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Contents

1. Blessed Shangri-La! The Promised Land of Healthy; AB-PMJAY: A Background Note 3
Amit Dhage, Gajanan Phutke

2. Health insurance in India: An overview and the way forward..... 7
N. Devadasan, Nikita Pandey

3. Health Insurance Schemes and Out-of-Pocket Expenditure: Evidence from the latest NSS rounds..... 13
Indranil, Mampi Bose, Bevin Vijayan

4. Reclaiming Public Healthcare in India: Without Insurance Based Financing..... 21
Ravi Duggal

5. On Ayushman Bharat: Notes from the Field 20
Compiled by Mithun Som

6. Digital Health in India: The Ayushman Bharat Digital Mission..... 29
Indira Chakravarthi

7. Public hospitals and public insurance: Distorting health care provision 35
Rajalakshmi RamPrakash

8. With a Friend: Over Some Tea..... 37
Poem by Radhikaa Sharma

9. Expansion Without Protection: A Critical Examination of the Employees' State Insurance Corporation 39
Jagdish Patel

10. On Insurance: From Previous Bulletins..... 42

11. News..... 43
compiled by Minal Madankar

In Memoriam 44

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About this Issue

In 2018, in an effort to achieve universal health coverage and protect vulnerable populations from the poverty trap caused by escalating out-of-pocket expenditure (OOPE), the Government of India launched Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). This issue of the mfc bulletin, critically examines the various dimensions of public health insurance initiatives—their historical trajectories and underlying contradictions.

Briefly sketching the history of health insurance, Dhage and Phutke, in their background note, argue that although PMJAY reduces the direct financial burden of healthcare, it remains a short-term relief that channels public funds into private healthcare providers, thereby undermining the right to healthcare. In an article on an overview of health insurance in India, Devadasan and Pandey contend that while AB-PMJAY lowers OOPE at the point of access, persistent inequalities and inefficiencies within the health system limit its intended impact. In their analysis of Government-Funded Health Insurance (GFHI), Indranil and colleagues. emphasise that it has often been ineffective in reducing OOPE among economically weaker households and that it paradoxically benefits the non-poor.

In his paper on how to reclaim India's public healthcare system without insurance-based financing, Duggal argues for an increase in budgetary allocations. He advocates for its strengthening through improved infrastructure, adequate deployment of healthcare personnel, and the strict prevention of the delivery of public resources to private sectors. In her exploration of the digitalisation of healthcare in India, Chakravarthy questions the excessive reliance on technological solutions for complex public health challenges that are deeply rooted in social contexts. She critiques the neglect of political economy factors, particularly within the framework of the Ayushman Bharat Digital Mission.

Drawing on the lived experiences of individuals accessing PMJAY scheme, RamPrakash questions the market-based principles underpinning the scheme, in the context of India's unregulated private healthcare sector and widespread illiteracy. In his article on the Employees State Insurance Corporation (ESIC), Patel argues that while it has achieved impressive numerical growth, improvements in healthcare delivery, benefit realisation, and occupational health protection have not kept pace.

Together, these contributions offer a timely and critical reflection on the limitations and challenges of PMJAY and the broader trajectory of health financing reforms in India.

Thresia C.U.

Poster promoting QR code–based OPD registration under the Ayushman Bharat Digital Mission at a community health centre in Chhattisgarh. However, on scanning the link it opens at https://en.wikipedia.org/wiki/Saraswati and not of the ABHA (Ayushman Bharat Health Account) app. (Photo by Dishari Khan)

Dear Reader,
This is to inform you that, beginning with this issue, the mfc bulletin will be published as a quarterly. We welcome contributions on any aspect of health/public health that you feel passionate about. We would particularly like to encourage first time authors.
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Blessed Shangri-La! The Promised Land of Healthy

AB-PMJAY: A Background Note

Amit Dhage and Gajanan Phutke

Keywords: AB-PMJAY, Health Insurance, UHC

Launched on 23rd September 2018, Ayushman Bharat- Pradhan Mantri Jan Aarogya Yojana (AB-PMJAY) is a flagship scheme of Central Government[1] , touted as the "world's largest government funded healthcare program targeting more than 107.4 million families equivalent to more than 50 crore beneficiaries" (PIB India, 2018: n.p.). Set out as India's step towards Universal Health Coverage (UHC), AB-PMJAY was said to provide cashless access to quality health services without facing financial hardships, through an annual insurance cover of up to 5 Lakh Rupees per family (ibid). Citing the 71st Round of National Sample Survey Organization (NSSO), the PIB release adds that this survey has found 85.9% of rural households and 82% of urban households have no access to healthcare insurance and that more than 17% of the Indian population spend at least 10% of household budgets for health services.

This scheme was later expanded to include ASHAs (Accredited Social Health Activist) in March 2024, and all those above 70 years age irrespective of socioeconomic status in October 2024 (PIB India 2024). The other, often less talked about or less financed, part of the Ayushman Bharat program is the upgradation of existing Primary Health Centres (PHCs) and Sub-Health Centre (SHCs) (>1.5 Lakh centers) into Health and Wellness Centres (HWCs) mandated to transform selective primary care model of the past decades (through various vertical programs) into a comprehensive primary care model. These rebranded HWCs were further rebranded into 'Ayushman Arogya Mandir' in November 2023.

Replacing Care with Coverage of Care

The roots of health insurance in the modern industrialised world can be traced back to the year 1883, when Bismarck led Germany passed the first ever act of social health insurance emphasizing solidarity and self-governance as guiding principles. The model evolved continuously throughout the political turmoil (republic and dictatorship states, two world wars and division and reunion of German national state) to gradually expand coverage and after almost a century later, by the 1980s, was able to include 90% of the German population. And yet, today, the German health system is grappling with an aging population and multimorbidity on the one hand and oversupply and discontinuous care on the other. (Busse et al., 2017)

In a world split by the cold war, the rise of new independent nations and non-alignment movement demanding effective control over their natural resources and economic activities through a New International Economic Order (NIEO) and success of community health projects like barefoot doctors in China, fueled the way towards consensus over 'Health for all' in the Alma-Ata declaration ("NIEO Declaration" 1974). However, despite the overwhelming support by many governments around the world, the momentum fizzled out over the next three decades citing overly idealistic (or not practical) and poorly described roadmaps for the goal of 'Health for all by 2000' (Pandey, 2018).

In 2005, after the failure to achieve Alma Ata's stated goals of 'Health for all by 2000', the 58th World Health Assembly agreed upon UHC as its next target, marking departure from 'health care' to 'health coverage' and from 'comprehensive primary care' towards 'selective primary care' which was advocated by Walsh and Warren (1979) for being more 'cost-effective' and 'achievable'.

In India, the National Rural Health Mission (NRHM) was launched in the same year and focused on reproductive and child health primarily targeting high Infant Mortality Rates (IMR) and

1Under the Bharatiya Janata Party (BJP) led National democratic Alliance (NDA).

high Maternal Mortality Rates (MMR) at the time, bringing with it a significant boost of financial and human resources to the public health system. This did increase public health spending by the government up to 30% of additional budget over regular budget, which had been historically below 1% of GDP for many decades; however, this increased expenditure did not translate into financial risk protection (Bhatt and Sandhu, 2016). In 2010, a High-Level Expert Group (HLEG) on UHC gave strategic recommendations to achieve this goal by greater engagement with contracted private health facilities in a public-private collaboration model in providing health care (Thakur, 2011, Gopichandram, 2019).

Promiscuity of Health Insurance: Equivocations of AB-PMJAY[2]

1. Myth of Universality: Not for everyone, Not available everywhere, No cover for many things
Started as a step towards UHC, PMJAY provides insurance coverage for about the bottom 40% of the population, leaving the "missing middle" uncovered and vulnerable to catastrophic OOPE (considering the upper high income group covered through private insurance) (PIB, 2021). The scheme does not cover outpatient care and provides limited inpatient care subject to availability of particular specialty services in empanelled public or private hospitals which is variable among districts and states; more empanelled hospitals are clustered in urban areas, developed states with prior health insurance schemes have more empanelled hospitals per lakh beneficiaries and the poorer aspirational districts have lesser specialty services, fewer empanelled hospitals, and lower beneficiary verification rates (Smith, 2019;Joseph, 2021). Scheduled Castes and Scheduled Tribes groups comprise about 28% of the country's population but record about 5% and 2% private hospital admissions since inception of AB-PMJAY (Dubey et al., 2023). The scheme therefore appears to conform with the inequities inherent to the contemporary sociopolitical environment and does not prevent them from intercepting access to equitable or affordable care.

2. Disempowering the Disempowered: Digital Divide Fueling Systemic Exclusion - The emergence and rapid penetration of technologies for electronic identity verification and tele communication over the last decade helped prepare the ground for pushing implementation of these technologies in welfare schemes; however the most marginalized communities were the most important beneficiaries of these schemes and many of them do not have the means of accessing these technologies due to obvious sociopolitical conditions that they live in, relevant not only for accessing healthcare but also food rations. Those who are able to reach the hospital are reportedly denied the benefit due to failure of identification for trivial errors such as spelling mistakes (that often take more than a fortnight to get corrected), disfigured or deformed facial features or fingerprints due to illnesses. The baseline census data (SECC, 2011) observed by the government agencies for delineating the beneficiaries of PMJAY often fails to recognise individuals who got separated from previous joint families and the newly formed nuclear families are not part of the list of beneficiaries (Badhani, 2024; Bharadwaj, 2018; Yadav, 2024). Besides the concerns of exclusion, concerns for data privacy of individuals need a separate discussion.

3. De-prioritising Primary Care: The Ayushman Arogya Mandirs (previously HWCs) were proposed to deliver comprehensive primary care through 12 care packages, but AB-PMJAY has ended up prioritising financing insurance based secondary and tertiary care. While the absolute numbers of total health budget described by the government shows an upwards trend, the actual share of allocation for NHM has been declining in recent years (Hooda, 2020).

4. Accountability for Outcomes of Healthcare: HLEG on UHC in 2011 in its report did warn against having a private entity to make purchase of services under UHC on behalf of the government and recommended that some government agency or quasi-govt autonomous agency should do such purchasing; the report explains in detail, how an independent agent will not be accountable for individual and population level wellness outcomes and would tend to produce extensive hospitalisa-

2 Here we use the word Promiscuity to indicate a promiscuous behaviour of health insurance towards health of the people, for offering healthcare on the outside but cultivating profiteering at its core at the cost of health of people which it is supposed to protect.

tion rather than prioritising promotive and preventive care. As per the 151st report of the Parliamentary committee, 23 states have opted for trust based model for implementation of PMJAY and 7 (down from 11) have adopted insurance company based model and 3 states have adopted mixed model; with an increasing trend for adoption of trust based model among states, but the reasons behind this trend are not explained in the report (Parliament of India, 2023). During times of public health crises like COVID-19 pandemic, there was a great reduction in essential healthcare services even for those enrolled as PMJAY beneficiaries. The emphasis on a public funded and publicly provided health system would have been vital not only to mitigate the threats from pandemic but also to ensure that an accountable health system is in place to help citizens exercise their right to health.

5. Impact on Financial Burden: There are no pan-India studies on impact of AB-PMJAY on OOPE, but state level studies from Maharashtra, Madhya Pradesh and Chhattisgarh have concluded that India's AB-PMJAY scheme is not associated with improved utilisation, financial protection, or quality for inpatient care and that long standing supply side gaps and poor provider regulation continue to hamper effectiveness of the scheme (Garg 2024a; 2024b). One study from Haryana showed reduction in direct costs due to AB-PMJAY but also admitted that these beneficiaries also incurred higher indirect costs (Kumar, 2025). Costs incurred in outpatient care are the highest contributor in OOPE in India, driven primarily by expenditure on medicines, where AB-PMJAY has no coverage (Thakur, 2024). NSSO data from 71st and 79th rounds do not provide comparable figures on average expenditure; one provides expenditure per hospitalisation and other gives expenditure for hospitalised care per household per year. The recent NSSO survey has shown that the penetration of the scheme has increased threefold covering about 45% and 32% population in urban and rural areas respectively and is associated with reduction in median healthcare spending and OOPE, but detailed report is not yet available in public domain (PIB India 2026).

Concluding remarks:

Emergence of AB-PMJAY as a health financing model is a result of neoliberal policies and pressure from various international and national stakeholders; and has been built over the experience of many of the older insurance schemes across the Indian states. Availability of funds from scale of coverage in this way may seem to help in reducing direct costs of care for many fortunate beneficiaries; however, it serves merely as a short-term band aid and in the long run hampers efforts towards comprehensive primary care and is doomed to drain off public resources to nurture the private sector resulting in imminent devitalization of public health infrastructure and resources, a move that is antithesis of 'right to health'.

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Beyond the Bill:
Illustration by Pratibha
Pratibha is a dentist-turned-public health professional, and illustrator

Health insurance in India

An overview and the way forward

N. Devadasan and Nikita Pandey

Keywords: Health Financing, Universal Health Coverage, Government-Funded Health Insurance, Financial Protection, India

Introduction

A broad spectrum of stakeholders has strongly criticized health insurance in India. Activists question its growing reliance on market-driven approaches that prioritise profitability over equity. Customers frequently express frustration with opaque policies and complex procedures that erode trust. Governments, for their part, remain wary of an industry whose profit orientation can conflict with public health goals. Even insurance company CEOs, paradoxically, express concern, as many firms continue to operate at a loss despite expanding markets. This article seeks to unpack these tensions by examining the history, typologies, and performance of health insurance in India, aiming to deepen our understanding of its evolving role.

What is health insurance?

Health insurance has been defined in multiple ways across disciplines. In 2000, the World Health Organization described it as:

> A mechanism by which money is raised to pay for health services by financial contributions to a fund; the fund then purchases health services from providers for the benefit of those for whom contributions are made or who are otherwise covered by the scheme. (WHO, 2000)

At its core, health insurance can be understood as a financing mechanism built on three foundational pillars: prepayment, pooling, and guarantee of service. Prepayment refers to contributions made in advance—by individuals or households—into a fund that covers healthcare costs when needed. These contributions typically take the form of taxes or insurance premiums. While both approaches have distinct advantages and limitations, there is now widespread consensus that prepayment is the best way to finance health care. Financing health care through direct payments at the point of use is unacceptable. To quote the WHO: "The key to [financially] protecting people is to ensure prepayment and pooling of resources for health rather than relying on people paying for health services out-of-pocket (OOP) at the time of use" (WHO, 2026).

Pooling involves aggregating financial contributions from diverse population groups into a common fund. This enables cross-subsidisation—between the rich and the poor, the healthy and the sick, and the economically active and inactive—ensuring that resources are allocated according to need rather than ability to pay.

