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Research Paper

National Health Policy Scheme (Ayushman Bharat) – An analysis

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ABSTRACT: *Ayushman Bharat, the National Health Policy Scheme, is a transformative initiative launched by the Government of India to address the long-standing challenges in healthcare accessibility and affordability. Encompassing two key components - the Health and Wellness Centers (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY) - Ayushman Bharat aims to provide comprehensive healthcare coverage to vulnerable populations across the country. The Health and Wellness Centers serve as the cornerstone of preventive and primary healthcare delivery, offering a range of essential services including maternal and child health, non-communicable disease management, and health promotion activities. By strengthening the primary healthcare infrastructure and expanding the scope of services, Ayushman Bharat aims to shift the focus towards preventive care and early intervention, thus reducing the burden on secondary and tertiary care facilities. The Pradhan Mantri Jan Arogya Yojana, often referred to as Ayushman Bharat - PM-JAY, is the world's largest government-funded healthcare insurance scheme. Designed to provide financial protection to over 500 million beneficiaries, PM-JAY offers cashless coverage for secondary and tertiary hospitalization expenses up to INR 5 lakh per family per year. The scheme covers a wide range of medical and surgical treatments, including pre-existing conditions, ensuring that no family is pushed into poverty due to healthcare costs. Through Ayushman Bharat, the Government of India aims to achieve the vision of Universal Health Coverage (UHC), ensuring that every citizen has access to quality healthcare services without facing financial hardship. By leveraging technology, promoting public-private partnerships, and prioritizing equity and inclusivity, Ayushman Bharat represents a significant step towards building a healthier and more prosperous India.*

Keywords: *Ayushman Bharat, Health financing, Health Insurance, Jan Arogya Yojana, Universal Health Coverage*

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I. INTRODUCTION

India, with a population of 1.3 billion, is a developing nation where 70% reside in rural areas and 30% in urban centers. Currently, India is undergoing an epidemiological health transition, facing a dual challenge of communicable and non-communicable diseases, posing significant threats to both health and economic stability. This transition stems from demographic shifts, globalization, urbanization, and changes in social and economic determinants of health. Ayushman Bharat, the National Health Policy Scheme, stands as a landmark initiative of the Government of India aimed at revolutionizing healthcare delivery and accessibility across the nation. Launched in September 2018, the Ayushman Bharat for a new India 2022 was announced which included two major initiatives, namely creation of health and wellness centers (HWCs) and an ambitious National Health Protection Scheme (NHPS).

Ayushman Bharat represents a comprehensive approach to address the longstanding challenges plaguing India's healthcare system, particularly in terms of affordability and inclusivity. Comprising two flagship components, the Health and Wellness Centers (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PM-JAY), Ayushman Bharat embodies the government's commitment to ensure universal health coverage for all citizens, especially those from marginalized and economically disadvantaged backgrounds.The Health and Wellness Centers serve as the foundation of Ayushman Bharat, redefining the concept of primary healthcare by providing a wide array of essential services closer to the community. These centers aim to promote preventive

healthcare measures, early detection of diseases, and timely intervention, thus reducing the burden on secondary and tertiary care facilities while improving overall health outcomes.

The Pradhan Mantri Jan Arogya Yojana, on the other hand, is hailed as the world's largest government-funded healthcare insurance scheme, offering financial protection to millions of vulnerable families across the country. Under PM-JAY, eligible beneficiaries gain access to cashless treatment for a range of secondary and tertiary care services, ensuring that healthcare expenses do not push families into poverty.

Ayushman Bharat represents a paradigm shift in India's healthcare landscape, emphasizing the principles of equity, affordability, and quality in healthcare delivery. By leveraging technology, strengthening infrastructure, and fostering collaboration between public and private sectors, the scheme aims to realize the vision of Universal Health Coverage (UHC), where every citizen can access essential healthcare services without facing financial hardship.

The lack of access to and poor quality of medical treatment lead to numerous fatalities in India. Healthcare expenses are escalating, particularly in rural areas and smaller urban towns, with annual health-related expenditures ranging from a few hundred rupees to as high as 10 lakh rupees. Additionally, individuals in these regions must often travel long distances to access comprehensive healthcare services. As India strides towards building a healthier and more prosperous society, Ayushman Bharat emerges as a beacon of hope, promising a brighter and healthier future for millions across the nation.

