Vol. 2; Issue 1; January 2024; ISSN No. 2583-6994

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Impact Visualization of Ayushman Bharat Scheme before and after Its Implementation on Indian Health Governance

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ABSTRACT

The "right to health" is central to exercising basic human rights. However, our constitution has yet to recognize health as a fundamental right. Further, a bit over 1% of India's GDP is devoted to public healthcare spending, which is one of the world's lowest levels. Therefore, the NHP-2017 (National Health Policy of India) has been launched by the government, which is entirely consistent with the concept of universal healthcare. For the ground-level implementation of the NHP-2017, the Indian government proposed the Ayushman Bharat Program in March 2018. This program was proposed with the aim of achieving a health system overhaul in India. It is targeted at preserving the financial health of 5,000 lakhs of the most disadvantaged Indians and stopping the decline of the 500–600 lakhs of Indians who slip into poverty each year as a result of out of pocket health expenses. However, the design and implementation of the Ayushman Bharat Program from the outset need to be effective and significant in reaching the intended health results. In order to investigate and visualize the impact of this programme before and after its implementation on health governance, the present study has been conducted. The study has been conducted using secondary data and has looked at the emotional tenderness or compassion of the scheme's beneficiaries as well as the scheme's impact. The present study will be a great help in

implicating inevitable and necessary future alterations, if required, to continue with the current program.

Introduction

The "right to health" is crucial to the enjoyment of fundamental human rights. Unfortunately, the Indian Constitution doesn't yet list health as a right or basic legal privilege. Numerous articles and evaluations by the honorable Supreme Court make ample arrangements for "access, under command precepts, to the citizens' health," but they fall short of including the right to be included in it as a fundamental human right. Hence, it can't be deceptive to say healthcare has been a major concern and a neglected governance problem. It has never been a top concern. It is typically a last-minute informal meeting with any political group seeking inclusion in the campaign platforms. Consequently, it's encouraging to see some recent examples of proactive action in the National Health Policy (NHP) 2017 to address this issue[1].

The 2017 National Health Policy's main goal is to strangely inform, clarify, prioritize, and solidify the government's involvement in forming healthcare systems in all of their aspects. All such aspects include healthcare investment schemes, organization and management of healthcare services, disease prevention and good health promotion, technological implementation, human resource development, promoting medical pluralism, knowledge base building, and stronger financial security measures[2]. NHP 2017 expands on the advancements made during NHP 2002. The Ministry of Health and Family Welfare has published a paper, "Background to National Health Policy 2017—Situation Analyses," to reflect its latest developments.

For the ground-level implementation of the NHP-2017, the Indian government proposed the Ayushman Bharat Program in March 2018. Ayushman Bharat for a New India 2022, which includes two significant projects, including the establishment of health and wellness centres (HWCs) and an ambitious National Health Protection Scheme (NHPS), was introduced in the 2018 budget speech[3]. Here, by converting subcenters (SCs) to HWCs, a wider and more complete package of primary health care has proposed to provide at the community level. On the other hand, the National Health Protection Scheme intends to give vulnerable 10 crore households (approximately 50 crore individuals, or 40% of the nation's population) with monthly health coverage of up to Rs. 5 lakh, depending on socioeconomic and caste census data. The programme will offer cashless coverage for some secondary and tertiary treatments in public and contracted private facilities, with no restrictions on family size or age. In order to investigate

and visualize the impact of these programs, the present study has been conducted. Based on secondary data, the current study proposes to investigate the emotional tenderness or compassion of the scheme's beneficiaries as a measure of the scheme's impact.

History of Indian Health Policies and Governance

India's administration and health policies are evolving. A report on the health survey and development committee, commonly known as the Bhore Committee Report, published in 1946, has been regarded as the foundation for India's present health policy and systems.

A three-tiered health care system has been proposed in the Bhore report. It recommended funding for preventive and curative treatment in rural and urban regions, while putting health professionals on government payrolls and minimizing the need for private practitioners. These proposals established the guiding principles for contemporary health policy and systems. This was done to ensure that an individual's socioeconomic position did not impact their ability to access primary care.[4]

Furthermore, in 1955, the Medical Education Conference proposed a reform that medical schools across the country need to establish a department of preventive and social medicine. It also goes by the name of "community medicine." In both urban and rural settings, preventative and health promotion duties were given to medical students and interns. The aim of this initiative was that by continuing with this mandated rotation, junior physicians should develop a sense of community. The Mudaliar Committee recommended in 1961 that public health schools be established across the country, in each state, to train medical officers, public health nurses, maternity and child welfare workers, public health engineers, sanitarians, and others[5].