Guarantee of service is perhaps the defining strength of insurance-based systems. Unlike tax-funded models, insurance operates through enforceable contracts between the insured and the insurer. In principle, this legal framework provides individuals with a formal guarantee of access to services, thereby enhancing accountability and empowering policyholders.

History of health insurance

The roots of health insurance lie in long-standing traditions of collective risk-sharing. Across communities, mechanisms have existed to pool resources and support members during times of illness. In rural India, for instance, villagers mobilise voluntary contributions to assist families facing hospitalisation (Ruducha et al., 2019). Among the adivasis of Gudalur in the Nilgiris, this practice—known as *piruvu*—reflects a deeply embedded ethic of mutual aid.

Modern health insurance, however, emerged during industrialisation in Germany, where low-income workers voluntarily contributed to employee-managed "sickness funds" that covered treatment and funeral expenses. In 1883, Otto von Bismarck formalised these arrangements by mandating sickness funds in all factories in Germany, financed by both workers and

employers (Barnighausen and Sauerborn, 2002). This Bismarckian model subsequently spread across Europe. Parallel developments emerged elsewhere. In Japan, the *Jyorei* scheme—documented as early as 1835—collected community contributions and compensated doctors for providing primarily curative outpatient services. By 1922, the Japanese state had formalised this approach through a National Health Insurance system (Ogawa et al., 2003). Chile adopted the Bismarckian model for industrial workers in 1924. India introduced the Employees' State Insurance Scheme (ESIS) in 1948 (Roemer, 1997).

In the United States, early attempts to establish contributory health insurance were led by the American Association for Labor Legislation before the First World War. These proposals envisioned shared financing by employees, employers, and the government. However, they failed amid wartime disruptions and strong opposition from the medical profession, which framed such initiatives as 'socialised medicine'(Ross, 2002). In the decades that followed, rising healthcare costs and declining patient volumes prompted hospitals and physicians to champion private insurance systems, leading to the creation of institutions such as Blue Cross and Blue Shield (Gorman, 2006).

From the 1980s onward, escalating healthcare costs and persistent gaps in financial protection spurred community health insurance initiatives across parts of Africa and Asia, including India. These locally organised schemes empowered communities to define premiums and benefits, with management often overseen by local leadership structures (Devadasan et al., 2006).

Today, health insurance broadly comprises three distinct forms: social health insurance (SHI) and community health insurance (CHI), both of which are not-for-profit initiatives that evolved to address people's needs, and private health insurance (PHI), which largely emerged from the imperatives of providers and insurance companies and is a for-profit initiative. The new Government Funded Health Insurance (GFHI) is actually not a true health insurance mechanism; it is essentially the government using taxes to purchase care from both the private and public sectors.

Health insurance in India

The evolution of health insurance in India reflects a complex interplay of historical influences, policy choices, and market forces. The timeline in Figure 1 traces its key milestones. Health insurance was first launched in India through the ESIS in 1948[1]. This was followed by the introduction of the Central Government Health Scheme for civil servants in 1954[2]. Private health insurance in the form of Mediclaim was first introduced in 1986 for individuals. Community health insurance schemes (CHI) mushroomed in the 1990s, and in 2003, there were more than 100.

1940s	1950s	1960s	1970s	1980s	1990s	2000s	2010s	2020s
ESIS								
	CGHS							
				Private HI				
					CHI			
						GFHI		

Figure 1: Key Milestones on Health Insurance in India

1 Employees' State Insurance - Wikipedia

2 Central Government Health Scheme - Wikipedia

However, the introduction of the Rashtriya Swasthya Bima Yojana (RSBY) and stricter regulation of health insurance laws led to the quiet death of this movement. The most famous of these CHI schemes was the Yeshasvini scheme in Karnataka, wherein 22 lakh members of the cooperative societies paid an annual premium of Rs 120. In return, they received hospital expense coverage up to Rs 2 lakh per person per year at 150 hospitals across Karnataka (Radermacher et al., 2005). In 2000, the government of India (GoI) opened the insurance sector to private players. In 2003, it introduced a health insurance scheme for the poor, the "Universal Health Insurance Scheme" (UHIS), with a premium of Re 1 per person per day. There were very few takers for this scheme. In 2007, Andhra Pradesh launched the first GFHI scheme, the Rajiv Aarogyashree Scheme. People below the poverty line were eligible to seek hospital care for high-cost, low-frequency medical events at an empanelled hospital anywhere in AP and would receive cashless treatment for up to Rs 200,000 (Rao et al., 2014). This model was followed by other state governments and as well as the central government when it launched the Rashtriya Swasthya Bima Yojana (RSBY) in 2008 (Devadasan and Swarup, 2008). Following the expansion of the RSBY, in 2013, the Insurance Regulatory and Development Authority of India (IRDAI) introduced comprehensive health insurance regulations. In 2018, the RSBY evolved into the Pradhan Mantri Jan Aarogya Yojana (PMJAY), providing financial protection against hospitalisation expenses up to Rs 5 lakhs per family per year[3]. This is touted as the world's largest health insurance programme, with more than 50 crore potential beneficiaries.

Performance of health insurance in India

The fundamental objective of most health insurance schemes is to expand access to healthcare while reducing the financial burden on individuals at the point of service. The underlying premise is straightforward: by removing financial barriers, insurance enables patients to seek hospital care more readily and at significantly lower cost than those who remain uninsured. This assumption—that insurance translates into improved access and financial protection—lies at the heart of health financing policy. However, its validity ultimately depends on how schemes function in practice. To assess this more rigorously, the key performance indicators of various health insurance schemes in India are presented in Table 1.

Table 1 makes one point unmistakably clear: that the majority of health insurance schemes in India today are not-for-profit, and collectively they cover a far larger share of the population than their private counterparts.

Admission rates serve as a proxy indicator of access to services under a health insurance scheme. While there are no universally accepted benchmarks, the available evidence suggests significant variation. The admission rates in the ESIS are strikingly low—at approximately 7 admissions per 1,000 beneficiaries—raising serious questions about effective access. In contrast, the PMJAY scheme reports a higher admission rate of 31.6 per 1,000 beneficiaries. However, this aggregate figure conceals stark regional disparities: southern states[4] record as many as 88 admissions per 1,000 beneficiaries annually, compared to just 35.4 in northern states[5]. Such uneven utilisation likely explains why empirical studies on access to hospital care continue to present a mixed and inconclusive picture (Garg, Bebarta and Tripathi, 2020; Parmar et al., 2023).

Financial protection remains a central objective of any health insurance scheme. Although there is a notable absence of recent evidence on schemes such as ESIS and CGHS, available studies on PMJAY suggest that it reduces out-of-pocket expenditure (OOPE) among beneficiaries compared with the uninsured (Parmar et al., 2023; Amneet P. Kumar et al., 2025). Evidence from Haryana, based on a robust methodological approach, demonstrates that both OOPE and the incidence of catastrophic health expenditure (CHE) are significantly lower among insured individuals ofcom-

3 www.nha.gov.in

4 Kerala, Tamil Nadu, Andhra Pradesh, Telangana, Karnataka, Goa

5 Bihar, Uttar Pradesh, Himachal Pradesh, Uttarakhand, Punjab, Haryana, Rajasthan, Madhya Pradesh, Chhattisgarh, Jharkhand, Jammu & Kashmir

Table 1
Characteristics and performance of key health insurance schemes in India (2026)

	ESI scheme*	CGH scheme^	PHI scheme#	GFHI scheme@
Type of HI scheme	Not-for-profit social health insurance scheme	Not-for-profit social health insurance scheme	For-profit voluntary health insurance schemes	Not-for-profit voluntary health insurance scheme
Eligibility	Industrial workers earning less than Rs 21,000 per month.	MPs, Supreme Court Judges, IAS/IPS officers, Central Government employees	Individuals who can afford the premium	The bottom 40% households on the 2011 SECC list
No. of enrolled beneficiaries	14.91 crores	0.44 crores	34.1 crores	40.45 crores
Premiums/ contributions	Compulsory contributions by employee and employer	Token contributions by the employee. Rest subsidised by MoHFW	Risk-rated premiums by individuals	100% subsidy by the government
Average expenditure per enrolled beneficiary	Rs 1,040	Rs 13,522	Rs 3,235	Rs 489
Organiser of the scheme	Employees State Insurance Corporation	Ministry of Health and Family Welfare	Health insurance companies	National Health Authority & State Health Agencies.
Admission rate	7 per 1,000 enrolled beneficiaries	?	103$ per 1,000 enrolled beneficiaries	31.6 per 1,000 enrolled beneficiaries
Cost per patient	?	?	Rs 14,010	Rs 13,068

Source: * ESIC Annual Report 2024-25; ^MoHFW Annual Report 2024-25; @ NHA Annual Report 2024-25; NA = Not applicable; $ = Includes admission to PMJAY; ? = Could not access the data.

parable socio-economic status. Similarly, a rigorously designed quasi-experimental study finds that both the incidence and intensity of OOPE were lower among beneficiaries of the Vajpayee Arogyashree Scheme[6] than among their uninsured counterparts (Sood et al., 2014). Taken together, these findings provide credible, though still partial, support for the financial protection hypothesis.

From a cost perspective, the ESIS stands out for delivering comprehensive healthcare at an estimated per capita expenditure of approximately INR 1,000—a figure that is nearly 13 times lower than the spending incurred on civil servants and parliamentarians. The PMJAY scheme, for its part, has demonstrated considerable negotiating power, securing relatively low premium rates and maintaining downward pressure on inpatient care costs. These features underscore the potential efficiency gains achievable under well-designed public insurance programmes.

Yet, despite these insights, one critical dimension remains inadequately understood: the quality of care. There is a conspicuous lack of rigorous, large-scale evidence assessing the quality

6 Vajpayee Arogyashree Scheme is a flagship health assurance program launched by the Government of Karnataka to provide Below Poverty Line (BPL) families with free, cashless treatment for catastrophic illnesses.

of services delivered under these schemes. Existing studies, often limited in scale and scope, rely heavily on patient satisfaction metrics that suffer from significant methodological limitations. As a result, any definitive assessment of quality remains elusive, pointing to an important gap in both research and policy discourse.

Discussion

It must be unequivocally acknowledged that in India, the majority of insured are covered by social health insurance or government-financed health insurance, both fundamentally not-for-profit in nature. Yet, the term "health insurance" continues to be narrowly and misleadingly equated with private health insurance. This persistent conflation distorts public understanding, obscures the diversity of financing models, and, critically, marginalizes approaches that are more aligned with equity and public welfare. This is reflected globally, with 54% of high-income countries, 44% of upper-middle-income countries, and 20% of lower-income countries using SHI to finance more than 10% of their current health expenditure. Countries in Western Europe, Latin America, and Japan use SHI as the main form of financing (>50%) for their health care services .[7]

Equally important is the recognition that health insurance schemes historically emerged from grassroots social movements among vulnerable populations seeking protection from prohibitive medical costs. This bottom-up foundation—anchored in solidarity, mutual aid, and equity—has been largely erased in contemporary discourse, which views all forms of health insurance through the lens of capitalist private models. Such oversimplification overlooks the transformative potential of equitable insurance systems.

The low utilisation of benefits under ESIS is not incidental; it signals systemic deficiencies. These include poor organisational capacity, inconsistent service availability, and widespread lack of awareness among beneficiaries. In contrast, the PMJAY demonstrates considerable untapped potential. While the average admission rate stands at 31.6 per 1,000 beneficiaries, rates as high as 80–90 per 1,000 beneficiaries in southern states clearly demonstrate what is achievable. This disparity underscores that PMJAY, if effectively implemented, can significantly expand access to hospital care.

There is strong evidence that PMJAY reduces OOPE at the point of care. (Parmar et al., 2023; Amneet P Kumar et al., 2025) Kumar's case-control study in Haryana reveals a stark contrast: insured patients incur an average expense of Rs 11,131 per admission, compared to Rs 31,675 for the uninsured. However, this protection remains incomplete. Insured patients continue to pay for medicines, diagnostics, and informal fees. This is not accidental—it reflects systemic distortions. Hospitals frequently justify such charges by citing inadequate reimbursement rates, effectively shifting costs back onto patients. Alarmingly, some patients accept these payments, perceiving them as minimal relative to total expenses, thereby normalising inequitable practices.

Health insurance organisers in India have begun to exert influence over the quality of care, but current efforts remain superficial and largely limited to enforcing basic infrastructural standards. This is insufficient. International experience clearly demonstrates that insurers can drive meaningful improvements by enforcing standard treatment guidelines and linking reimbursements to adherence (Preker et al., 2007). Such mechanisms promote rational, ethical, and evidence-based care. India stands at a critical juncture: if the National Health Authority (NHA), State Health Agencies (SHAs), and private insurers align on standardised guidelines, pricing, and measurable outcomes, they can fundamentally transform an otherwise fragmented and weakly regulated health system.

As Sunil Nandraj aptly observed, "The Golden Rule is that He who has the Gold, makes the Rules."[8] This insight is not merely rhetorical—it underscores the immense regulatory power embedded within health financing structures

To conclude, health insurance is not merely a financial instrument; it is a powerful mechanism for structuring access to care. Through prepayment, risk pooling, and guaranteed service provision, it is designed to shield individuals from

7 Global Health Expenditure Database

8 Sunil Nandraj worked as the cluster head of Health Systems in the WHO. He has worked in many parts of the country, especially in Kerala, and taught Health Systems at NIE Chennai.

catastrophic health expenditure. In India, however, the system remains nascent and underperforming in critical areas. Strengthening its design and implementation is not optional—it is imperative. A robust health insurance system can dramatically expand access, substantially reduce financial burden, elevate quality of care, and impose long-overdue discipline on the healthcare sector.

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Health Insurance Schemes and Out-of-Pocket Expenditure

Evidence from the latest NSS rounds

Indranil, Mampi Bose and Bevin Vijayan

Keywords: Out-of-pocket expenditure, government funded health insurance, hospitalisation, PMJAY, health expenditure

Introduction

High Out-of-pocket expenditure (OOPE) on healthcare pushes the population, especially the marginalised ones, to a more vulnerable state, economically, socially, physically and emotionally. The government's role in terms of reinstating a fair situation in the healthcare market is thus widely sought. In 2005, the World Health Organisation (WHO) came up with the agenda of Universal Health Coverage (UHC), which advocates for an increasing role of the government in the health sector through greater public investment. Since then, member countries have embarked on different trajectories to ensure the increasing role of the government in the health sector. With the acceptance of New Public Management (NPM) ideas in the public sector under the UHC regime, several countries have prioritised purchasing care rather than providing it. Subsequently, quite conspicuously, the concept of "Strategic Purchasing" was elucidated in the National Health Policy of India in 2017. Over the last two decades, both the Union and state governments have launched several government funded health insurance (GFHI) schemes.