II. HEALTH AND WELLNESS CENTERS

A comprehensive overhaul of primary healthcare delivery is underway with the transformation of sub centers (SCs) into Health and Wellness Centers (HWCs), operating at the grassroots level. The focus has expanded beyond mere prevention to encompass promotion, cure, and palliative care. The upgraded HWCs will boast state-of-the-art facilities, including point-of-care services, dedicated wellness rooms for activities like yoga and physiotherapy, private consultation spaces, free diagnostics, pharmacies, telemedicine capabilities, and spacious waiting areas accommodating over 30 individuals.

The ambit of services offered at HWCs is extensive, covering a spectrum of healthcare needs such as common ophthalmic and ENT ailments, oral health, mental health disorders, geriatric and palliative care, emergency medical services, management of both communicable and non-communicable diseases, and general outpatient care. Furthermore, reproductive, maternal, neonatal, child, and adolescent health services are also integral components. Importantly, the creation of electronic health records, supported by a robust IT infrastructure, is a pivotal aspect of the initiative.

While the existing sub centers are typically staffed by one male and one female health worker, the HWCs will necessitate additional dedicated medical and paramedical staff, necessitating a reorientation of staffing and infrastructure. It's implicit that these HWCs will continue to fulfill their roles in all national health programs, including interventions for malnutrition correction and vaccination drives. Launched by the Honorable Prime Minister on April 14, 2018, in Odisha, this scheme endeavors to elevate all sub centers across the nation to the standard of Health and Wellness Centers, marking a significant stride towards enhancing primary healthcare accessibility and quality across India.

III. AYUSHMAN BHARAT NATIONAL HEALTH PROTECTION SCHEME

This centrally sponsored flagship scheme endeavors to offer an annual health cover of up to Rs. 5 lakh to approximately 10 crore vulnerable families, which translates to around 50 crore individuals, constituting approximately 40% of the country's population. Eligibility is determined based on the Socio Economic and Caste Census database. Under this scheme, beneficiaries will have access to cashless coverage for identified secondary and tertiary treatments, available in both public and empanelled private healthcare facilities, with no restrictions on family size or age. All preexisting conditions will be covered from the inception of the policy. Additionally, the benefits will encompass pre- and post-hospitalization expenses, as well as a transport allowance.

In the current year, the implementation of this scheme has commenced with a robust demand generation campaign. This initiative involves extensive health education drives, community mobilization efforts, and the systematic identification and collection of beneficiary information through Gram Sabhas. April 30 has been designated as Ayushman Bharat Divas, wherein rural beneficiaries will not only be briefed about the scheme but also have their data recorded, including mobile numbers, ration card details, and changes in family status. Each eligible beneficiary will be linked with a Health and Wellness Center (HWC) to ensure equitable access to scheme benefits for all.

The National Health Protection Scheme (NHPS) will absorb existing centrally sponsored schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) and the Senior Citizen Health Insurance Scheme. Popularly known as Modicare, this scheme is poised to become the largest state-funded health insurance initiative, marking a significant leap towards Universal Health Coverage (UHC). By reducing out-of-pocket expenditures

(OOPE) and shielding approximately 40% of the vulnerable population from catastrophic healthcare expenses, Modicare holds immense potential to transform healthcare accessibility and affordability nationwide.

IV. MEASURE OF POVERTY ALLEVIATION

In India, the burden of medical expenses weighs heavily on households, with the average annual total medical expenditure standing at approximately Rs. 9,373, as per the India Consumer Economy 360 Survey. Household expenditure on health varies across different settings, with urban households in towns with populations under one million spending an average of Rs. 13,198 annually, while households in metropolitan areas spend Rs. 11,387. Conversely, households in underdeveloped rural areas incur lower medical expenses, averaging Rs. 6,371 annually.

Financial constraints prevent approximately 30% of the rural population from accessing necessary medical treatment. Moreover, hospital admissions, whether in rural or urban areas, often lead to families resorting to loans or selling assets to cover expenses. The WHO's India Health Profile Report of 2014 highlighted the dire consequences of high out-of-pocket (OOP) expenditure, with an estimated 3.2% of Indians falling below the poverty line annually due to healthcare expenses. Additionally, the report revealed that three-quarters of Indians exhaust their entire income on healthcare and medication purchases.

