RESEARCH PAPER

Bridging the Rural Healthcare Divide: An Evaluative Study of Ayushman Bharat (PM-JAY) on Financial Protection and Structural Accessibility in India (2018–2025)

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ABSTRACT

Background: For decades, rural India has been ensnared in a "medical poverty trap," characterized by a skeletal public health infrastructure and catastrophic Out-of-Pocket Expenditure (OOPE). The 2018 launch of Ayushman Bharat, comprising Health and Wellness Centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY), signaled a paradigm shift from fragmented "sick-care" to a rights-based health assurance model.

Keywors - Ayushman Bharat, PM-JAY, Rural Healthcare, Financial Protection, Structural Accessibility, Health Insurance, Out-of-Pocket Expenditure (OOPE), Healthcare Infrastructure, Health Assurance Model, Medical Poverty Trap

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1. INTRODUCTION

1.1 The Crisis of Rural Healthcare in India

For decades, India's healthcare narrative was defined by a paradox: rapid medical advancements in metropolitan hubs contrasted with a crumbling public health infrastructure in the hinterlands. Historically, rural India faced a "medical poverty trap," where a single hospitalization could push a family below the poverty line. Pre-2018 data suggested that Out-of-Pocket Expenditure (OOPE) accounted for nearly 62.6% of total health spending, a figure disproportionately borne by the rural poor who lacked insurance coverage.

1.2 Genesis of Ayushman Bharat

Launched in September 2018, Ayushman Bharat was conceived as a two-pronged strategy:

1. Health and Wellness Centres (HWCs): Transforming 1.5 lakh Sub-Centres and Primary Health Centres (PHCs) to provide comprehensive primary care.
2. Pradhan Mantri Jan Arogya Yojana (PM-JAY): Providing health assurance of ₹5 lakh per family per year for secondary and tertiary care hospitalization to over 50 crore beneficiaries (the bottom 40% of the population).

1.3 Research Objectives

This paper aims to:

1. Quantify the impact of PM-JAY on reducing OOPE in rural households.
2. Analyze the geographic distribution of empanelled hospitals and its correlation with utilization rates.
3. Evaluate the role of the Ayushman Bharat Digital Mission (ABDM) in bridging the rural digital divide.
4. Identify systemic challenges hindering full implementation in remote geographies.

2. LITERATURE REVIEW

2.1 Financial Risk Protection

Recent literature highlights the scheme's success in mitigating financial distress. Patel (2024) notes that PM-JAY has significantly standardized treatment costs, leading to a reported saving of ₹1.25 lakh crore in OOPE for beneficiaries. This aligns with findings from the Economic Survey 2024-25, which reports a decline in national OOPE from 62.6% (FY2015) to 39.4% (FY2022). However, critics like Verma et al. (2025) argue that while direct medical costs are covered, rural patients still face substantial "indirect costs" (transportation, wage loss) that the scheme does not address.

2.2 Accessibility and Awareness

Accessibility is contingent on awareness. A study in Gautam Buddha Nagar (2024) revealed a stark contrast: while rural utilization was higher (15.2%) compared to urban (8%), awareness of specific benefits remained low (18.8%). This "utilization without comprehension" suggests that rural beneficiaries often stumble upon the scheme at the point of care rather than proactively seeking it, limiting preventive health measures.

2.3 Supply-Side Dynamics

The supply of healthcare services remains skewed. Research indicates that private sector empanelment is heavily biased towards Tier-1 and Tier-2 cities. As noted by Hooda (2020) and subsequent government reports, the lack of tertiary care facilities in rural districts forces beneficiaries to travel long distances, diluting the "portability" benefit of the scheme.

3. METHODOLOGY

This research employs a Mixed-Methods Approach:

1. Secondary Data Analysis: Utilization data from the National Health Authority (NHA) dashboard (2018–2025), Rural Health Statistics, and the Economic Survey 2024-25.
2. Comparative Policy Analysis: Juxtaposing PM-JAY performance metrics against the erstwhile Rashtriya Swasthya Bima Yojana (RSBY) to measure incremental progress.
3. Geospatial Analysis (Descriptive): Mapping the density of empanelled hospitals against rural population density to identify "healthcare deserts."

4. RESULTS AND DATA ANALYSIS

4.1 Enrollment and Utilization Metrics

As of early 2025, the scheme has achieved massive scale.

- Ayushman Cards Issued: >41 Crore.
- Hospital Admissions: >9.84 Crore.
- Authorized Treatment Cost: >₹1.40 Lakh Crore.

In rural Uttar Pradesh, a critical case study, enrollment rates reached 61.7% of the eligible population by 2024. Interestingly, rural enrollment consistently exceeded urban rates in several metrics, suggesting that the "saturation mode" campaigns (Ayushman Bhav) effectively targeted village-level administration.