Either in the form of insurance premiums or through direct payment to providers, governments sponsor access to high-cost, low-frequency hospitalisation care, particularly in the private sector. The stated objective is to provide free care and bring down financial hardships faced by households engaged in the informal sector, particularly those below the poverty line (BPL) or those who are socio-economically disadvantaged.

In this article, we attempt to compare the OOPE while seeking hospitalisaiton services to understand whether the Pradhan Mantri Jan Arogya Yojana (PMJAY), along with other state government sponsored GFHI schemes, was able to bring a certain level of respite to the beneficiaries by lowering the OOP expenditure. We use descriptive statistics from the latest available NSS Health and Social Consumption data (80th round) and the Household Consumption Expenditure Survey of 2023-24 to study the effectiveness of these schemes in ensuring financial protection.

The following section discusses a brief history of GFHIs and current coverage of the schemes. Section three deals with OOPE on health; section four is on the catastrophic expenditure of households; and we end with a discussion in section five.

History and Coverage of GFHI

Since 2003, India has witnessed a plethora of GFHI Schemes at both the national and state levels. The Yeshasvini scheme started as an insurance scheme for worker cooperatives in 2003 in Karnataka, including all rural co-operative society members, members of Self-Help Groups / Sthree Shakti Groups and their family members (including members of joint family). The Rajiv Aarogyasri Scheme (RAS), specifically targeting the BPL population of Andhra Pradesh was introduced in 2007. The scheme became popular and was soon extended to almost the entire population.

The Rashtriya Swasthya Bima Yojna (RSBY), launched in 2008, is at the other end of the spectrum. It is also voluntary in enrolment and was initiated by the Central Government (Ministry of Labour and Employment) as a national health insurance scheme targeting the BPL population. Other notable state-sponsored schemes included Chief Minister's Health Insurance Scheme in Tamil Nadu (2009), Vajpayee Arogyasri (2009) in Karnataka and Swasthya Saathi (2018) in West Bengal.

Prime Minister's Jan Arogya Yojana, launched in 2018, is an extension of these schemes which aims to merge all the existing schemes and provide coverage up to 5 lakh rupees for hospitalisation. This is a merger of two on-going centrally sponsored schemes - Rashtriya Swasthya Bima Yojana (RSBY), Senior Citizen Health Insurance Scheme (SCHIS), and other state-sponsored schemes..

All the state sponsored GFHIs have now been merged into PMJAY. The most recent addition being Swasthya Saathi, the West Bengal Scheme. States like Rajasthan, Kerala, Haryana have often put in additional resources to include non-poor sections with low and heavily subsidised premiums.

According to the NSS 80th round, around 41.1 per cent of the population – 45.5 per cent in rural and 31.8 per cent in urban areas - is covered by different GFHIs. This has been achieved mainly by more than a two-and-a-half-fold increase in coverage between 2017-18 and 2025 of GFHIs schemes such as the PMJAY and Swasthya Saathi (in West Bengal).

Table -1 shows that 25.6 per cent of the population covered by GFHI belongs to households that draw a major component of their income from casual wage work or are self-employed. The share of the same in urban areas is 18.3 per cent. Around 57.4 and 39.6 per cent of individuals belonging to households with a major share of income from self-employed work are covered by PMJAY and State Health Insurance.

In rural areas, around 52.4 and 45.7 per cent of the top two quintile groups are covered under GFHI, while in the urban sector, coverage is almost evenly distributed across quintile groups (Table-2).

To sum up, GFHI schemes cover individuals across all income groups and household types. Although the scheme was launched to cover poor and marginalised sections, greater inclusion of salaried households and high-income groups suggests otherwise. Inclusion of households above the

Table-1
Population covered by GFHI across Household Types (%)

Type of Households	Rural	Urban
Casual	25.6	18.3
Regular Wage/salary earning	14	36.6
Self-employed	57.38	39.6
Others	2.9	5.6

Source: Authors' calculation using unit records of NSS Social Consumption Health -80th round.

Table-2
Coverage of GFHI across income groups (%)

Income Group	Rural	Urban
Q1	38.1	36.5
Q2	45.9	34.6
Q3	51	35.3
Q4	52.4	34.6
Q5	45.7	25.3
Total	**45.5**	**31.8**

Source: Authors' calculation using unit records of NSS Social Consumption Health -80th round.

poverty line is not problematic since these households may be equally vulnerable to high OOP expenditure. The problem lies in the poor coverage of casual labourers and poor households. As the evidence suggests, the coverage of individuals from casual labourer households and the poorest income group in rural areas are around 25.6 and 38.1 per cent, respectively. The same for the urban sector are 18.3 and 36.5 per cent. Quite obviously, the GFHI schemes suffer from an inefficient targeting approach (Bonu and Bhusan, 2026).

Hospitalisation and OOPE

Among those covered by GFHI, around 53.6 per cent of hospitalisations occur in public facilities. The same figures for rural and urban areas are 44.1 and 53.3 per cent, respectively. Table- 3 shows that at private facilities, there is little difference between the average medical expenditure and transportation costs (per hospitalisation) for those covered under GFHI and those not covered by any insurance scheme. In fact, in rural areas, the average medical expenditure at private facilities for those covered under GFHI was higher than that of those not covered (Table- 3). People covered under GFHI, and going to private facilities in rural areas, ended up spending more on average on blood-related problems, cardiovascular diseases, ear problems, endocrine and meta bolic diseases, infection, kidney Failure, psychiatric & neurological, and respiratory problems. Excess average expenditure across a few diseases is also observed in urban private facilities.

Although Table- 3 indicates slightly lower OOP expenditure incurred by those covered by GFHI compared to those without financial protection, the extent of these benefits cannot be measured. As per the instructions in the field investigators' document, for cashless services, information on the cost of treatment is supposed to be reported

Table- 3
Average OOP expenditure across facilities and sectors (INR)

	Medical Expenditure			Transportation		
Facility Type	**Rural**	**Urban**	**Overall**	**Rural**	**Urban**	**Overall**
Covered under GFHI						
Public	3795	3980	3836	901	665	849
Private	43340	48259	44779	1614	1149	1478
Not covered						
Public	4994	5339	5096	813	667	770
Private	40869	51672	44974	1357	981	1214

Note: Childbirth included
Source: Authors' calculation using unit records of NSS Social Consumption Health -80th round

under reimbursement. As per the database, the total reimbursement for GFHI beneficiaries is zero. This may indicate two things: first, none of the GFHI beneficiaries received any benefit during the reference period, which seems unrealistic and second, the information is not collected and documented judiciously, and that it is a quality issue.

Nonetheless, the question at hand remains the same. Now, with this limitation, another way to dig into it is to look at whether the beneficiaries received any of the services for free during hospitalisation or not. By comparing beneficiaries with their counterparts, we find that more than 50 per cent of those covered by GFHI had to pay, either partially or fully, for services they received during hospitalisation. Table 4 shows that beneficiaries received services for free, fully or partly, during hospitalisation in more than 80 per cent of the cases at public facilities, whereas at private facilities, in more than 80 per cent of the cases, services were provided on payment. In other words, beneficiaries who had gone to private facilities had to bear the entire cost of the services they had received most of the time. This again reinforces our previous findings of higher OOPE during hospitalisation in the private sector.

Our findings are consistent with the existing evidence that the GFHIs have limited or no effect on financial protection. A large number of studies on GFHIs in India, and on the centrally funded RSBY suggest that cashless insurance mechanisms failed to reduce OOPE (Nandy S. et al., 2022; Ranjan A et al., 2017; Sakthivel 2018). A systematic review of literature by Reshmi et al., (2021) provides information related to the impact of GFHIs on financial risk protection and utilisation of healthcare. The review found inconclusive evidence for financial risk protection, which is one of the avowed goals of any GFHI. Further, there is a lack of substantial evidence for the reduction in OOPE by GFHI schemes in India.

A recent analysis of the PMJAY scheme by Kamath and Brand (2023) concludes that multiple impact evaluation studies of the RSBY and state GFHIs show very little or no impact on the reduction of OOPE. GFHIs are prone to double charging, where the hospital makes the patient pay for some or all services/medicines/diagnostics which are covered under the GFHI and also claims reimbursement from GFHI. Global evidence also suggests that GFHIs in a private provider-dominated ecosystem fail to reduce OOPE (Indranil et al 2025).

Catastrophic expenditure of households

When households face a health shock, a significant portion of their household budget gets diverted from other requirements to meet health expenses. A key measure of financial hardship is the share of OOPE in total household budget. Anything above 10% is called Catastrophic Health Expenditure (CHE). We use HCES 23-24 round for analysis of CHE.

Evidence suggests that less than one in every eight hospitalisation cases (11.75%) in rural areas and one in every ten in urban areas (9.65) benefit from GFHIs. Even for the bottom three quintile groups, in case of only one out of every eight hospitalisation episodes, some form of benefits is provided, while the remaining seven are left uncovered (Fig- 1).

Overall, almost half of those who benefited from GFHI cards during hospitalisation in rural areas ended up incurring CHE, measured at 10% of household budget (CHE-10). In urban areas, this is as high as 45%. For the bottom 20% of the population in rural and urban areas, the incidence of CHE-10 is higher among those who received some benefits from GFHI cards than among those who did not use the cards (Table-5). This clearly indicates the ineffectiveness of GFHIs in reducing financial hardship.

CHE incidence is significantly higher in the private sector, where more than two-thirds (68.4%) of beneficiaries in rural areas and 60 per cent in rural areas experience CHE-10. By contrast, individuals seeking care in private hospitals without using cards are less likely to face CHE. As expected, CHE incidence remains much lower in public hospitals. These findings indicate that GFHIs fail to provide effective financial protection, particularly when care is sought in the private sector.

Discussion

While the state devises different means for achieving UHC for different populations, efficient targeting of each cohort becomes the most critical prerequisite for the successful implementation of these programmes. In the case of GFHI, the evidence suggests the existence of both type one (including those who are not valid targets as per the guidelines of the programme, also called false pos-

Table- 4
Incidence of payments on services received during hospitalisations (%)
(beneficiaries and non-beneficiaries)

	Government facilities		Private facilities	
Services	**GFHI**	**Not covered**	**GFHI**	**Not covered**
Type of ward				
Free	97.0	93.4	13.9	2.6
Paying general	2.6	5.8	69.7	75.8
Paying special	0.4	0.8	16.4	21.5
Surgery				
Free	88.0	80.5	15.4	1.5
Partly free	4.9	7.6	3.7	1.2
On payment	7.0	11.9	80.8	97.3
Medicine				
Free	55.6	45.8	7.3	0.7
Partly free	37.4	42.7	6.4	1.3
On payment	7.0	11.5	86.3	98.1
X-ray/ECG/EEG/Scan				
Free	72.7	62.9	10.0	1.0
Partly free	16.2	21.5	4.3	1.0
On payment	11.1	15.6	85.8	98.0
Other Diagnostic Test				
Free	73.1	63.9	8.9	1.0
Partly free	16.9	22.0	4.3	0.9
On payment	10.0	14.1	86.7	98.1

Source: Authors' calculation using unit records of NSS Social Consumption Health -80th round

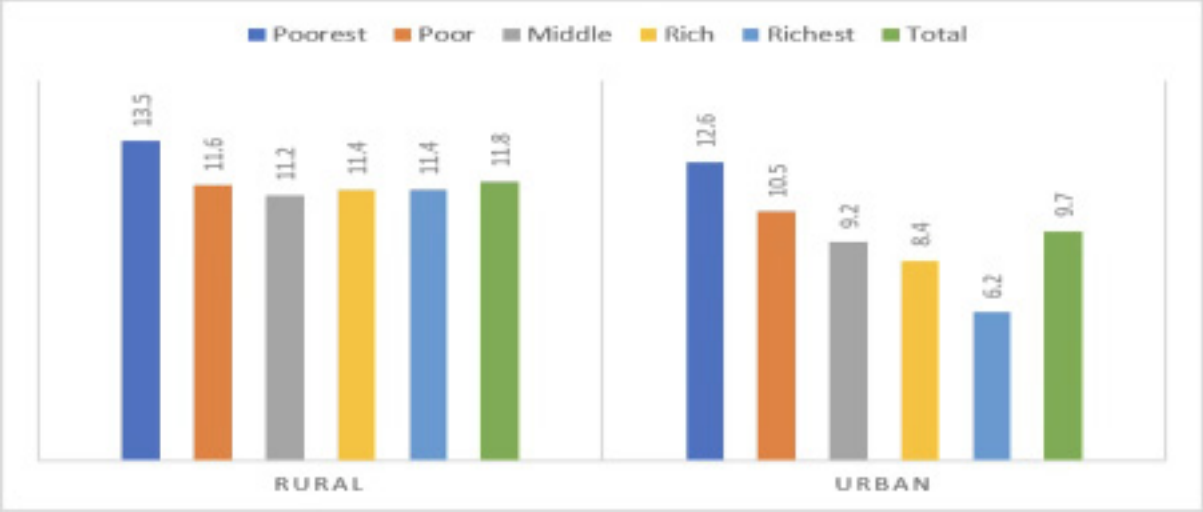

Figure- 1
Share of hospitalisation episodes supported by GFHI cards (%) by quintile groups: 2023-24

Source: Authors' calculation using unit records of NSS Social Consumption Health -80th round

Table -5
CHE-10 among those hospitalised
(benefitting from the GFHI cards vs those who did not)

Quintile Groups	Rural		Urban		R+U	
	Used GFHIs	Did not use GFHI	Used GFHIs	Did not use GFHI	Used GFHIs	Did not use GFHI
Poorest	33.3	36.7	30.1	29.8	32.2	34.3
Poor	41.5	39.8	42.2	35.3	41.7	38.4
Middle	53.3	44.7	54.9	36	53.7	42.1
Rich	56.4	49.7	50.2	43.4	55	47.9
Richest	60.5	58.5	69.7	44.2	61.7	55.4
All	49.6	46.8	45.1	37.3	48.5	44

Source: Authors' calculation using unit records of NSS HCES 23-24

Table- 6
Incidence of CHE-10 by provider type beneficiaries and non-beneficiaries of GFHI cards
(% of hospitalised)

Provider	Rural		Urban	
	Used GFHI card	Did not use	Used GFHI card	Did not use
Public Only	36.4	19.3	29.9	15
Private	66.6	66.6	59.7	48.4
Mixed	68.4	54.3	66.4	38.9
Total	49.6	46.8	45.1	37.3

Source: Authors' calculation using unit records of NSS HCES 23-24

itive) and type two (excluding actual targets, also called false negative) errors – which are essentially the targeting issues. Both databases suggest the inclusion of non-poor households under GFHI. While we argue that all households just above the eligibility criterion may not always be protected by other insurance schemes and may encounter similar challenges due to high OOPE, we would also like to highlight the fact that non-poor income groups have received higher benefits during hospitalisation compared to their poorer counterparts. In addition, the inclusion of comparatively well-off households led to higher utilisation of services, which eventually inflated the cost of care.