The Insurance Regulatory and Development Authority (IRDA) reported in 2017 that a staggering 76% of the population lacked health insurance coverage, exacerbating the financial strain on families and resulting in high rates of out-of-pocket (OOP) expenditure on healthcare. In response to these challenges, the Government of India introduced the Ayushman Bharat Yojana- National Health Protection Scheme (AB-NHPM) in 2018. This ambitious scheme aims to provide financial protection to households across all states and union territories, covering all districts in the country.

The World Bank's 2004 report highlighted that 4.128814% of the population was pushed below the $1.90 ($2011 PPP) poverty line due to out-of-pocket healthcare expenditure. This proportion decreased to 3.620288% in 2009 following the launch of the Rashtriya Swasthya Bima Yojana (RSBY) on April 1, 2008. However, due to policy paralysis, there was a resurgence in 2011, with the proportion of the population pushed below the poverty line by out-of-pocket healthcare expenditure rising to 4.164312%.

This scenario underscores the potential of innovative policies, with necessary adjustments, to address the issue. By reforming existing policies or introducing new ones, the government can significantly reduce this ratio and make progress towards meeting sustainable development goals. Providing health insurance to individuals can be a game-changer in this regard. With access to health insurance, individuals can seek medical assistance without bearing the entire financial burden themselves, thereby reducing their out-of-pocket expenditure on healthcare and lifting them out of poverty.

Through such initiatives, the government can empower individuals economically and enhance their overall well-being, aligning with the broader objectives of sustainable development. The World Bank's focus on health equity and financial protection is articulated in its 2007 Health, Nutrition, and Population Strategy. Within this strategy, "preventing poverty due to illness (by improving financial protection)" stands as one of the four strategic objectives. The Bank's health team, through its analytical work and regional operations, is dedicated to tackling vulnerability stemming from health shocks. This commitment underscores the recognition of the profound impact that health crises can have on individuals and communities, often pushing them into poverty. By enhancing financial protection mechanisms, the World Bank aims to mitigate the economic repercussions of illness, ensuring that individuals are not forced into poverty due to healthcare expenses.

Through rigorous analysis and targeted interventions, the Bank seeks to strengthen health systems and promote policies that shield vulnerable populations from the financial burden of illness. By addressing these challenges, the World Bank endeavors to promote health equity and contribute to broader efforts aimed at poverty reduction and sustainable development. The World Bank's strategy underscores the significance of equity in health outcomes as a second strategic objective, aiming to "improve the level and distribution of key health, nutrition, and population outcomes, particularly for the poor and the vulnerable."

To achieve this objective, the Bank collaborates with governments to implement a range of policies and programs designed to reduce disparities in health outcomes and enhance financial protection. These initiatives typically involve the establishment of mechanisms that address various barriers to accessing care, including geographic, social, and psychological obstacles. Additionally, efforts are made to alleviate the financial burden of healthcare expenses, particularly out-of-pocket costs for treatment. By supporting governments in implementing these interventions, the World Bank aims to promote equitable access to healthcare services and improve health outcomes, particularly for marginalized and vulnerable populations. This approach aligns with the broader goal of reducing health inequalities and advancing the well-being of all individuals within society. Examples include:

- Reducing the direct cost of care at the point of service, e.g. through reducing/abolishing user fees for the poor or expanding health insurance to the poor (including coverage, depth and breadth). AB thus is doing so

by providing the health insurance to the economically weaker families of upto rs. 5 lacs per family of 5 members

- Increasing efficiency of care to reduce total consumption of care, e.g. by limiting "irrational drug prescribing," strengthening the referral system, or improving the quality of providers (especially at the lower level). This is taken up by AB by providing and creating Sub-Centers(SC), Primary Health Centers(PHC) and Community Health Centers(CHC).
- Reducing inequalities in determinants of health status or health care utilization, such as reducing distance (through providing services closer to the poor), subsidizing travel costs, targeted health promotion, conditional cash transfers.
- Expanding access to care by using the private sector or public-private partnerships.

The World Bank's health team actively promotes the monitoring of equity and financial protection by disseminating global statistics on disparities in health status, access to care, and financial protection. These statistics serve as valuable tools for policymakers, government officials, and researchers in understanding and addressing inequalities in healthcare.

