nonetheless, the costs incurred on the drug consumption seem to have been incurred mostly in public hospitals, at about 60% compared to 25% that were incurred in private hospitals, with $\chi^2=57.8$ at $p<0.001$. According to the study, there was not much variation in statistics irrespective of the regression model used.

The data was collected in accordance with the required normality and the homogeneity of variance, as proven by the Shapiro-Wilk test and Levene's test. With the large effect sizes of 1.2 or above, statistics obtained in this analysis are very reliable.

Discussion

The discrepancies revealed through statistically reliable means must be addressed through precise policy measures related to the gaps in financial protection in the provision of medical services and in urban circumstances under AB-PMJAY. The significant persistent differences, evident even after controlling for observable factors, indicate that the variations in healthcare financing are systemic rather than incidental.

Similar findings were obtained in studies carried out in different areas of the country. As one comprehensive analysis found, PMJAY reduces the out-of-pocket expenditures for beneficiaries by 90 percent, thus relieving many poor people from their financial burden (Gruber et al., 2022). However, it has been calculated that only one-third of the entitled cases actually use the insurance, which indicates it is possible that there are gaps in terms of awareness about the program among beneficiaries and acceptance by hospitals.

The effectiveness of public insurance programs is evident because the former pays for almost 85% of the expenditure incurred in the hospitals. On top of that, the unprecedented advantage of PMJAY is in the reduced hospital packages which amass 65% of reductions in prices

thus saving as much as 90% for the insured (Gruber et al., 2022). However, it should be noted that the rate of coverage is contingent on the sum of money paid with respect to the below-mentioned amounts: 100% for the total cost lower than ₹5000, 92.56% for ₹5000 - ₹10000, and 75% for a total cost exceeding ₹50000 (Gruber et al., 2022). On a side note, the research taking place in Kerala shows the level of coverage of insurance system at approximately 74%, which is lower than the average national level of 90.25% (Ravindran et al., 2020).

Even though these reforms have taken place, the uptake rate among hospitals in the PMJAY program is still just 32.59% thereby indicating that less than one-third of hospitalizations of individuals that are eligible for SECC program are getting benefit from this program (Gruber et al., 2022). Low uptake is a result of low awareness, limited number of empanelled hospitals and patients' personal preference for those hospitals which are not empanelled (Gruber et al., 2022). Comparative analysis of other similar government-sponsored insurance programs shows similar results. In the Yeshasvini Scheme in Karnataka the uptake was 2%, the Aarogyasri scheme in Andhra Pradesh was 0.6% while the Rashtriya Swasthya Bima Yojana (RSBY) had an uptake at 2.5% (La Forgia & Nagpal, 2012). In Kerala, a study of the state Comprehensive Health Insurance Scheme conducted in 2012 revealed that out of all hospitalizations of insured individuals only 40% were covered by insurance which later on increased to 60% according to current calculations under the PMJAY program (Philip & Kannan, 2012).

Summary of Major Findings

The outcomes of the study can be stated as follows:

A large number of PM-JAY service users stated that they incurred no extra expenses for treatment. This indicates that the scheme brought real financial relief to most of the respondents.

Residual OOPE continued to exist among 37.1 per cent of the people who availed of the service. Most users reported that expenses were below ₹5,000, which will have different meanings for various households depending on their financial resources.

Data from disease-specific categories show a difference in the incidence and magnitude of OOPE. For example, OOPE levels for cancer and cardiac treatment are much higher than for ophthalmology and dialysis.

8.6 per cent of the service users reported having to borrow money or to sell their assets to cover health-related expenses. It shows that some households were still financially vulnerable even after receiving treatment supported by the scheme.

The public and private sectors comparison shows that the OOPE in private hospitals is, generally, higher than in public ones.

Policy Implications

It may be essential for policymakers to consider extending insurance to cover outpatient care, diagnostics, and other medication after discharge in order to diminish the shortfall of out-of-pocket payments.

Communication infrastructure in rural areas should be upgraded with the enhancement of ambulance services, availability of doctors, and by implanting the sponsorship of private hospitals to treat those remote and rural patients.

Social campaigns should be fashioned to focus on marginalised people, particularly SC/ST classes, elderly people and illiterate people using the services of ASHA workers and local media.

Meanwhile, medical facilities must improve public hospitals as well as the pricing of medical services that are not included in PM-JAY.

In addition, the construction of effective patient feedback mechanisms is required for the redressal of grievances in relation to the service-related issues.

Conclusion

In conclusion, the merits of PM-JAY should not merely be evaluated by the number of beneficiaries. It shall include the parameters of how the households are protected against broader implications of the disease. This can be achieved by enhancing medicine availability, diagnostic coverage, continuity of care, public hospital capacity, and accountability of private providers, as well as by informing the beneficiaries of the scheme. For the health insurance system adequately to provide protection financially, the beneficiaries should not only be entitled to access the covered hospital admission. Apart from being able to gain treatment, the beneficiaries should not lose any property nor jeopardize consumption of essential goods.

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