It is of utmost importance to note at this juncture that such a high cost of care, coupled with the fiscal constraints of the states, leads to delays in reimbursement to private providers. This entire chain of events sends a signal to the private providers about the inadequacy of fiscal resources; subsequently, the confidence of the private providers in the programme starts deteriorating. After the lower package rates of GFHIs, delays in reimbursement becomes another major source of discontent among private providers who are usually driven by profit-maximising principles. Eventually, all sorts of unethical and inhuman practices, such as cream skimming[1], become increasingly unavoidable (Indranil et al 2026). Most of the time, poor patients end up spending extra.

Another important finding presented in this article is the ineffectiveness of the programme in terms of reducing the financial hardship endured by poor households due to high OOPE on healthcare. With different sets of limitations, none of the databases capture the extent of benefits received by the individuals covered by different GFHIs. In such cases, the most critical indicator is the incidence of CHE -10 to find the impact of OOPE on households' income. Incidence of CHE, in any case, is higher in private care; ironically, it became more so for GFHI beneficiaries when they claimed their entitlement.

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On Ayushman Bharat

Notes from the field

Excerpts from mfc e-forum posts by members, edited for brevity and clarity, and published with author's consent; Compiled by Mithun Som

The main problem is the Ayushman Bharat [AB] scheme itself. First, Contrary to what JSA [Jan Swasthya Abhiyan] has been saying and what the HLEG [High Level Expert Group] report had recommended, the AB scheme is based on policy which travels further in the direction of insurance based (illusory) UHC [Universal Health Coverage] and the privatization that underlies this framework. Secondly, in practice, this supposedly benevolent AB scheme is more of a virtual reality. The budget of Rs. 6400 crores in the first year was not even half of what even the govt was talking about and there was no increase this year! 150,000 Health and Wellness centres were to be functional in 5 years; out of which only 27,000 were reportedly functional in the first three years!

Anant Phadke
22nd December 2020

I don't think PMJAY covers outpatient care at all, which is a major contributor to OOPE [out-of-pocket-expenditure]. It does not cover a wide range of secondary and tertiary care needs. The general medicine packages cover 81 conditions while 97 conditions qualify for urology specialty alone. The General Medicine packages have that rare quality of equality/ samdrishti, where regardless of whether you have malaria/severe malaria/ dengue/dengue shock/pneumonia/respiratory failure/acute bronchitis/endocarditis, the same charges are given! If you have surgical conditions of course the charges are individualised. If you have TB and need hospitalization, please note that you need to have pleural, pericardial or meningeal TB to qualify. Patients with pulmonary TB, please excuse! Diabetes figure only once in the packages under obstetrics. So, all men with diabetes with complications should go elsewhere! Ayushman Bharat is an example of selective care of a selected group of conditions. The packages are often an exercise in dark humor.

Anurag Bhargava
2nd May 2024

We often help patients with Ayushman cards get admitted in government hospitals, only to find that the process for Ayushman activation is quite lengthy. The doctors typically order several thousand rupees worth of tests in the first 24-72 hours, which the patient has to pay out of pocket. For instance, one of our MDR TB patients recently admitted spent Rs 12,000 on blood tests and an albumin injection during her first 3 days in hospital. Ironically, she was discharged shortly after the Ayushman activation process finally concluded, preventing her from taking full benefit! Is there an official rule or guideline on how long Ayushman activation should take?

Yusuf Bhai
29th March 2025

Talking about enrollment [in AB scheme], from my recent experiences in Chhattisgarh. All the human resource people (CHO, ANMs, ASHA, district officials) complained about how so much of their work and focus is taken away by the AB card without much result. Why? Aadhaar generated OTP is the most used/ available option (to cross verify with SECC – Socio-economic caste census— list in the AB-PMJAY portal) which ends up not working due to incorrect mobile numbers being linked or a common mobile number linked for many village people (other verification options, such as facial recognition, fails often and biometric machines for finger print have not been provided). A village worker coordinating the PMJAY card enrolment camps in her village said that even if the people come to the PMJAY card camps, most of them have to return because of technical issues and only a few of them actually get their cards made. One sarpanch and a district official hit the point when they said instead of organising one after the other PMJAY camps in the villages, they should put camps for rectification of Aadhaar card to correct the mobile number linked and other errors. But that facility, on the other hand, is only available all the way up at the district level! However, the larger question remains that even when 100 percent enrollment is done, the foundational issues of denials, copayments, irrational treatments, cost benefit analysis do not go away.

Deepika Joshi
19th September 2023

Reclaiming Public Healthcare in India

Without Insurance Based Financing

Ravi Duggal

Keywords: Insurance based financing , public healthcare, PMJAY, health policy, government funded health insurance

Introduction

Around the world, where governments provide universal access to healthcare with equity, the financing of such healthcare is via taxes and/or social insurance. Be it developed capitalist countries within the OECD bloc[1] or emerging economies in Latin America, Africa and Asia, this is the reality. The burden on health financing rests with governments even though healthcare provisioning may either be publicly provided or a mix of public and regulated private healthcare purchase. To make this possible such governments rein in taxes from the Gross Domestic Product (GDP) at a rate of over 25% of GDP. This fiscal space is a foundational requirement for a robust welfare state where social sectors like health, education and social security are guaranteed to all citizens. This essentially implies that healthcare is a public good and the State is responsible for assuring that all citizens get access to it in an equitable manner. Of course there are exceptions like Thailand, Mexico, China who have similar Tax: GDP ratios as India – around 18%, but, unlike in India, in these countries there is a strong political will to assure healthcare access to all. Since 2017, a publicly funded insurance scheme, the Ayushman Bharat Pradhan Mantri Jan Aarogya Yojana (AB PMJAY; here after PMJAY) has been promoted as way to financing health care costs. This has in effect acted as a means to support private sector hospitalizations resulting in further neglect of public hospitals which were already starved of funds. This article examines the role of PMJAY in healthcare financing and argues that it is possible to provide universal health care without relying on an insurance-based financing.

Historical Context

Historically the healthcare approach and strategy in India since Independence has been one of creating silos of programs and schemes which are targeted to specific population groups and at best are firefighting mechanisms, despite the clear articulation in favour of a National Health System by the Bhore Committee (1946) on the eve of Independence whose ten year plan then was estimated to cost 1.8% of the Gross National Product annually. But post-independence, the Second Provincial Health Ministers Conference in 1948 termed the Bhore Committee recommendations as too expensive for the Indian economy (at that time India was spending 0.4% of GNP on healthcare) . Instead, the country opted to select a path for healthcare that prioritised the most urgent needs and thus restricted the healthcare strategy to firefighting and left a large part of healthcare at the mercy of the market. Bits and pieces from the Bhore Committee short term plan were selected and subsequently the Five-Year Plans took the onus and adopted a selective program-based approach to healthcare. This approach considered healthcare provisioning peripheral and hence over the years the public health sector remained underinvested with the public budgets committing between 0.5% and 0.9% of GDP to publicly provided healthcare. This was when the government's own health policy documents from 1982 to 2017 were pitching for at least 2.5% of GDP to be allocated for the public health sector.

The first efforts at strengthening the public health system came post Alma Ata commitment guided by the 1982 National Health Policy under India's Minimum Needs Program during the 5th and 6th Five Year Plans. In 1987, this reached a peak of public spending on health care at 1.6% GDP (Reserve Bank of India 1989) resulting in the huge expansion of primary healthcare infrastructure in rural India during the eighties. But the structural economic reforms of the early nineties put a pause to this and reduced public health spending back to 0.8% of GDP through the nine-

1 OECD: The Organisation for Economic Co-operation and Development is an intergovernmental organisation with 38 member countries.

ties. Another less resilient effort at strengthening public healthcare came with the launching of the National Rural Health Mission which took public health expenditure to over 1.3% of GDP around 2012 but after that neglect of the public health system, resurfaced and since then has kept public health expenditures stagnant around 1.2% of GDP.

In 2017 a new health policy was tabled in Parliament and adopted. This policy too reiterated a budgetary commitment of at least 2.5% of GDP for healthcare by 2025 but we still are below 1.2% of GDP today (Ministry of Health and Family Welfare, 2017). The government claims that they spend 1.9% of GDP on health and wellness and this magic is done by adding the water and sanitation budget as part of healthcare (Ministry of Finance, 2024). The 2.5% commitment in the national health policy is for Ministries of Health spending. In fact the National Health Policy (NHP) 2017 is a diluted version of the 2015 draft national health policy which following the High-Level Expert Group (HLEG) recommendations, advocated for a National Health Legislation on right to healthcare and debunked health insurance-based schemes. In sharp contrast, the NHP 2017 pushed for public private partnerships, privatization of healthcare and provided a boost for private health insurance under the advice of the NITI Aayog. As a consequence, in 2018 the Rashtriya Swasthya Bima Yojana (RSBY)[2] scheme was redesigned as the PMJAY which promoted insurance-based financing and provided public funds to support private sector hospitalizations. This has resulted in further neglect of public hospitals which were already starved of funds.

Ayushman Bharat – Rebranding the public health system

The Ayushman Bharat initiative was an outcome of the 2017 NHP and was launched on 23rd September 2018 with the aim of universal coverage for healthcare but in retrospect it clearly seems to be an exercise in rebranding public healthcare. The two initial pillars of PMJAY, which was an expanded version of the RSBY scheme, and the Health and Wellness Centres that sought to upgrade primary health centres and sub-centres did not make any structural changes in the healthcare system but turned out to be only a renaming exercise to project that the government was concerned about people's healthcare. Yes, PMJAY did provide a boost to the government funded health insurance by allocating increasing resources but in reality, it was a subsidy to the private, especially the corporate, hospitals as over three-fourth of PMJAY scheme payments went to private hospitals. The PMJAY which covered the bottom 40% of households as per the 2011 Socio Economic Caste Census list was complemented by tax rebates for private health insurance so that those not eligible for PMJAY, basically the middle classes, could access catastrophic healthcare via private insurance. In the latest budget the government has even removed the 18% GST on health insurance as the premiums were becoming unaffordable for the middle classes. This government policy provided a huge boost to private health insurance which over the last decade has witnessed a Compounded Annual Growth Rate (CAGR) of 25%.

The second pillar of Ayushman Bharat, the health and wellness centres, did not get the required budgetary support and hence the PHCs and subcentres continued to be neglected with huge vacant positions of doctors, nurses and various paramedic staff, inadequate medicine supplies, and poor maintenance of infrastructure. These health and wellness centres were rebranded as Ayushman Aarogya Mandirs, but budgetary commitments continued to elude the primary healthcare system.

In recent years two additional pillars have been added under Ayushman Bharat, the Ayushman Bharat Digital Mission and the Ayushman Bharat Health Infrastructure Mission. The former "digitally links all health facilities—from village clinics to big hospitals. It aims to develop the integrated digital health infrastructure of the country. It will connect different stakeholders of the healthcare ecosystem through digital highways." And the latter "builds robust healthcare capacity—from village health centres to district hospitals"[3]. These latter pillars have received some budgetary support in last few years but one does not get to

2 RSBY was the precursor of PMJAY started by the UPA government with limited insurance cover of Rs 30000 for hospitalisations, mainly secondary care

3 https://www.pib.gov.in/PressReleasePage.aspx?PRID=2185049&reg=3&lang=2

Table 1
PMJAY State-wise Expenditures (in Rs lakhs) and GFHI and PFCE trends

State/UT / Rs lakhs	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25#
Andaman and Nicobar	0.6	12.2	109.1	109.1	264.9	236.3	61
Andhra Pradesh	37918	169304.3	190953.9	271731.5	335611.8	389269.9	104895.3
Arunachal Pradesh	0.6	28.5	7.7	18.7	187.8	256.2	90.3
Assam	18.7	20.7	14095.2	26736.6	39198.4	89814.8	28055.6
Bihar	2493.8	16318.5	8027.9	13717.5	23175.4	42415.8	27668
Chandigarh	72.7	367.5	334.5	554.5	952.8	1766.9	588.8
Chhattisgarh	25811.8	76763.2	54855.2	99759.3	154248.9	219909.4	61968.4
Dadra & Nagar Haveli & Daman & Diu	797.4	3120.9	1172.4	1488.4	1646.3	1468.4	494.5
Goa	0.5	12.6	28.7	38	79.2	152.5	53.7
Gujarat	60023.9	215359.7	69562.2	162063	264646.6	360702.1	106330.2
Haryana	2063.9	13341.4	15822.4	24223.8	42536.1	90063.7	32556
Himachal Pradesh	1064.3	5045.4	3600	7082.7	8074.3	9019.5	2956.8
Jammu and Kashmir	569.6	3658.1	6714.9	45400.1	71539.2	83328.7	21158.4
Jharkhand	11056.3	39633.1	29884.1	44610.4	49915.1	58366.3	15753.8
Karnataka	30735.1	83926.7	79291.6	111833.1	168209.7	208359.9	56608.4
Kerala	0	69011.1	76838	156988.3	170269.1	173681.6	40578.5
Ladakh	0	0	0	68.2	846.4	1049.3	323.8
Lakshadweep	0	0	0	20.4	131.6	129.8	35.4
Madhya Pradesh	6849.3	41526.9	54910.1	116957.5	193544	193823.5	63055.9
Maharashtra	23869.8	48531.4	53705.9	73604.4	77001.3	91858.8	68935.2
Manipur	281.3	1998.4	1660.2	3096	5403.3	6983.7	2689.3
Meghalaya	83	9588	9557.9	11761.2	18070.3	21838.1	6679.4
Mizoram	586.5	2624.1	2105.4	1768.8	3141.9	4013.8	1445.2
Nagaland	36.2	1407.5	1076.9	1124.9	2692.9	6424.6	1669.8
Puducherry	0	119.3	109.6	750.3	2036.1	3386.6	881.3
Punjab	0	23723.7	47338.3	66884.2	38110.5	72978.9	21826.7
Rajasthan	0	39547.2	21000.4	82630.8	171789.6	212428.4	53099.3
Sikkim	1.4	167.3	162.8	192.1	439.1	727.9	163.8
Tamil Nadu	48706.1	101720.4	82847.6	163975.8	137410.2	135261.9	59185.5
Telangana	0	0	0	69582.8	114598	130693.2	35724.7
Tripura	403.6	3035.4	2409.9	4061.1	7903.6	11255.2	2874.2
Uttar Pradesh	8660.5	33686.5	30221.1	57683.5	128850.1	302642.2	109969.2
Uttarakhand	2230.9	11929.2	17370.4	40106	59479.2	81635.8	20714.8
All India*	264335.8	1015529	875774.3	1660741	2292004	3005944	949091.2
Private Final Consumption Expenditure (PFCE) Health Rs crores$	**518151**	**593527**	**616875**	**736089**	**847957**	**1007517**	**1158645e**
Govt Funded Health Insurance (GFHI)@ Rs crores	**5672**	**4921**	**4290**	**6076**	**8480**	**10514**	**9459**

Notes: *West Bengal has not accepted the scheme and Delhi and Odisha joined only in 2024-25; This includes Centre and state expenditures, including both insurance-based and trust-based financing, but not states own specific schemes; # For 2024-25 data upto July 2024
$ From National Accounts Statistics 2025; @ From IRDAI Annual Reports, respective years; e Estimated by author
Source: RAJYA SABHA Unstarred Question 1723 24th Aug 2024 PMJAY Beneficiaries

see the expected transformation of primary healthcare facilities and access to them. Thus, the major focus of Ayushman Bharat remains on PMJAY.