Furthermore, the Bank's health team provides training sessions for government officials, policymakers, and researchers on how to effectively measure and monitor these indicators of equity and financial protection. By equipping stakeholders with the necessary skills and knowledge, the Bank empowers them to identify areas of concern, track progress, and design targeted interventions to improve health outcomes and ensure financial security for all segments of the population. Through these efforts, the World Bank contributes to building capacity and fostering a culture of data-driven decision-making, ultimately advancing the goal of achieving equitable access to healthcare and protecting individuals from the financial burden of illness.

Table-1. Out of Pocket Expenditure on Healthcare by Providers (2013-2014)

Providers	%
Pharmaceuticals	51.67
General Hospitals-Private	22.21
Medical and Diagnostic Laboratories	9.61
Provider of Patient Transportation Emergency Rescue	6.24
Private Clinics	4.93
Government General Hospitals	2.82
Others	2.52

The objectives of the AB-NHPM align closely with those of the Rashtriya Swasthya Bima Yojana (RSBY) scheme, which provided Rs 30,000 in health insurance coverage per family annually for secondary and tertiary hospitalization. However, in its nearly nine-year existence, the RSBY has failed to fully achieve its objectives. Numerous studies have highlighted compromised healthcare quality due to insufficient coverage under the RSBY. The Ayushman Bharat scheme represents a positive advancement by increasing coverage to Rs 5 lakh. Nonetheless, some undesirable aspects from the RSBY have unfortunately carried over into the AB-NHPM scheme.

The current design of the AB-NHPM scheme has limitations in its ability to effectively reduce out-of-pocket expenses (OOPE) despite the expanded coverage. Three primary reasons hinder its effectiveness, necessitating early intervention for successful implementation of the scheme.

- One, similar to the RSBY, outpatient expenditure, which forms a major part of OOPE, has been left out of the ambit of the AB-NHPM.
- Two, relying on a single rate card for the entire country could possibly limit private sector participation.
- Three, preparing the entire medical procedure list at the central level is a potentially suboptimal move, given the heterogeneity in healthcare needs across the country.

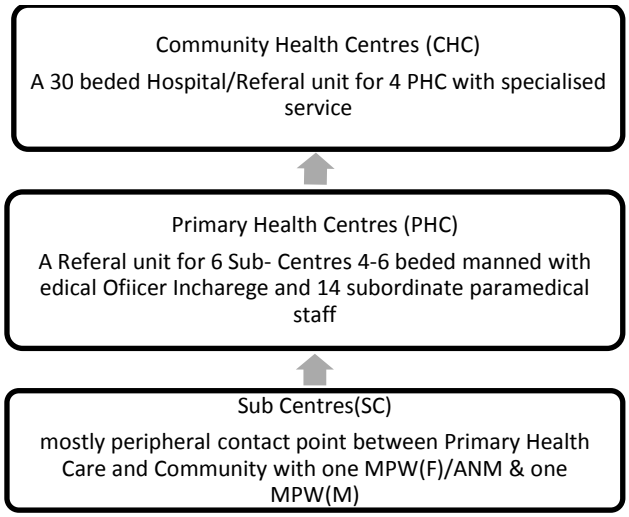

Fig. 1. Rural Health Care System In India

Due to the skewed availability of data, we have limited insights into the changes in the average rural population covered in Sub-Centers (SC), Primary Health Centers (PHC), and Community Health Centers (CHC). On average, in 2001, there were 5,204 rural inhabitants in SCs, 32,129 in PHCs, and 230,444 in CHCs. The lowest average rural population in SCs was in Mizoram, at 5,204, while the highest was in 22,493. In PHCs, the minimum was in Chandigarh (0), and the maximum was in Delhi (118,090). In CHCs, the minimum was in Delhi (0), and the maximum was in Bihar.

Under Ayushman Bharat, the objective is to increase the coverage, particularly in areas with lower accessibility, such as SCs and PHCs. This initiative aims to enhance healthcare availability for the economically disadvantaged who currently lack adequate infrastructure support. Consequently, this improvement is expected to reduce illness occurrences among the population, leading to decreased healthcare expenditure. Ultimately, the income effect resulting from reduced health expenses is anticipated to boost the income levels of individuals.