In continuation of the Bhore Committee, the Shrivastava Committee was formed in 1975. The main agenda of this committee was to target the essential urban orientation of medical education across the country, which specifically included schemes for family welfare and maternal and child health, etc. As per the recommendation of this committee, there is a need to reorient undergraduate medical education as per the country's needs[6].

The government launched a programme called Re-Orientation of Medical Education (ROME) in 1977 and then expanded it to cover the entire country in order to engage medical colleges and promote the use of preventative and curative health care in community engagement blocks[7]. This was meant to provide a sorely needed link between medical

colleges and communities by combining health care delivery and referral for the community with an opportunity for medical colleges to acquaint new medical graduates with rural populations. However, the approach was only successful in the least specialized schools where it could introduce medical students to rural health.

In 1985, an expert committee for Health Manpower Planning, Production, and Management was formed to analyse current and projected needs for public healthcare manpower in pre-we intermediate level health care programmes, as well as to recommend key academic institutions and infrastructure to support the manufacturing of the requisite groups of health manpower.[8] In 1983 was India's first NHP was created, with the goal of providing universal access to basic healthcare by the year 2000[9]. It has emphasis on developing a network of primary healthcare services using health volunteers and affordable technology, as well as effective referral networks and a cohesive network of specialty facilities. Further NHP 2002 expanded on NHP 1983 and aimed to provide a health services to the broader population through decentralization, utilization of the private sector, and raising overall public spending on health care[10].

In continuation of all of these measures, Dr. Manmohan Singh, the country's then-prime minister, formed the Public Health Foundation of India (PHFI) in 2006[11] as a concerted endeavor to address supply-side deficiencies of human resources in the Indian health system. The following section provides an overview of the present state of Indian health policies and governance.

Ayushman Bharat Scheme under NHP-2017

With 1.3 billion people, India is among the fastest-growing nations on the globe. Of this population, 66% live in rural areas, while 34% live in urban areas[12]. As per the declaration of the WHO, universal health coverage aims to provide all people and groups with access to the promotive, precautionary, restorative, and hospice care health services they require, of an adequate standard to be effective, without placing the user at risk of financial hardship. It takes into account equity in access, quality, and the reduction of financial risk[13]. But as per the reports of the current NHP, despite a significant rise in health care expenditure in India since 2019, the state's expenditure on medical services is among the lowest in the world. As a result, a sizable proportion of Indian households are unable to access health care because of high out-of-pocket expenditures. Financial constraints are the limiting factor for people who did not obtain medical treatment. To finance their health-care costs, most urban and rural inhabitants

borrow money from banks or sell assets. As a result, the Indian government has launched "Ayushman Bharat," a comprehensive health-care programme aimed at achieving universal health coverage. The two main components of the Ayushman Bharat plan are the Pradhan Mantri Jan Arogya Yojana (PMJAY) and Health and Wellness Centers (HWCs).

The programme aims to provide 100 million Indian households, or around 500 million Indians, with healthcare. The programme is designed for people who, according to the government's 2011 Socio-Economic and Caste Census, are living below the poverty level (SECC). Everyone in the family is covered, regardless of how many or how old they are. Each recipient is eligible for a benefit totaling INR 500,000 per year. 40% of the program's financing comes from the budgets of each state and the federal government. It has merged with the existing government-funded health insurance system (GFHIS) in the states where it exists. The programme is either managed through an insurance system, in which case a private health insurance corporation handles claims and payments, or it is run through a non-profit trust established particularly for this purpose by the states. Medical treatment is provided by public or accredited private health facilities that have made sensible investments.[14]

The progamme has proposed to cover roughly 40% of India's total population. It has been expected that when it reaches its target coverage, it will be the world's largest GFHIS[15].