PMJAY- diverting public resources to the private sector

Since its inception in 2018 till 16th April 2026, the PMJAY has supported 10.56 crore Hospital admissions with a total outflow of Rs 146,551 crores (NHA Dashboard of PMJAY)[4], of which, an estimated two-thirds to three-fourths went to the private sector over the eight years of the scheme. According to the NHA Annual Report of 2024-25 as on 31st March 2025 Rs 129,386 crores was spent under PMJAY of which 66% was claimed by private hospitals for 52% of the hospitalizations that the private hospitals treated[5]. Data, especially financial parameters for the PMJAY scheme are not provided in detail by the National Health Authority. The dashboard website only provides cumulative data and not year wise breakup. The NHA Annual Reports are more coffee table albums than a source for analytic data. The earlier RSBY website was much more transparent and provided most of the necessary data. Hence, the only source for PMJAY details is the occasional Rajya Sabha and Lok Sabha Questions, the latest being from August 2024 which has been compiled as Table 1. The table indicates the trend since inception of the program year wise for each state and shows a huge growing trend in PMJAY related expenditures. This crossed Rs 30,000 crores in fiscal 2023-24 and has been growing over 30% each year, with a dip only during the covid peak in 2020-21. This indicates that during the covid years the PMJAY failed to pay for hospitalizations because of its larger reliance on private sector which had receded into the background during the covid period.

The last row in Table 1 also indicates the insurance premium outflows over the same period for Government Funded Health Insurance (GFHI) collected by insurance companies. There has been some declining trend in GFHI as more and more states have moved towards a Trust model because of their experience with insurance frauds. As per the latest NHA Annual Report 25 states use a Trust model where no insurance company is involved, 7 states use an insurance model and 3 states a hybrid model, that is Trust and Insurance combined[6]. Even though most states use the Trust model their reliance on private hospitals for the scheme has not reduced and so there is an ever-increasing subsidization of the private sector through tax payers' money.

Apart from PMJAY some states have their own schemes[7] but the Table 1 data excludes these state specific schemes and so the outflow of state funds to the private sector through such schemes is actually much more than shown in the table. Unfortunately, no compilation of all such schemes together is available and hence it is not possible to know the real size of the Government Funded Health Insurance (GFHI) routing of public funds to the private sector. And given the increasing out-of-pocket expenditure as indicated by Private Final Consumption Expenditure (PFCE) (second last row of Table 1) it is evident that private health expenditure burden of households too continues to rise rapidly. Further, the current experience on the ground shows clearly that the GFHI model of financing, whether through insurance or otherwise, is a road towards privatization with a consequent neglect of public health facilities which are deprived of budgetary resources.

Another concern related to strengthening of the private sector is the growing presence and patronage of private health insurance in India. Table 2 shows the growing trend of private insurance premiums which largely come from the middle classes and those working in the organised private sector. This increased dependence on buying health insurance is largely because the public health system is not adequately functional to reach the entire population. This shift of the

4 https://dashboard.nha.gov.in/public/

5 https://nha.gov.in/strapi/uploads/NHA_Annual_Report_2024_25_e9dfbac7cd_90dae48f7a.pdf

6 ibid

7 These are Mahatma Jyotirao Phule Jan Arogya Yojana in Maharashtra, Chief Minister's Comprehensive Health Insurance Scheme in Tamil Nadu, Karuna Arogya Suraksha Padhiti in Kerala, Comprehensive Health Insurance of Antyodaya Units in Haryana, NTR Vaidya Seva in Andhra Pradesh. Both West Bengal and Delhi, earlier also Odisha, had rejected the PMJAY and instead had their own schemes - West Bengal had Swasthya Sathi which was universal coverage, Delhi did not have an insurance based scheme but instead had Aam Aadmi mohalla Clinics and Odisha too had its own state insurance scheme (Gopalbandhu Jan Aarogya Yojana) with universal coverage which is now merged with PMJAY

Table 2
Health Insurance trends in India

Health Insurance Premiums by source of funds 2011-2025 Rs billion														
Source of Funds	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Government	22.25	23.48	20.82	24.74	24.25	30.9	39.81	56.72	49.21	42.9	60.76	84.8	105.14	94.59
Private Group	59.48	71.86	80.58	88.99	116.21	147.18	177.57	216.76	258.81	281.08	368.91	462.46	556.66	614.35
Private Individual	48.96	59.19	73.55	87.72	103.53	125.84	152.91	175.25	199.56	258.4	300.85	347.66	415.01	466.11
Total	130.69	154.53	174.95	201.45	243.99	303.92	370.29	448.73	507.58	582.38	730.52	894.92	1076.81	1175.05
Private Total	108.44	131.05	154.13	176.71	219.74	273.02	330.48	392.01	458.37	539.48	669.76	810.12	971.67	1080.46
Health Insurance coverage by source of funding 2011-25 person millions														
Source of Funds	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Government	161	149	155	214	273	335	359	357	362	343	307	297.7	261.1	245.4
Private Group	30	34	34	48	57	70.5	89.4	72.9	94	119	162	199.4	255.9	275.1
Private Individual	21	24	27	26	29	32	33.3	42.1	43	53	52	52.9	55.9	60.1
Total	212	207	216	288	359	437.5	482	472	499	515	521	550	572.9	580.6
Private Total	51	58	61	74	86	102.5	123	115	137	172	214	252.3	311.8	335.2

Source : IRDAI Annual Reports respective years

middle classes moving towards private insurance began in the late eighties and early nineties when private employers of the organised sector middle classes offered health insurance as an option to their workers and the middle classes switched gears and deserted the public health system which they were all using until the advent of health insurance[8]. As a result, the public health system lost its knoweldegable/aware and vocal clientele and it became a health system for the poor and hence a POOR system with reduced budgetary commitments along with the migration of doctors and nurses to the rapidly expanding private sector.

Reclaiming Public Healthcare

It is clear from the above analysis of the PMJAY and health insurance that it is not achieving its goals of decimating out-of-pocket expenditures. It is in effect transferring public resources to the private sector, and providing a boost to private health insurance which all together has caused grave harm to the public health system and its credibility. The neglect of the public health system is evident from the declining budgetary commitment for the public health system. The only way to reclaim the public health system is to immediately increase its budgetary support to at least 2.5% of GDP. This would mean at current GDP estimate of Rs 393 lakh crore for 2026-27 (Ministry of Finance, 2026) the Centre and states together have to allocate Rs 982,500 crores.As per the 2017 NHP, the share of the Centre would need to be 40% of this total or Rs 393,000 crores and the balance would have to be provided by the state governments. This is not an easy task given that currently the Union budget allocates only Rs 110,939 crores, including grants to states, and the state governments budget about Rs 400,000 crore for healthcare. Thus, the gap is huge and the fiscal space for governments very restricted, with the Tax:GDP ratio being only 17%.

Thailand, on the other hand, has the same Tax:GDP ratio as India and yet it spends 3.8% of its GDP for public healthcare[9]. This it achieved through a strong political backing and support for public healthcare and rejection of insurance-based financing. Thailand restructured its public health infrastructure, strengthened its public facilities with adequate budgetary support, unified its healthcare system into a single healthcare system which provided equitable and universal access to all citizens and minimized discrimination within the healthcare system. It also assured availability of human resources through compulsory public service for 3 years[10] and improved supply chains and maintenance of facilities and equipment. With the present government in India having an overwhelming majority there is no reason why India cannot achieve what Thailand did in the past decade or so.

Therefore, if we wish to provide universal access through a robust public health system, we will have to do what Thailand did or what countries like Brazil, Mexico, Canada, and the UK have done in the past.

The way forward

To begin with we need to assure budgetary allocations as per the 2017 NHP. The current budgetary commitments are too low even to run the existing public health system. Table 3 gives an outline of recent trends of health budgets in India across the Union and state governments. The analytic ratios reveal a very inadequate commitment to making resources available for the public health sector. The low level of budgetary commitment has led to the following deficits that can be seen in the public health system of India, and this needs correction if the government wants to provide universal access and right to healthcare:

- Deficit of demand-based planning (Program Implementation Plans, District Planning Committees, Gram Panchayat Development Plans etc..)[11] : need to strengthen devolution

8 This was true for the public sector employees as well. Many public institutions also offered choice of insurance to their employees and the Central Government Health Scheme (CGHS) also began outsourcing both hospitalization and specialist consultations to the private sector.

9 https://statbase.org/data/tha-health-expenditure-gdp-share/

10 https://pmc.ncbi.nlm.nih.gov/articles/PMC2865657/

11 Program Implementation Plans are part of the decentralized planning and budgeting under the National Health Mission which are supposed to be formulated in consultation with local communities but at ground level these are mostly done by

Table 3
Trends in public spending on health by Union and state governments

Rs Billions	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23R	2023-24B
State Health Expd (SHE) including Centre Grant	1100.78	1251.89	1463.83	1817.14	1966.61	2162.1	2508.77	3027.58	3239.04
Centre Health Expd (CHE) excluding State Grant	145.67	207.16	257.62	280.11	281.03	309.4	370.90	395.79	442.56
Total Health Expenditure	1246.45	1459.05	1721.45	2097.25	2247.64	2471.5	2879.67	3423.37	3681.60
Per capita Health in Rs	981.46	1139.88	1324.19	1600.95	1689.95	1830.74	2101.95	2462.86	2629.71
% Centre share net	11.69	14.2	14.97	13.36	12.5	12.52	12.88	11.56	12.02
% SHE of State Budget	4.7	4.8	5	4.9	4.9	5.1	5.93	5.76	5.60
%SHE of GDP	0.8	0.81	0.86	0.96	0.96	0.96	1.08	1.13	1.10
%CHE of Centre Budget	0.7	0.9	1	1	0.9	0.8	0.98	0.95	0.98
%CHE of GDP	0.11	0.13	0.15	0.15	0.14	0.14	0.16	0.15	0.15
% Total Health of Total Budget	2.83	3.05	3.19	3.29	3.15	3.17	3.99	3.62	3.58
%Health of GDP	0.91	0.94	1.01	1.11	1.1	1.1	1.24	1.28	1.25

Source: Union Budget Expenditure Volume, various years, Ministry of Finance, GoI, New Delhi; State Budget: RBI Finances of the State Governments, various years, RBI, Mumbai

of budgets to facilitate bottom-up planning and involving various stakeholders at the local level to develop plans and budgets for the public health system as per their local needs and demands.

- Deficit in the primary healthcare infrastructure and hospitals for secondary and tertiary care : the healthcare infrastructure needs to be upgraded to a minimum level as specified by the Indian Public Health Standards (IPHS) norms, requiring the strengthening of Health and Wellness Centres through creation of mid-level healthcare providers and upgrading primary health centres and strengthening of the sub-district hospitals (Community Health Centres) as per IPHS and upgrading the district hospitals to teaching hospitals.
- Deficit in Health Human Resources : Doctors, Nurses and Specialist doctors are grossly inadequate even for the existing public health infrastructure with vacancy of sanctioned positions being between 20-40% for doctors and nurses and 60-80% for specialists across various states (Ministry of Health and Family Welfare, 2025). It is not that India does not produce adequate human resources, but the problem is that most of what is produced goes to the private sector or worse as brain drain to other countries. With over 100,000 MBBS doctors, 60,000 specialists and 60,000 AYUSH doctors being produced every year[12] a two or three year compulsory public service will more than fill the gaps in human resources.
- Deficit of Governance and implementation: the top-down decision making cannot work in a sector like health which is highly local oriented. Decision making and management have to be left to the local institutions and governance and not a top down bureaucratic mechanism.
- Deficit of accountability and legislative oversight : this is the failure of our legislators to hold the executive (bureaucracy) accountable for the implementation of plans, policies and budgets; this leads to neglect and failure of public service delivery being implemented effectively; community oversight through Community Based Monitoring and Planning (CBMP) needs to be implemented across the board - the Maharashtra model in 14 districts has shown how CBMP can help reclaim the public health system.
- Deficit of political will and executive commitment: healthcare is not politicised enough; elections are not fought on issues of healthcare.
- Deficit in policy -Healthcare system driven by markets: moving away from healthcare as a public good to healthcare as a commodity; health as a public good has to be reclaimed.

In conclusion

Clearly if the above deficits of the public health system are to be dealt with, then the current budgetary allocations, as indicated in Table 3, are grossly inadequate. If we wish to transform the public health system like Thailand did, then our government will have to be serious about allocating more resources. This would mean:

- budget allocations of over 2.5% of GDP or about Rs 6500 per capita[13];
- have reasonably well functioning public health facilities;
- ensure, where needed, that all human resources are in place, with compulsory public service;
- public health infrastructure is expanded and all inputs assured as per IPHS standards;
- eliminate all forms of private transfers from public resources to the private sector via schemes like PMJAY and other PPPs; and
- a strong regulation of the private health sector and, where needed, to in source private provisioning for public health goals.

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the district bureaucracy. District Planning Committees and Gram Panchayat Development Plans are a statutory mechanism under the Panchayat Raj Act that mandates citizen participation in local govt planning and budgeting.

12 https://www.pib.gov.in/PressReleasePage.aspx

13 A few states like Sikkim, Mizoram, Jammu and Kashmir, Goa, Puducherry, Himachal are already doing this.

Finally, for all such structural reforms, political will from the ruling government will be essential as it will have to take the legislative route to assure right to health care and provide the required budgetary resources.

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Digital Health in India

The Ayushman Bharat Digital Mission

Indira Chakravarthi

Keywords: ICT in health, Ayushman Bharat Digital Mission, ABHA ID, Digital exclusion

Digital health refers to tools and services that use information and communication technologies (ICT)[1] in medicine and other health-related professions, in personal and public healthcare services, to improve prevention, diagnosis, treatment, monitoring and management of health-related issues. The scope of digital health is broad and covers telehealth and telemedicine, digital/information technology as electronic health/medical records, robotics, artificial intelligence, big data analytics, advanced computing, and mobile health through use of smartphones-wearables-mobile health applications and various monitoring devices. Digital health services have been in use in India since the 1990s, in the form of telemedicine and digital health information systems[2]. The application of digital technologies for health information exchange, particularly of electronic health records (EHR) and Personal Health Records (PHR)[3] is seen as having much potential to improve access, quality, efficiency and cost effectiveness of healthcare delivery (Payne et al., 2019).