V. CRITICAL REVIEW

The level of public spending on healthcare in India has been relatively low, with both central and state governments allocating around 1.01-1.3% of GDP between 2008 and 2015, slightly increasing to 1.4% in 2016-17. This is notably lower than the global average of 6%. Consequently, out-of-pocket expenditure (OOPE) by citizens constitutes a significant portion of total healthcare expenditure, accounting for nearly 70%. This percentage is considerably high compared to other countries worldwide.

An analysis of expenditure breakdown reveals that 51% of healthcare expenses, funded out of pocket, are directed towards outpatient treatment (OPD). Therefore, while the objective of reducing OOPE is central to healthcare policy, achieving this goal solely through health insurance, which typically covers inpatient treatment or hospitalization expenses, may be insufficient.

Addressing the issue of high OOPE requires a multifaceted approach that goes beyond insurance coverage for hospitalization. Initiatives to improve primary healthcare infrastructure, enhance access to essential medicines, promote preventive healthcare measures, and strengthen social safety nets are also essential components in reducing the financial burden on individuals and families. Efforts to increase public spending on healthcare and implement comprehensive health financing reforms are crucial steps towards achieving universal health coverage and reducing the reliance on out-of-pocket expenses for healthcare in India.

5.1 Dependence on Private Healthcare

It is clear from Table A: Majority of Indian Population relies and prefers Private health care providers.

Types of Hospitals	**Rural**			**Urban**		
	1995	2004	2016	1995	2004	2016
Public	42.0	42.0	42.0	43.0	38.0	32.0
Private	58.0	58.0	58.0	57.0	62.0	68.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

The scheme mandates the automatic empanelment of public or government-run hospitals. However, beneficiaries may not prefer these facilities for their treatments. The scheme also sets fixed rates or package rates for particular treatments and surgeries. Private hospitals may prefer treating patients outside the scheme, as they can charge higher rates than the fixed package rates. This preference may lead to poor scheme beneficiaries being perceived as secondary or lower priority by private healthcare providers.

5.2 Poor Existing Healthcare infrastructure

India currently has just over one million allopathic doctors to serve its population of 1.3 billion. Additionally, the bed-to-patient ratio stands at 0.9, meaning there are only 0.9 beds available per person in the population. With the implementation of this scheme, we are generating increased demand for healthcare services. However, the existing health infrastructure is insufficient to accommodate this surge in demand. Position of States as financier to the scheme

AB – NHPM scheme is to be implemented as a partnership of central government and states with 40% of the scheme to be funded by states and balance by central government

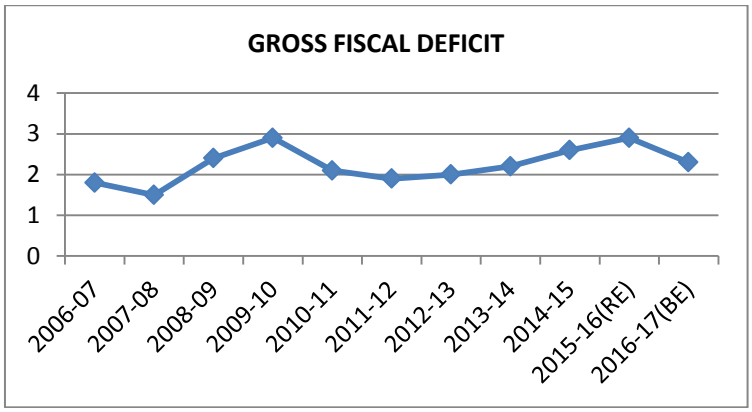

Diagram- 1 Gross Fiscal Deficit

According to the Reserve Bank of India (RBI), India's central bank, the Gross Fiscal Deficit (GFD) to Gross Domestic Product (GDP) ratio in 2015-16 exceeded the 3% ceiling of fiscal prudence for the first time since 2004-05. States are increasingly resorting to large-scale borrowings to meet their fiscal requirements. Additionally, several states have implemented farm loan waivers, further straining fiscal resources. Moreover, states' own pay commissions have increased salaries for employees, adding to fiscal pressures. The uncertainty surrounding Goods and Services Tax (GST) revenues poses additional downside risks, according to the RBI.

5.3 Inadequate Funds

The scheme aims to establish and upgrade 1.5 lakh Health and Wellness Centers (HWCs) to address the medical treatment needs of its centers. However, only 1200 crores have been allocated for this purpose under the scheme. This amount is grossly inadequate considering the number of centers the scheme intends to establish.