The programme pays for all secondary and, in most circumstances, tertiary care operations that require hospitalisation at hospitals having empanelled status. It also covers treatments before and after hospitalisation. The provided coverage is fully digital, requiring no paper or documentation, and is transferable across all hospitals in India having empanelled status. Pricing for these treatments has been set for about 1,350 treatment bundles[16]. It is expected that the funding allotted to this component of the programme would increase to INR 100 billion over the next five years, up from INR 20 billion currently.

The plan calls for strengthening and developing approximately 150,000 health and wellness centers across the country as well as to provide healthcare coverage for hospitalized persons. These facilities would offer complete primary health care, such as maternal, child, early-life, teen health services and family planning services, such as family welfare and abortion services; management of communicable and non-communicable diseases; and common eye, ear, and throat conditions. These health and wellness facilities will cost roughly INR 12 billion to build and operate.

Along with all of these benefits, the Ayushman Bharat scheme also aims to bring about an improvement in the healthcare sector, including uniform standard care in both private and public hospitals, cost control, the establishment of the Registry of Hospitals in Network of Insurance (ROHINI), enhancements of the National Health Resources Repository (NHRR), and others.

It seems that the Ayushman Bharat scheme has great potential to be a solution to the country's issues with access to health care and services. Strong voices both in favor of these assertions and those raising doubts about them are both presented in the present study. The program's supporters seem to assert that it can increase market competition between public and private health care providers and boost service quality. It also looks like it will eventually reduce healthcare costs and improve the effectiveness of hospital-based secondary and tertiary care services. However, some issues also seem to be coming up in the path of its ground-level implementation, such as the plan's critics' expressed worries about moral hazard, the scheme's limited reach and exclusion of vulnerable populations due to ineffective targeting, the inadequacy of regulations for private insurers and providers, the possibility of supplier-induced demand, and the scheme's opponents, etc. As a result, an in-depth inquiry of the ground reality of the scheme's execution, as well as a research of the beneficiaries' fair experience with the same, is required. On this basis, the current study was conducted.

Exploratory Analysis of the Ayushman Bharat

This section gives detailed exploratory analysis based on the dataset from the Ministry of Rural Development, Government of India, and the Socioeconomic and Caste Census about the ground reality of the implementation of the Ayushman Bharat scheme along with its success in reaching target volumes.

Count Analysis of Ayushman Card Holder

The detailed information Ayushman Bharat card holder distribution (state wise) has been given in figure1.

It has been noticed from the data of SECC, for Rajasthan and Andhra Pradesh, specifics on individual beneficiary card holders are not readily available. The total number of Ayushman cards also includes the 4.68 billion beneficiary cards that the state of West Bengal issued utilizing its IT infrastructure. Maximum of card has been issued in Tamil Nadu and minimum in Andhra Pradesh.

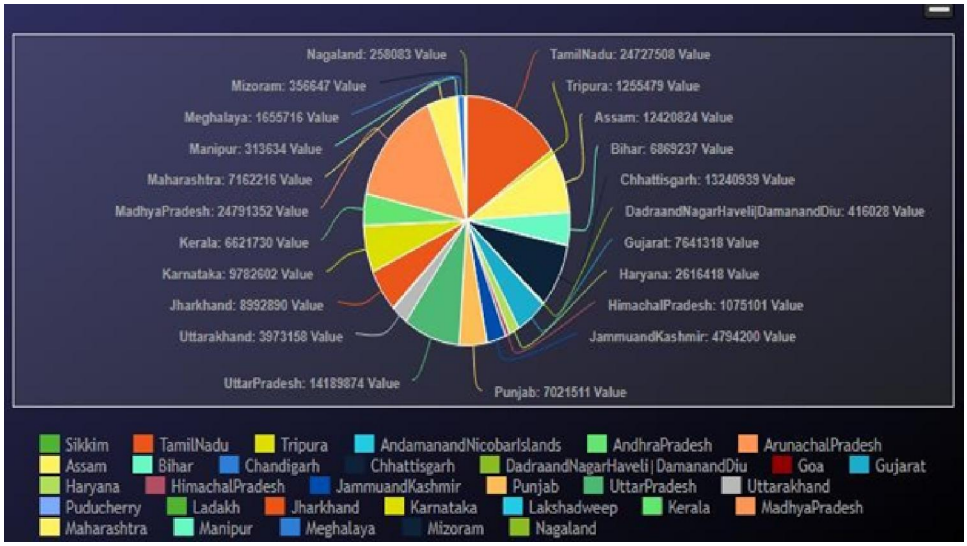

Fig. 1: State wise Ayushman Bharat card holder count[17]

Funding Detail Analysis

Figures 2, 3, and 4 show detailed information about the state-by-state allocation of funds under Ayushman Bharat for health and wellness centers. The figure 2 contains the data for 2018–2019, while the figure 3 and figure 4 contain the data for 2019–2020 and 2020–2021, respectively.