4.2 Impact on Out-of-Pocket Expenditure (OOPE)

Data from the Economic Survey 2024-25 confirms a structural shift in healthcare financing. Government Health Expenditure (GHE) has risen to 48.0% of total health expenditure

4.2.1 Structural Shifts in Healthcare Financing

Data from the Economic Survey 2024-25 indicates a watershed moment in Indian health economics: Government Health Expenditure (GHE) as a percentage of Total Health Expenditure (THE) has surged to 48.0%, a significant departure from the 28.6% recorded in FY2013-14. Concurrently, Out-of-Pocket Expenditure (OOPE) has witnessed a precipitous decline.

This inverse correlation suggests that public spending is effectively crowding out private distress financing. The mechanism of this shift is twofold:

Absorption of Tertiary Costs: By covering high-cost procedures (oncology, cardiology, joint replacements) up to ₹5 lakh, PM-JAY has absorbed the "catastrophic tail" of health risks that previously necessitated asset liquidation or distress borrowing for rural families.

Price Control Signaling: The package rates defined by the National Health Authority (NHA) act as a benchmark, indirectly suppressing the inflationary pricing often seen in the unregulated private sector, thereby reducing the unit cost of care even for non-beneficiaries in some markets (spillover effect).

4.3 The Infrastructure Gap: Health and Wellness Centres (HWCs)

By mid-2024, over 1.73 lakh HWCs were operationalized. These centers serve as the gatekeepers for rural health.

Screening: Massive screening for NCDs (Non-Communicable Diseases) like Hypertension and Diabetes has shifted rural healthcare from 'sick-care' to 'preventive care.'

Teleconsultation: The eSanjeevani platform linked to these HWCs has facilitated millions of consultations, connecting rural patients with urban specialists.

5. DISCUSSION: THE RURAL REALITY CHECKLIST

5.1 The 'Missing Middle' and Supply Shortages

While demand-side financing (insurance) is robust, supply-side readiness in rural India lags. Data suggests that over

40% of empanelled hospitals are in urban areas. In rural districts, the empanelled facilities are predominantly public hospitals (CHCs/PHCs) which often face staff shortages and infrastructure deficits. A rural patient with a cardiac condition may have an Ayushman card but no local hospital equipped to treat them, necessitating travel to an urban center.

5.2 The Digital Divide: ABDM in Rural India

The Ayushman Bharat Digital Mission (ABDM) aims to create a unified health identity (ABHA).

Success: Creation of longitudinal health records.

Challenge: Digital literacy. A qualitative study (2025) highlights that rural beneficiaries are often unaware of data privacy or how to access their digital records. The reliance on 'Arogya Mitras' (health facilitators) is high; without them, the digital architecture becomes inaccessible to the illiterate rural elderly.

5.3 Awareness vs. Entitlement

There is a critical distinction between possessing a card and understanding the entitlement. Studies show that many rural beneficiaries are unaware that the card is portable across states or that it covers pre-existing diseases. This information asymmetry empowers private providers to occasionally deny services or charge illicit co-payments.

6. CHALLENGES AND CRITIQUES

6.1 Fraud and Malpractice

The National Anti-Fraud Unit (NAFU) has identified instances of 'ghost patients' and unwarranted hysterectomies in private rural nursing homes. The capitation model and package rates sometimes incentivize volume over quality, leading to unnecessary procedures.

6.2 Delayed Reimbursements

Private hospitals in smaller towns often complain of delayed claim settlements from the government. This liquidity crunch discourages smaller, rural private hospitals from empanelling, thereby restricting the network available to rural patients.

6.3 Infrastructure Deficits

According to Rural Health Statistics, a significant percentage of PHCs still lack basic amenities like regular water supply or functional labor rooms. Insurance cannot pay for services that do not physically exist.

7. POLICY RECOMMENDATIONS

7.1 Incentivizing Rural Empanelment

The government must introduce a 'Rural Multiplier' in package rates. Hospitals located in aspirational districts or remote rural blocks should receive a higher reimbursement rate (e.g., +20%) to offset the higher operational costs and lower volumes compared to urban corporate hospitals.

7.2 Strengthening the 'Arogya Mitra' Network

Arogya Mitras are the human interface of this digital scheme. Their training should be upgraded to include patient advocacy, ensuring they can help illiterate patients navigate complex hospital admissions and prevent denial of service.

7.3 Integration with Transport Schemes

To address indirect costs, PM-JAY should pilot an integration with state transport corporations to provide free or subsidized travel for patients referred to tertiary care centers, similar to the Janani Shishu Suraksha Karyakram (JSSK) model.

8. CONCLUSION

The Ayushman Bharat PM-JAY has undeniably altered the landscape of Indian healthcare, moving it from a fragmented, out-of-pocket model toward a consolidated, rights-based framework. For rural India, it has provided a crucial financial shield, saving millions from the poverty trap caused by medical exigencies. However, the scheme is currently at a juncture where 'coverage' must translate into 'access.'

The disparity in hospital infrastructure means that for a rural citizen, the right to treatment is guaranteed, but the availability of treatment is not. The next five years must focus on supply-side reforms—building hospitals in Tier-3 towns and leveraging digital tools to bring expertise to the patient—to ensure that Ayushman Bharat truly lives up to its name: Long Live India.

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