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (hereafter PMJAY), is one of the two components of the Ayushman Bharat programme launched in 2018 for strengthening the public healthcare services to achieve universal health coverage[4]. PMJAY is the health insurance component, subsuming the earlier Rashtriya Swasthya Bima Yojana, and providing cashless coverage of Rs 500,000 per year to low-income families, for hospitalization care for a total of 1961 procedures, and is being implemented by the National Health Authority (NHA) (Government of India 2025a : 30-41).

Ayushman Bharat Digital Mission (ABDM)[5]

1 ICT – refers to all communication equipment or application software: for example, radio, television, mobile phone, computer, network hardware and software, and satellite system, as well as various services and application software related to it, such as video conference and distance learning

2 More than 20 Health Monitoring and Information Systems (HMIS), exist such as ANMOL (ANM-Online) app for ANMs, ASHA reporting system and electronic health records particularly by large private hospitals.

3 PHR refers to electronic health information managed by the individual; EHR refers to electronic medical information created and managed by the doctor/healthcare professional.

4 Health and Wellness Centres (HWCs) (called Ayushman Arogya Mandirs) is the second component.

5 The National Digital Health Mission put together by the NITI Aayog in 2018 has been re-named and developed as the Ayushman Bharat Digital Mission.

was launched in 2021 for creating an integrated digital health infrastructure in India, for provision of a wide-range of data, information and infrastructure services by leveraging an open, interoperable, standards-based digital system, while ensuring the security, confidentiality and privacy of health-related personal information (Government of India, 2025a:108-9). The National Health Authority (NHA), under the union Ministry of Health and Family Welfare (MoHFW), is responsible for the creation of this digital health infrastructure under ABDM and ensuring its implementation at the state level (Government of India, 2025a:112-3). Ostensibly, the ultimate purpose of the ABDM infrastructure is to create a seamless digital platform for exchange and portability of health-related information between the patients, healthcare providers, insurance companies and other concerned parties (Government of India, 2025a :115-118).

This article discusses some aspects of the Ayushman Bharat Digital Mission (ABDM).

Components of ABDM

The purpose of the digital architecture created under the ABDM is to store individual health records and their exchange / portability based upon consent, through providing a unique and verified health identity to citizens, healthcare professionals, and health facilities. The core components are three major digital registries (Government of India, 2025a: 114-115).

1. **Ayushman Bharat Health Account (ABHA):** a unique Health (UHID) to store, access and share, with appropriate consent, their digital Personal Health Records (PHR) / Electronic Medical Records. It is a randomly generated 14-digit number created using basic demographic details, which are verified through Aadhaar or driving license[6]. The ABHA application is a PHR app, available on android and iOS platforms to create and use the ABHA.
2. **The National Healthcare Providers Registry:** It consists of two distinct registries: the Healthcare Professionals Registry (HPR) and Healthcare Facilities Registry (HFR) of public and private facilities across all systems of medicine. However, it is a unified portal for all healthcare providers, providing a comprehensive platform for registering healthcare professionals and health facilities under the ABDM.

These registries developed under ABDM are depicted as 'a single source of truth' (Government of India, 2025a:110) as they would incorporate robust verification mechanisms, such as through Aadhaar or Driving Licence for ABHA creation, and verification through respective councils or authorised verifiers for the remaining. According to the National Health Authority, no other such verified and compiled registry exists in the country. By early 2025, there were over 76 crore ABHA IDs, around 1.5 crore ABHA app downloads, around 23 lakh active users, 5, 85,827 healthcare professionals and 3,84, 310 facilities registered and 51.3 crore records linked (Government of India, 2025a:122). There is no central repository of health records, rather the data are stored in a decentralized manner at the site of creation (federated architecture). To support the information exchange (interoperability) between the ABHA holders and healthcare providers, three major gateways have been developed: Health Information Exchange Consent Manager, Unified Health Interface (UHI), and National Health Claim Exchange (Government of India, 2025a :114). Individuals will require a ABDM enabled Personal Health Record application, while healthcare facilities will need the ABDM-enabled Hospital Management Information System. The NHA assures that adequate attention is being given to ensure privacy and security in the operation and use of this digital infrastructure.

The NHA states that participation in this digital ecosystem of ABDM is entirely voluntary (Government of India, 2025a :110). Pilot and IEC schemes have been launched to spread awareness, to encourage large-scale adoption: such as the Model ABDM Facilities (public and private) to demonstrate the ABDM, and Digital Health Incentive Scheme to incentivize and address the upfront high costs to me-

6 ABHA can be generated by self-registration at www.https://abha.abdm.gov.in or using the ABHA or any ABDM-enabled PHR App, ABDM-enabled software, or in assisted mode by visiting any health facility where such service is available. It is similar to the patient ID number allotted nowadays in big private and public hospitals at the time of initial registration, which is mandatory to access the services at such facilities. This number becomes the patient identifier for all subsequent interactions at this particular facility.

dium and small private facilities of digitalization.

Evidently, the digital architecture envisaged in ABDM entails development of different kinds of software, digital platforms and application programming interfaces for all the parties involved, and this is an ongoing process. The private sector is playing a significant role in the development and testing of this digital infrastructure, for which the ABDM provides a Sandbox facility (Government of India, 2025a:118) that allows different applications and systems to be developed and evaluated for compatibility while safeguarding real-time data.

Issues and Concerns

What emerges is that ABDM is a work-in-progress on most of its fronts, even while it is being implemented across the country. Several issues discernible at this stage are as follows, foremost being the impact on access to services.

1. Will ABHA id become mandatory for accessing government health services? The National Medical Commission, in 2024 (Government of India, 2024a), 2025 (Government of India, 2025b) and in 2026 (Government of India, 2026), made the ABHA id mandatory for registration for all those seeking medical care in the hospitals attached to medical colleges. However, the 2024 letter also said that patients without ABHA id should not be denied treatment. Yet, there are reports that in some states the ABHA id is part of out-patient registration (Sundararaman, 2024), without which treatment could be delayed or denied. Another instance of policy uncertainty is seen in the linking of the Central Government Health Services (CGHS) id with the ABHA id. In March 2024 the Ministry of Health and Family Welfare (MoHFW) made it mandatory to link the CGHS beneficiary id with the ABHA id, compelling CGHS beneficiaries to create an ABHA id (Government of India 2024b). Yet, in December 2024, in reply to a Rajya Sabha question, it was told that this linking was optional (Government of India 2024c). The FAQs on the CGHS portal of the MoHFW (Ministry of Health and Family Welfare, n.d) also says ABHA is not required for availing CGHS services and that it is an extra benefit, that re-imbursement claims are not linked to ABHA idand that the functionality for the linking of ABHA id with CGHS is under development.

At present, on paper, the ABHA id is not necessary for Ayushman card eligibility (although the two can be linked through the ABDM platform). Years of lived experiences of people in accessing welfare schemes such as PDS rations, wages, pensions (Narayanan, 2024) or meals for children in anganwadis (Tapasya, 2022) show that, on the ground, there is a lot of exclusions or denials or delays, often leading to disastrous consequences. This raises apprehensions that similarly the ABHA id too would be made mandatory in practice in the coming years, to access PMJAY or even healthcare services in general, i.e., those (population and ailments) that fall outside the government insurance schemes[7]. This apprehension and mistrust gains further ground from the fact that it is the same agency, the National Health Authority, that is also implementing the AB-PMJAY and has facilitated the development of specific IT platforms and applications for this purpose (Government of India, 2025a: 18). And the ultimate objective of National Health Authority is to integrate multiple health insurance and assurance schemes onto its advanced IT platform (Government of India, 2025a: 162).

2. Regarding the emphasis on unique patient ID, digital records and interoperability, it has been pointed out that:

> It is not lack of patient identification and patient records that are barriers to good care; rather the problems with access and continuity of care lie in the organisation of services and simply lack of services. There is a lack of proper protocols and pathways for transfer or referral of patients from the primary to higher level facilities. Given the inadequacies of the peripheral health services, many patients bypass these pathways

7 While ABHA is optional now, to get the ABHA id the AADHAR is required. To get the Ayushman card too, the AADHAR is required. So, not having the AADHAR means you don't get them if you wish to. Without the Ayushman card one will not get the medical care as per their eligibility, meaning without an AADHAR card one will not get medical care too. If the ABHA is also made mandatory, then even with the Ayushman card medical care could be denied. In fact, the very recent developments over the Special Intensive Revision (SIR) for electoral rolls and the announcement in some states to deny citizenship and welfare benefits such as ration etc to those deleted from the electoral list, raises newer concerns regarding access to welfare rights (Dasgupta 2026)

> and directly approach the tertiary level. Particularly in the case of those with conditions which are stigmatised, such as AIDS, such patients prefer anonymity and actually use different names to avoid being identified locally. (Sundararaman, 2024: n.p).

Similar observations have been raised by the Indian Medical Association (IMA), namely, people have a limited set of records (Indian Medical Association, 2020); and furthermore, the requirements of portability are small (Balachandran, 2020).

3. While ABHA adoption and user experiences, including those of the providers and facilities, remain an under-studied topic, the few studies there are, indicate financial and other barriers in its adoption among individuals: such as lack of mobile phone, lack of Aadhaar, costly internet data plans, difficulties in language and in using digital health apps, poor/no internet access, electricity issues, privacy and security concerns (Ranjan et al., 2026; Toppo et al., 2025). So, digital inequalities, including limited digital literacy, could become another set of barriers in accessing healthcare, along with pre-existing financial precarity.

4. The number of active internet users in India has increased since 2019 to around 90 crores, with the rural-urban and gender gaps also reducing (KANTAR and IAMAI, 2024). Much of this internet activity is for communication-entertainment-social media, and e-commerce. Notwithstanding this large mobile and internet access and usage, it cannot be assumed that users will be able to use all the digital tools. For those who do not have the skills and access, mandating use of digital tools to seek medical services can increase their reliance on others to assist them, making them vulnerable to fraud and manipulation. It can also increase the disparities between those who have skills and access to digital tools and those who do not, thereby increase existing health disparities. In such a situation digital access and skills could well become another social determinant of health, shaping access to other social determinants of health, including access to hospital services. Along with the availability of digital infrastructure, digital preparedness of individuals, of healthcare workers and health facilities needs further research.

Hence, systematic documentation and empirical studies are required in different parts of the country to track the developments in the coming years regarding ABHA requirements, its utilisation, and its impact on access to all kinds of medical services, public and private, including access to the respective publicly funded health insurance. Other implementation and governance aspects are also important and need examination: as financial allocations and expenditures on ABDM; transparency; the role, accountability and regulation of the private parties in creating the digital infrastructure for Ayushman Bharat DM.

Concluding Remarks - Beyond the obvious

The continuing fascination with technology as a panacea for issues identified as problems in health and health systems, and the imperative to deploy digital technology (Hofmann, 2002), through private players, is a running theme in the dominant ABDM discourse. While not obviously stated or acknowledged, such uncritical reliance on technology is nevertheless discernible and shapes policy. There is a singular pre-occupation with generating and distributing health data of individuals in a particular format. . Not only is there little to no attempt to evaluate: why doctors are not available even now for telemedicine, or the status and utilization of data available in the existing Health Monitoring and Information Systems databases; or of the question of access to the means to use these digital platforms. What continues to remain missing is the lessons for public health that have accumulated over the past century, of what are the factors that have led to improvements in health, to falling mortality levels, to improvements in healthcare services (Birn 2005). In short – the current approach continues with the 'narrowly conceived understanding of health as the product of technical interventions divorced from economic, social, and political context' (Birn, 2005: 2).

This pre-occupation and approach end up circumscribing the discourse on the ABDM and obscuring aspects shaping the genesis of this type of 'digital health', such as the neo-liberal societal context of healthcare today in which such schemes are embedded; the excitement over big data mining in healthcare (Chakravarthi, 2024); what counts as health data and 'datafication of health' (Rad-

hakrishnan, 2021), monetization of data and information flows; significant involvement of big private, commercial actors and global corporations in inventing digital applications; how such political economy factors are shaping the deployment of digital technologies in health, have shaped the genesis of schemes such as Digital India, ABDM, of applications such as the Unified Health Interface.

The question is, will more such technology and more data mean improved access and improved healthcare, and better health? The 2012 United Nations (UN) report on the opportunities and challenges of using big data for development states,

> It is important to recognise that Big Data and real-time analytics are no modern panacea for age-old development challenges. That said, the diffusion of data science to the realm of international development nevertheless constitutes a genuine opportunity to bring powerful new tools to the fight agsinst poverty, hunger and disease. (United Nations Global Pulse, 2012:4)
>
> Application of these approaches to development raises great expectations, as well as questions and concerns, chief of which is the analytical value – and thus ultimately the policy relevance of big data to address development challenges (United Nations Global Pulse, 2012:6 & 7).

There is thus a need to discuss and debate more widely the current uncritical acceptance and trust of technology in general, of digital technologies and their role in medicine and health in particular.

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With a friend over some tea

"Don't bring politics to health care, bondhu," you tell me,
Smiling benevolently- and you are probably right.
Politics doesn't reach the rarefied air of Delhi's
air-conditioned cabins, bondhu,
And we have probably all forgotten how
The road leading to my health centre cannot be used by
everyone, bondhu,
And the water in the village's tubewells runs brown more
often than not.
The ASHA didi gets no network here, to log her home
visits,
But our policies don't care, bondhu, and tell us she wasn't
there at all.
Outside your well-regulated life, bondhu, migrants strug-
gle
At the edges of the capital to make ends meet.
Their faces never reach your office in Lutyens, bondhu,
Even as their sweltering bodies pave your streets.
The akhbaar tells me we are doing well, bondhu,
While the ribs on children's chests grow sharper.
Tell me what you want to hear, we'll say it;
But bondhu, don't teach me about politics in health care.
It was waiting for me when I got here
It will outlast the last of our bones.

Radhikaa Sharma,
Public health physician

Public hospitals and public insurance

Distorting health care provision

Rajalakshmi RamPrakash

Keywords: PMJAY, health insurance, public health system, Tamil Nadu

Introduction

One of the major criticisms against Publicly Funded Health Insurance Schemes (PFHIS) such as the Pradhan Mantri Jan Arogya Yojana (PMJAY) that has been fore fronted for a long time, is that they disproportionately benefit the private sector depriving the public sector of resources. In this article, based on my doctoral research in Tamil Nadu (RamPrakash, 2018), and ongoing research on PFHIS, I argue that an increased share of public sector utilization of PFHIS is not necessarily an indicator for celebration. On the contrary, it may signal a retrogression of entitlements to healthcare as it introduces perverse incentives, ethical dilemmas, discrimination and denial of healthcare and a slippery slope of dismantling of public health architecture on which, the poorest of poor and the systematically excluded heavily depend on.