5.4 Rejection of the scheme

Twenty states have already committed to administering the scheme within their jurisdictions. However, states with existing healthcare schemes will need to either integrate their schemes into AB-NHPM or initiate the scheme anew. Notably, West Bengal, Karnataka, and Odisha have chosen to opt out of the scheme and instead plan to implement their own healthcare initiatives. A common factor among these states is that the ruling party at the central level does not govern them. Looking ahead, there is a possibility that opposition parties may come to power in other states and reject the AB-NHPM scheme. Such rejections could impede the success of the program, as it relies on broad participation from states for effective implementation.

5.5 Empanelment of Private Hospitals under the scheme

The government has introduced fixed package rates for 1350 medical procedures and surgeries in an effort to standardize treatment procedures. However, private healthcare providers have expressed concerns about the sustainability of these rates, stating that they are too low and may compromise the quality of services provided to patients. With a medical inflation rate of 15%, these package rates may become unviable in the future if not regularly revised.

Enrolling private hospitals in the scheme presents a challenge for the government. While the government argues that the package rates are adequate for treatments in general ward category rooms, states have been given the flexibility to increase them by 10%. Private hospitals would need to adjust their business models to succeed profitably under the scheme, shifting from a model focused on low-volume business with high profit margins to one centered around high volumes of business with lower margins.

However, many large private hospital chains are corporatized and publicly held, with shareholders influencing decision-making. Transitioning to a new business model may prove difficult for these hospitals due to existing shareholder expectations and organizational structures. Whether private hospitals will be willing to adapt their existing business models remains to be seen.

5.6 Premium through Tendering Process

The government has clarified that there will be no limit on premiums for the scheme, with premiums being determined through a tender process. Insurers submitting the lowest bids will be selected on a state-by-state basis. Additionally, each state will have a different premium based on factors such as total population and population profile.

Chhattisgarh has become the first state in India to release a tender for the scheme. However, there are concerns that this approach may lead to unhealthy competition and result in price discovery at unsustainable rates. This could potentially lead to insurers discontinuing their participation after a year. It remains to be seen how both private and public insurers will respond to these tenders and whether they will be able to sustainably provide coverage under the scheme.

5.7 Faulty Coverage's

The inclusion of covering pre-existing diseases from day one and removing caps on the age of beneficiaries in the scheme poses a significant challenge for insurance companies. This creates a high-risk pool of participants, which is likely to increase the loss ratios of private insurers and impact their profitability.

It's noteworthy that previous schemes like the Pradhan Mantri Jeevan Jyoti (low-cost life insurance) and Suraksha Bima Yojna (personal accident insurance) have upper age limits of 55 years and 70 years respectively. By contrast, the absence of age limits in the new scheme adds complexity and elevates risk for insurers, potentially straining their financial sustainability.

5.8 High Loss Ratios of government sponsored Schemes

Government-sponsored schemes in India often face challenges related to high loss ratios and claims. The Net Incurred Claims Ratio (ICR), which measures the ratio of net claims incurred to the net premium earned, is a crucial metric for assessing the incidence and magnitude of claims.

A high ICR indicates that a significant portion of premiums collected is being used to pay claims, suggesting that the scheme may not be financially sustainable in the long run. Therefore, it's essential to monitor and manage the ICR effectively to ensure the viability and success of government-sponsored healthcare schemes.

VI. CONCLUSION

This ambitious program is set to revolutionize the healthcare industry, creating unprecedented demand for healthcare services. However, the government has not provided clear answers on how it plans to generate the necessary resources for the scheme. Without adequate revenue to meet the increased expenditure, there's a risk of increasing the fiscal deficit. While the scheme focuses on addressing the demand for healthcare services, the government must also address the supply side by upgrading existing infrastructure and investing in new government hospitals, primary health centers (PHCs), community health centers (CHCs), and tertiary referral centers. Relying solely on health insurance funding may not be sustainable in the long term; it's crucial for the government to invest more in public healthcare infrastructure. Additionally, fully subsidizing the scheme without any contribution from beneficiaries unnecessarily burdens the government's finances. A small token payment from beneficiaries could instill a sense of ownership and value in the scheme, even among the poor. The true impact of the scheme can only be evaluated post-rollout, when all variables and constraints come into play. Through learning from past schemes and experiences from other countries, improvements can be made to ensure its success. Proper implementation of the scheme could significantly reduce out-of-pocket expenditure, thereby aiding in poverty alleviation efforts.