Increase in public share under PMJAY

There is no reliable single source to capture trends in public-private claims from PMJAY since its inception. A reduced share in utilization of PMJAY benefits by public hospitals has been acknowledged as a concern by the Government and policy analysts, researchers and activists alike. Studies have noted that during the early periods of PMJAY, around 63% of volume of claims were from private hospitals with 75% share in claim value, despite private hospitals being only 56% of all empanelled hospitals (Dubey et al. 2023). Some of the solutions to address this gap has been to increase the empanelled public hospitals, actively 'identify' patients coming to public hospitals who have insurance cards and cover their treatment under PMJAY (provided it fits into the pre-approved list of packages), which will increase both the number and value of claims from public sector. There are currently initiatives by National Health Authority (NHA) such as Beneficiary Facilitation Agencies (BFA) for "strengthening public health facilities and bringing them at par with private hospitals" (National Health Authority Annual Report, 2024, :97-99). According to NHA Annual report 2024-25, private hospitals cater to approximately 55% of the total hospital admissions by count (an increase compared to early years of PMJAY) though their share among empanelled hospitals remains at 45% (NHA Annual report ,2024: 86).

In Tamil Nadu, efforts to improve public share in state's PFHIS[1] has been ongoing even before the merger with PMJAY in 2018. Public hospital share increased from 30.8% in 2012-13 to 37.4% in 2015-16 (Karan et al. 2017). During 2022-23, out of the total claims of Rs 1,152 crores, 48% (around Rs 554 crores) was paid to government hospitals. This claim amount was among the highest earned by public hospitals in India, resulting in Tamil Nadu bagging the Best Practices Award for 'effective utilisation of government funds' by the Government of India (The Hindu Bureau, 2023a).

A mirage of 'benefits' through PMJAY in public hospitals

The introduction of PFHIS in public hospitals is believed to be beneficial to not only increase utilization through public facilities but also bring in a 'supplementary financing route' (Prinja et al. 2022). PFHIS through its packages, allows the medical team in public hospitals to purchase consumables such as implants, stents, artificial limbs, etc. which were until then unthinkable through the regular mechanisms of financing. About 72% of the claims amount is credited to the institution's account, with a share of 15% to the doctors and their team, 40% to consumables and 17% to hospital upgradation funds. It is true that the additional development fund generated through PFHIS claims allows freedom and flexibility to utilize the funds, without having to wait for budget line approvals. However, this has gradually created a reduction in budget allocation, over-reliance on

1 In Tamil Nadu, until 2012, the PFHIS was called Kalaignar Scheme, from 2012 to 2018 it was called Chief Minister's Comprehensive Health Insurance Scheme-CMCHIS, and from 2018, it is known as PMJAY-CHMIS

revenue generated through insurance claims, and a change in purchasing mechanisms. For instance, in Tamil Nadu, the acclaimed Tamil Nadu Medical Services Corporation (TNMSC) used to supply medicines and other consumables to public hospitals but after the entry of CMCHIS-PMJAY, this has reduced as hospitals can directly procure them (Josephine, 2025). With lower utilization of line-item budgets every year, this is likely to reduce subsequent allocations from the treasury making hospitals dependent on insurance generated revenue for their next year's operations. However, there has been little independent research to evaluate the impact of such financing from the providers, hospital administration, and patient's perspectives.

Evidence from my doctoral study (RamPrakash, 2018) as well as recent research show how this form of financing has created more harm than benefit for hospitals, providers and more importantly for poor patients and their families' seeking treatment in public health hospitals, as explained in the following section .

Resurgence of 'targets' for healthcare providers

As early as 2015, Government hospital doctors interviewed during my doctoral study talked about 'targets' to achieve in admitting patients covered under PFHIS with diseases covered under the approved packages to generate revenue for their departments as well as for the hospital. This pressurised the doctors to generate money through the scheme and forced them to act like 'agents with admitted patients.' (Josephine, 2025)

Doctors also reported facing several challenges. PFHIS is designed to cover high end procedures. Because of this, hospitals not equipped with necessary infrastructure and specialists, such as the district hospitals and departments such as dermatology that usually do not perform tertiary level procedures, found themselves unable to meet the targets and were perceived as 'low performing' units.

> It is okay [to raise revenue through the CMCHIS] for the teaching [medical college] hospitals but here [secondary- level public hospital], we don't have specialists. Only Dr. K, an orthopedic, is here. (Administrator of a District Public Hospital, Tamil Nadu). (RamPrakash and Lingam 2021:12)

Not only does the market-based health insurance model pit public hospitals against private, it also introduces competition among different types of public hospitals and departments within them to maximise revenues or 'profits'.

Providers reported that they were being pulled up during performance review meetings for not generating adequate revenues. In 2023, the TN Government Doctors Association (TNGDA) came out openly on these imposed insurance 'targets' and threats of transfers and punishments if they were not met (The Hindu Bureau : 2023b) Healthcare providers also felt that lot of unnecessary time and efforts had to be spent on administrative processes related to insurance claims which should be devoted to patient care and upskilling.

Given the pressure and incentivisation, it may be possible that public providers like their private counterparts are also indulging in provider-induced utilisation within public hospitals. This was pointed out by a Third-Party Administrator while referring to the unusually higher number of claims from neonatology for the period 2013-15 (Karan et al., 2017). Similarly, a high number of hysterectomies were noted in the claims data in my study, raising concerns of whether they were all necessary and appropriate (RamPrakash 2018).

These patterns of policy induced pressures and provider behaviour bring chilling memories of the impact of family planning targets in Tamil Nadu where providers had to 'motivate' women to 'accept' sterilisation and IUDs violating voluntary and informed decision making, a practice that continued for a considerable time (Rajalakshmi, 2007; Van Hollen, 1998).

Denials and Discriminations

The requirement on public providers to increase revenue through insurance route results in (i) prioritizing patients who are already insured and have the card (ii) selecting patients whose diseases allow treatments neatly included under covered packages (iii) forcing patients who do not have the card to enroll themselves in the scheme causing (iv) delays in starting the treatment until card is procured (v) denial of treatment when they don't match covered packages (vi) providing unnecessary treatment to increase insurance

claims. Provider-induced moral hazards which are usually associated with health insurance in private sector have thus found inroads through PMJAY in public insurance and public hospitals.

The case of Nancy[2], a 45-year-old single woman reveals the irony of the same public health system which encouraged her to seek screening for cancer, letting her down later because of the skewed priorities introduced by health insurance.

> Nancy, after watching a breast cancer awareness program in nearby school, went to a government teaching hospital in Chennai for a painful cyst in her breast. Doctors screened her and said it was non-cancerous, and that though she had the CMCHIS card, she could not use it (PMJAY covers only malignancy) and sent her away. As the pain became unbearable and interfered with her tailoring work, she made repeated visits requesting removal of the cyst but was turned away every time. Once, a resident doctor took pity on her and admitted her. However, "there was another senior doctor, who came and said, if we do (surgery) for such small ones, it will not count (for CMCHIS) and scolded the other doctor (who had agreed for surgery) and said 'send her away' ". Nancy was discharged without being operated upon and before leaving the hospital, she had to plead for pain medications. Only a few months later, after some persistence, was she admitted and the cyst finally removed.

Thus, poor patients, who already delay seeking treatment, are turned away, made to run around, they and their families undergo severe stress, foregoing wages, and spend out of pocket for the sole purpose of 'improving public share of claims' in PFHIS (RamPrakash and Lingam, 2021).

> They had to do heart surgery for me. They said go and get the card. My son went once or twice but he couldn't get [card] …. Then I went there [to the district kiosk] ... even though I was unwell.... Then luckily that day, one officer noticed me. I was feeling breathless ... then he asked for what I have come. I told him that the doctor told me to get the CMCHIS card. He immediately told the staff there … so I got it done. (Patient, Tamil Nadu) (RamPrakash and Lingam 2021:13)
> Why are they asking in the Government hospital? All these days they didn't ask for the card, right? From the time this card was given, they are asking it for everything. Suppose the card is not there at all? Will they wait till life goes out? How can they do like this? (Patient, Tamil Nadu) (RamPrakash 2021:191).

A doctor at a District Hospital in Tamil Nadu had this to say about some patients' reluctance to use their card:

> We try to "counsel" them ... "convince" them.... Sometimes we say then only this hospital will get some funds to repair some machine and improve something … that treatment will get delayed otherwise. Sometimes this will change their mind, and they will agree [to use their card]. (RamPrakash 2018: 192)

During my doctoral study, I also met a few patients who had undergone treatment in public hospitals and were completely unaware that their treatment was covered by insurance. Once their surgery was planned, they were simply asked to produce a copy of their ration card at the hospital. They did not know that the hospital traced their CMCHIS-PMJAY's policy details using the ration card and linked their treatment to the scheme. All the cases discussed above show that having an insurance card hardly provided a 'choice' to the poor patients. In fact, the entire 'utilisation' journey was marred by little or no information and patient involvement, raising the question of who does the scheme actually benefit.

Concluding remarks

PFHIS such as the PMJAY, founded on market-based insurance principles, cannot be an effective or equitable health financing model for a country like India, where healthcare, whether in public or private, is unregulated and a large section of beneficiaries lack literacy and negotiating power. This model of health insurance is fundamentally opposed to patient rights, medical ethics and social justice, diverting resources that should be used to strengthen primary health care instead of cover-

2 Pseudonym

ing disease packages. For long, even activists with best intentions have questioned why in PMJAY the share of public hospitals is lower than that in the private? Through this article I have argued that the real question to ask is - 'does a higher share of public hospitals in PMJAY is what we want for our patients?' and more importantly, "do we need a publicly funded health insurance scheme for India?'

About the Author

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In honour of the Manjhi tribes who cannot access Ayushman Bharat because their finger prints are too worn out, or are away collecting Mahua at the time of registration; Illustration by Gayatri

Expansion Without Protection
A Critical Examination of the Employees' State Insurance Corporation

Jagdish Patel

Keywords: ESIC, social insurance, working class, labor, occupational health

Introduction

The Employees' State Insurance Corporation (ESIC), established under the Employees' State Insurance Act, 1948, was envisioned as a cornerstone of social security for India's industrial workforce. Designed to provide medical care and cash benefits during sickness, maternity, disablement, and death, it remains one of the most ambitious contributory welfare systems in the developing world. Over time, its coverage was extended beyond factories to shops, cinemas, and other establishments. In recent years, ESIC has increasingly projected itself as a success story. Annual reports highlight growing numbers of registered employers, insured persons (IPs), and contribution collections. Contribution rates have also been reduced, making compliance more attractive to employers. These indicators are frequently presented as evidence of institutional efficiency and expanding social security coverage.

Yet the central question is not whether ESIC is expanding, but whether expansion has translated into effective social protection. Registration does not necessarily imply actual access to healthcare, continuity of benefits, or meaningful protection against illness and occupational disease. This article argues that while ESIC has achieved impressive numerical growth and improvements in healthcare delivery, benefit realisation, and occupational health protection have not kept pace. The result is a widening gap between formal coverage and substantive welfare.

Expansion Without Coverage

Despite mandatory coverage provisions, a substantial proportion of eligible workers remain outside the scheme because of weak enforcement and under-compliance. According to the ESIC Annual Report 2024–25, approximately 3.24 crore employees and 24.8 lakh employers are registered under the scheme. However, ESIC does not publish the total number of establishments that ought to be covered or the total number of eligible workers employed in such establishments. Without this denominator, the true compliance gap remains invisible.

Independent studies suggest that this gap is substantial. Sakthivel et al., (2020), in a study commissioned by the International Labour Organization, estimated that around 13 million workers who met eligibility conditions were not receiving ESI benefits. Field-based studies by the People's Training and Research Centre in Gujarat point to similar patterns.

Studies conducted in Thangadh in 2015 and Morbi in 2025 found that more than 90 percent of workers employed in eligible establishments located in notified areas were not covered under ESI despite meeting statutory conditions. While these findings relate to specific industrial clusters, they raise serious concerns regarding compliance and enforcement elsewhere in the country.

A conservative triangulation using labour force data suggests that while around 3.3 crore workers are presently covered, the number of workers meeting eligibility conditions may be between 5 and 7 crores. This implies that approximately 2–4 crore workers remain outside the scheme. When contract labour, under-reporting, and administrative exclusions are taken into account, the effective coverage gap may be considerably larger.

The distinction between registration and actual coverage is therefore critical. Numerical expansion alone cannot be taken as evidence of social protection.

Expansion Without Access

Even among workers formally covered by ESIC, access to healthcare remains uneven and often inadequate.

Healthcare delivery under ESIC depends largely on a network of dispensaries and hospitals. While the number of dispensaries may appear broadly consistent with norms pre-

scribed in the ESI Medical Manual, such aggregate figures conceal important deficiencies.

Medical services are delivered by State Governments, while financing and policy authority remain with ESIC. This division creates fragmented accountability. Responsibility for poor service can be shifted between State Governments, ESIC, and the Central Government, leaving insured workers with little effective recourse. Many dispensaries continue to suffer from staff shortages, inadequate infrastructure, limited diagnostic facilities, and restricted working hours. Consequently, the mere existence of a facility does not guarantee effective access to care. The problem is particularly acute for migrant workers. While workers are registered at their place of employment, their families often remain in their native districts or states. Although the ESI Act provides for portability of benefits, implementation remains weak. Administrative hurdles, lack of awareness, delays in documentation, and poor coordination between states frequently prevent dependents from accessing healthcare.

A similar problem affects workers employed in urban industrial centres but residing in surrounding rural and peri-urban areas. Although formally covered, they often live far from ESI facilities. Long travel distances, wage losses associated with seeking care, and administrative rigidities discourage utilisation. Consequently, many workers remain nominally insured but effectively excluded from medical benefits.

Expansion Without Infrastructure: A Case Study of Vadodara

The experience of Vadodara district illustrates the mismatch between expansion of coverage and expansion of healthcare infrastructure.

Prior to 2019, only parts of Vadodara district were covered under the ESI Act. From 1 April 2019, coverage was extended to the entire district, bringing several industrial areas—including Padra, Jambusar, Savli-Manjusar, and Karjan—within the scheme. In 2024, the author filed a Public Interest Litigation (No. 55 of 2024) before the Gujarat High Court seeking the establishment of dispensaries in newly covered areas. Information obtained through the Right to Information Act revealed the trends in Table 1.

While employers, insured persons, and contributions increased substantially, the number of dispensaries declined by half. The data reveals a pattern in which expansion of enrolment has not been accompanied by corresponding expansion of healthcare infrastructure.

Whether similar trends exist elsewhere remains difficult to assess because ESIC does not routinely publish data linking newly covered populations with corresponding investments in healthcare facilities.

Expansion Without Utilisation

Limited access is reflected in low utilisation of services. According to ESIC Annual Reports, the incidence of "new cases" attending outpatient departments was reported as 507 per 1,000 insured persons in 2021–22 and 546 per 1,000 in 2022–23.

Table 1:
Changes in ESI Resources in Vadodara District (2017–2022)

Item	2017	2022	Change
Employers	1,158	2,921	+142%
Insured Persons	2,71,000	4,98,000	+65%
Contributions Collected	Rs 158.69 crore	Rs 190.75 crore	+20%
Dispensaries	18	9	-50%

Even assuming that each new case represents a unique individual—which almost certainly overestimates utilisation—only about half of insured persons appear to have visited ESIC facilities during a year. In reality, the same individual may generate multiple "new cases" through repeated illness episodes. ESIC reports disease episodes rather than unique users.

Low utilisation may therefore indicate not exceptional health among insured workers but barriers to accessing services.

Expansion Without Protection

Sickness Benefits: Efficiency or Exclusion?

Sickness benefit is one of the core protections offered under the ESI scheme. Yet expenditure on sickness benefits remains strikingly low.

Workers frequently report difficulties in obtaining medical certification, securing adequate periods of certified leave, and navigating administrative procedures. Informal pressures may also exist to minimise certification periods and restrict claims. Coverage itself is often unstable. Many workers move in and out of eligibility because of employment insecurity, contractual employment arrangements, and fluctuations around the wage ceiling. Such interruptions weaken continuity of protection.

If reduced expenditure on sickness benefits is presented as evidence of efficiency, this reflects a troubling shift in institutional priorities. A social security system should not measure success by how little it pays out. Lower expenditure may instead signify exclusion, underutilisation, or barriers to access.

Contributions versus Benefits

The imbalance becomes particularly evident when contributions are compared with direct benefits. Even after including medical expenditure, only about 14–15 percent of annual contributions appear to return to insured persons in the form of direct benefits (Table 2). The annual medical expenditure of approximately INR 3,200 per insured person covers not only workers but also their dependents, amounting to less than INR 270 per month.

The issue is therefore not simply low cash benefits but a broader pattern of limited benefit realisation despite substantial contribution collections. As a consequence, ESIC has accumulated large reserves and recurring annual surpluses. While financial stability is important, persistent surpluses in a social insurance programme may indicate unmet needs rather than efficient management.

Expansion Without Occupational Health Protection

The limitations of ESIC become even more visible in the field of occupational health. ESIC has established seven Occupational Disease Centres, including a central institute in Delhi and six regional centres. However, the Corporation publishes almost no information regarding their functioning. Annual Reports provide no separate data on expenditure, patient load, diagnostic activity, research output, or occupational disease detection.

The absence of transparency raises an important question: are these centres functioning as active institutions for diagnosis, surveillance, and prevention, or do they exist largely on paper?

The issue becomes particularly significant in relation to pneumoconiosis and other dust-related occupational diseases. ESIC Annual Reports consistently report very low rates of pneumoconiosis among insured persons and even among family members . The appearance of pneumoconiosis among family members may initially seem anomalous because it is classified as an occupational disease.

Table 2: Contribution versus Benefits under ESIC

Year	Contribution per IP (INR)	Sickness Benefit (INR)	Medical Expenditure (INR)	Total Direct Benefit (INR)	% Returned
2020–21	18,000	104	2,400	2,504	13.9%
2021–22	21,000	141	2,900	3,041	14.5%
2022–23	23,000	146	3,200	3,346	14.5%

However, such findings are plausible through para-occupational exposure pathways, including contaminated work clothing and household exposure to dust.

Rather than prompting investigation, these observations remain unexplained in official reporting. Pneumoconiosis is reduced to a statistical category without analysis, interpretation, or discussion of surveillance implications.

The data therefore suggest not the absence of occupational disease, but the absence of systematic diagnosis, surveillance, and institutional accountability.

Concluding remarks

ESIC presents a paradox. It has achieved remarkable growth in registrations, contribution collections, and institutional reach. Yet expansion has not been matched by equivalent improvements in healthcare access, benefit utilisation, or occupational health protection.

The evidence reviewed here points to persistent gaps between formal coverage and actual protection. Eligible workers remain unenrolled, insured workers face barriers in accessing care, sickness benefits remain underutilised, and occupational disease surveillance lacks transparency and accountability.

The question, therefore, is not whether ESIC is expanding—it clearly is. The real question is whether it is fulfilling its foundational purpose: protecting workers and their families from the economic and health consequences of illness and occupational risk. Until welfare outcomes become more important than numerical growth, ESIC's claims of success will remain incomplete and open to serious challenges.

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On Insurance: from Previous Bulletins

Sr. No.	Year	B NO.	TITLE	AUTHOR
1	1991	177-178	Rural Health Insurance Schemes, Sevagram (India) Experience	Ulhas Jajoo
2	1993	190-191	Why Universal Medical Insurance?	Phadke Anant
3	2000	268-269	Implications of the Insurance Regulatory and Development Authority Act for Health Insurance ...	V. R. Muraleedharan
4	2000	276-277	Towards universal health insurance: a rural perspective	Shyam Ashtekar
5	2000	276-277	Extending Health Insurance to the Poor	Anil Gumber
6	2000	276-277	Universal Access to Health Care through Social Insurance	Neha Madhiwalla
7	2000	278-279	Can Health Care Insurance Ensure Right to Health for All?	Amar Jesani
8	2000	278-279	Two Community-Based Pre-Payment Schemes in Kheda, Gujarat	M. Kent Ranson
9	2000	278-279	Reforming Health Policy For Universal Health Care	Ravi Duggal
10	2000	278-279	Community Insurance - Which Way to Go? ... Learning from SEVAGRAM	Ulhas Jajoo
11	2010	339	Making the Case for Community Health Insurance	Denny John
12	2012	352-354	Social Security Budgets in India: A Critical Assessment	Ravi Duggal
13	2012	352-354	Finances of Selected Social Health Insurance Programs	Ravi Duggal
14	2015	367-368	How Inclusive is Universalised Insurance Scheme in Chhattisgarh? Experience of Poor Urban Women ...	Sulakhsana Nandi, et al
15	2018	377-378	Social Security of Indian Workers	Amitava Guha
16	2019	380	Reengineering Social Health Insurance	Ravi Duggal

NEWS

compiled by Minal Madankar

Menstrual health part of Right to Life under Article 21: Supreme Court

The Supreme Court has declared menstrual health a fundamental right under Article 21, mandating free biodegradable sanitary pads for girl students in all schools. States and UTs must also ensure functional, gender-segregated toilets with water and soap, and establish menstrual hygiene management corners. This ruling aims to uphold the dignity and right to education for adolescent girls.

Judgement at: Menstrual Health as a Facet of Right to Life: https://www.scobserver.in/supreme-court-observer-law-reports-scolr/dr-jaya-thakur-v-government-of-india18873/. Accessed on 07 May 2026.

For a commentary read: Roy, S. (2026) 'Dignity, Equality, and Menstrual Health: A Constitutional Moment for India', *Health and Human Rights*: https://www.hhrjournal.org/2026/02/12/dignity-equality-and-menstrual-health-a-constitutional-moment-for-india/

Due to the lack of clean toilets or affordable sanitary products girls often miss a week in school every month ultimately leading to drop-outs. 23 million girls' drop out of school when they start menstruating in India and the crisis is vastly aggravated in rural areas where school infrastructure is a major challenge. This indicates that girls are paying a tax in the form of education loss to manage the biological need of their body. This defeats the purpose of free and compulsory education under RTE act. The judgement should help the girls to thrive and transform in their life with dignity and care.

No fault compensation policy for serious adverse events after covid vaccination: SC to Centre

New Delhi: The Supreme Court on Tuesday directed the Centre to frame a no-fault compensation policy for serious adverse events of covid vaccination saying the Constitution envisions the State as an active guardian of welfare and dignity and not a "distant spectator" to human suffering.

Read judgement at: Compensation for Adverse Events Following COVID-19 Vaccination - Supreme Court Observer Read more at: https://pharma.economictimes.indiatimes.com/news/policy-and-regulations/frame-no-fault-compensation-policy-for-serious-adverse-events-after-covid-vaccination-sc-to-centre/129444536

The petition was filed by the grieving parents of the children who died shortly after receiving COVID-19 vaccination during massive vaccination drive that was held in the country during COVID-19 outbreak. In this context the judgement favours the rights of the citizens of India by not isolating the suffered families to fend for themselves.

Supreme Court refuses to stay Transgender Amendment Act

The law introduced sweeping changes to the legal framework governing the recognition, rights and protection of transgender persons.

The Supreme Court on Monday sought the response of the Central government and States to petitions challenging the Constitutional validity of the Transgender Persons (Protection of Rights) Amendment Act, 2026.

Read new amendment at: Transgender Persons (Protection of Rights) Amendment Act, 2026; https://images.assettype.com/barandbench/2026-03-31/x7z6ize9/THE_TRANSGENDER_PERSONS__PROTECTION_OF_RIGHTS__AMENDMENT_ACT__2026.pdf

Read Analysis here: An Analysis Of the Transgender Persons Act And The 2026 Amendment Bill; https://www.livelaw.in/articles/legislative-metamorphosis-constitutional-guarantees-transgender-persons-act-527509

Read article on implications: 'The Work Had Just Begun' - by Karthik Madhavapeddi: https://weekly.indiaspend.com/p/the-work-had-just-begun

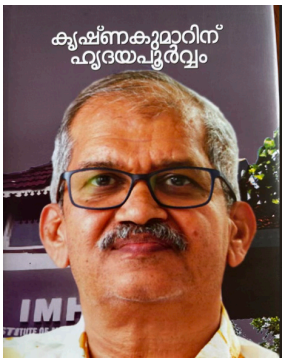
Link to original Transgender person protection of rights act 2019: https://www.indiacode.nic.in/bitstream/123456789/13091/1/a2019-40.pdf

Read analysis of the original act: Beyond the binary: Supreme Court reclaims the promise of transgender equality - Supreme Court Observer; https://www.scobserver.in/journal/beyond-the-binary-supreme-court-reclaims-the-promise-of-transgender-equality/

Comments: The amendment removes the right of a person to self-identity and dignity of their own body based on their psychological understanding, rather they have to be dependent on a so call "Biological test" certified by a medical board appointed by the government to understand their own body. However, government defends the amendment citing the problem of exploitation of welfare aids and reservations granted to the Transgender community under original 2019 Transgender act. The recent amendment will have serious impact on the psyche of the Transgender community in the country.

P. Krishnakumar: A tribute

Lasting testament of love and respect



(1961-2025)

You are 'Jeevanmashai', the rhythm of life

In the days of the moonlit road,
To be a bush, a candle
We longed for more
And how much time has passed

We have seen many dreams together
We have walked many separate paths
We have turned our teenage dreams into fire
The times of protest and drunken joy
Endless search

You turned the rhythmic breaks into a symphony
You formed 'IMHANS' with the sound of the land,
struggling with the market and varying health pathways
You are the one who knows the pulse of the sand

Jagadeesan C K

P. Krishnakumar, a crusader for mental health and the architect of the Institute of Mental Health and Neurosciences, a Centre of Excellence, had a long association with the MFC right from his student days. He credited this association for his vision on medical ethics and public health. Along with friends, he had taken the initiative to organize the 50th anniversary conference in 2024, just months before he passed away. He was a staunch advocate of public mental health and designed several programs for children with neurodevelopmental disorders, people with mental health problems, the elderly and those from tribal communities. He established the Centre for Interdisciplinary Brain Sciences, one of the few centres for neuroscience research in this part of the country. Rehabilitation of patients with mental illness was also high on his agenda. In the months following his sudden tragic death, there was an outpouring of public grief that was unprecedented. This was reflected most vividly during the solemn farewell at the Institute of Mental Health and Neurosciences, which he had established and nurtured with a single-minded determination and dedication. The idea of a memoir came up during a meeting of friends and family in the week after his passing. Slowly, the idea came to fruition through the painstaking efforts of an editorial team, most of whom are members of the MFC.

In this bilingual (Malayalam and English) memoir, entitled 'Krishnakumarinu Hridayapoorvam' ('For Krishnakumar with love'), more than a hundred contributors have shared their memories. Contributors included opinion leaders, people from literature, art, colleagues, friends,neighbors, family and parents of children he had treated. The reflections by mothers of children with neurodevelopmental disabilities who had been followed up for years, are particularly poignant. The book also includes a list of Krishnakumar's publications in indexed journals. This is a collector's item and a work of art dedicated to a most unassuming, humane, and remarkable human being who left us all too soon.

Geeta M Govindaraj

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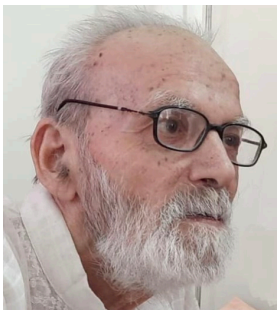
Ramesh Billorey



(1942-2026)

On 10th May 2026, Ramesh Billorey, an author, researcher, and environmental thinker associated with the Narmada Bachao Andolan, passed away. Friends, social workers, and writers paid their tributes by referring to him as a 'human repository' of the Narmada struggle, an 'intellectual nomad' and a 'true son of Narmada'. Ramesh Billorey began working on the question of the Narmada valley even before the Narmada Bachao Andolan took formal shape. He studied the social, environmental, and human impact of big dams early on, which later became an important part of the ideological base of the Narmada struggle. His book, Damming the Narmada: India's Greatest Planned Environmental Disaster, which he co-authored with another environmentalist, Claude Alvares, is considered to be one of the most important intellectual contributions to the politics of dams and the model of development it represents. Published in the year 1988, this study is counted among the earliest evidence-based critiques of the Narmada project.

Ramesh Billorey's relation to Narmada was not just ideological or limited to the movement; it was personal. He devoted his whole life to issues of displacement, resettlement, environmental justice, and people's struggles in the valley.

We have not just lost a dear friend in Ramesh Billorey, we have also lost a lively source of memories of the movement, ideological clarity, and grassroots experience. He was closely associated with Sarvodaya Press. Sarvodaya Press Family pays heartfelt tribute to Ramesh Billorey.

Source: https://www.spsmedia.in/senior-colleague-ramesh-billore-passes-away/

(Translated by Mohit P. Gandhi)