REFERENCES

[1]. Bakshi, H., Sharma, R., & Kumar, P. (2018). Ayushman Bharat Initiative (2018): What we stand to Gain or Lose! Indian Journal of Community Medicine : Official Publication of Indian Association of Preventive & Social Medicine, 43(2), 63–66.

[2]. Bakshi, Harsh, Rashmi Sharma, and Pradeep Kumar. 2018. Ayushman Bharat initiative (2018): what we stand to gain or lose! Indian Journal of Community Medicine 43: 63.

[3]. Chatterjee, Patralekha. 2018. India launches Ayushman Bharat's secondary care component. Lancet 392: 997.
[4]. Chokshi, Maulik, B. Patil, R. Khanna, Sutapa Bandyopadhyay Neogi, Jyoti Sharma, V.K. Paul, and Sanjay Zodpey. 2016. Health systems in India. Journal of Perinatology 36 (Suppl 3): S9–S12.

[5]. Dasgupta, Anu Garg, Yogesh Jain, A. K. Shiva Kumar, Nachiket Mor, Vinod Paul, P. K. Pradhan, M. Govinda Rao, et al. 2011. High level expert group report on universal health coverage for India. New Delhi.
[6]. Dasgupta, R., and I. Qadeer. 2005. The National Rural Health Mission (NRHM): a critical overview. Indian Journal of Public Health 49 (3): 138–140.
[7]. Devadasan, Narayanan, Tanya Seshadri, Mayur Trivedi, and Bart Criel. 2013. Promoting universal financial protection: evidence from the Rashtriya Swasthya Bima Yojana (RSBY) in Gujarat, India. Health Research Policy and Systems 11: 29.
[8]. Guru, G. 2018. Ayushman Bharat—long live private healthcare. Economic and Political Weekly 53 (46): 8
[9]. Jan Swasthya Abhiyan. 2018. Abandon Ayushman Bharat. Economic and Political Weekly 53 (39): 5. Karan, Anup, Arpita Chakraborty, Hema Matela, Swati Srivastava, Sakthivel Selvaraj, Elna James Kattoor,
[10]. Karan, A., Yip, W., & Mahal, A. (2017). Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare. Social Science Medicine (1982), 181, 83–92.
[11]. Khanna, Renu. 2011. Universal health coverage in Thailand: what lessons can India learn? Medico Friend Circle Bulletin 342–344 (Aug2010-Jan2011): 34–42
[12]. Lahariya, Chandrakant. 2018. 'Ayushman Bharat' program and universal health coverage in India. Indian Pediatrics 55: 495–506
[13]. Lakshmi Ramakrishnan, Tirumaal Arumugam, Umakant Dash, V.R. Muraleedharan, and Girija Vaidyanathan. 2017. Process evaluation report of Chief Minister's comprehensive health insurance scheme, Tamil Nadu. New Delhi: Public Health Foundation of India.
[14]. Nandan, Deoki. 2010. National rural health mission: turning into reality. Indian Journal of Community Medicine 35 (4): 453.
[15]. Nandi, Arindam, Ashvin Ashok, and Ramanan Laxminarayan. 2013. The socioeconomic and institutional determinants of participation in India's health insurance scheme for the poor. PLoS One 8 (6): e66296.
[16]. Nandi, Sulakshana, Helen Schneider, and Priyanka Dixit. 2017. Hospital utilization and out of pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh state, India: lessons for universal health coverage. PLoS One 12: e0187904.
[17]. Press information Bureau Government of India. Ministry of Finance. Ayushman Bharat for a new India -2022.

Web sources:

[1]. http://www.irda.gov.in
[2]. http://pib.nic.in
[3]. http://www.abnhpm.gov.in
[4]. https://www.nhp.gov.in
[5]. http://planningcommission.gov.in
[6]. http://pib.nic.in/newsite/PrintRelease.aspx?relid=176418
[7]. https://mohfw.gov.in
[8]. https://data.gov.in/search/site?query=Rural+Health+Statistics+in+India