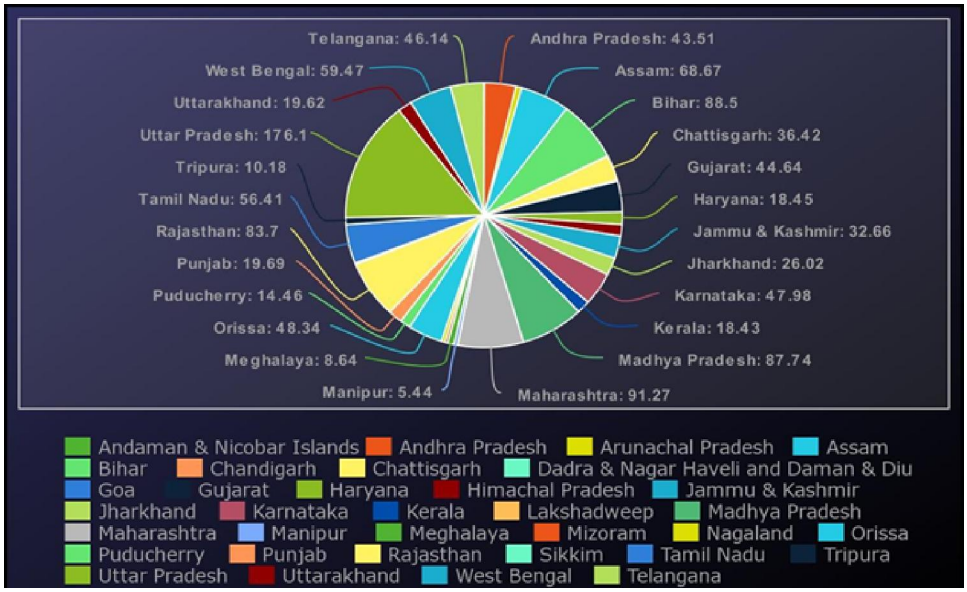

Fig. 2: State wise Funding for year 2018-2019 in crore[17]

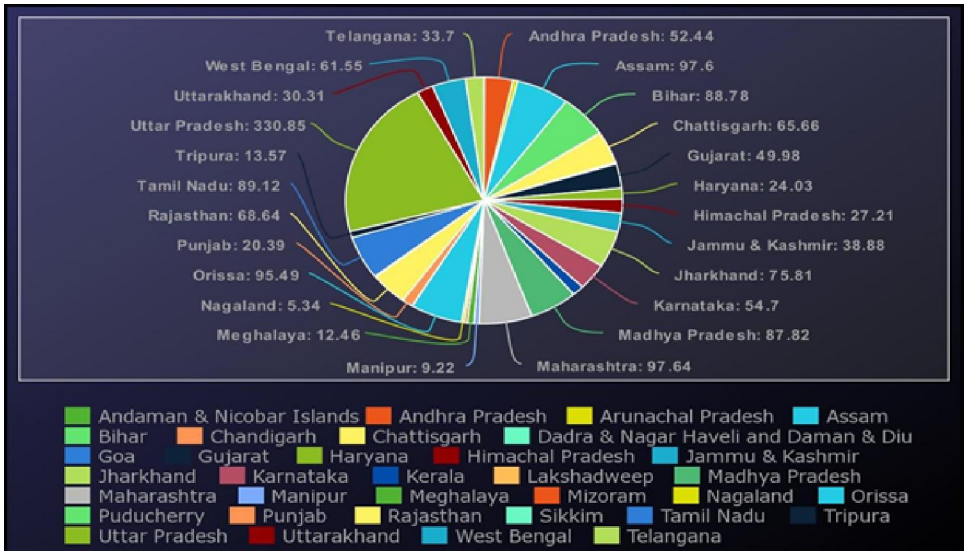

Fig. 3: State wise Funding for year 2019-2020 in crore[17]

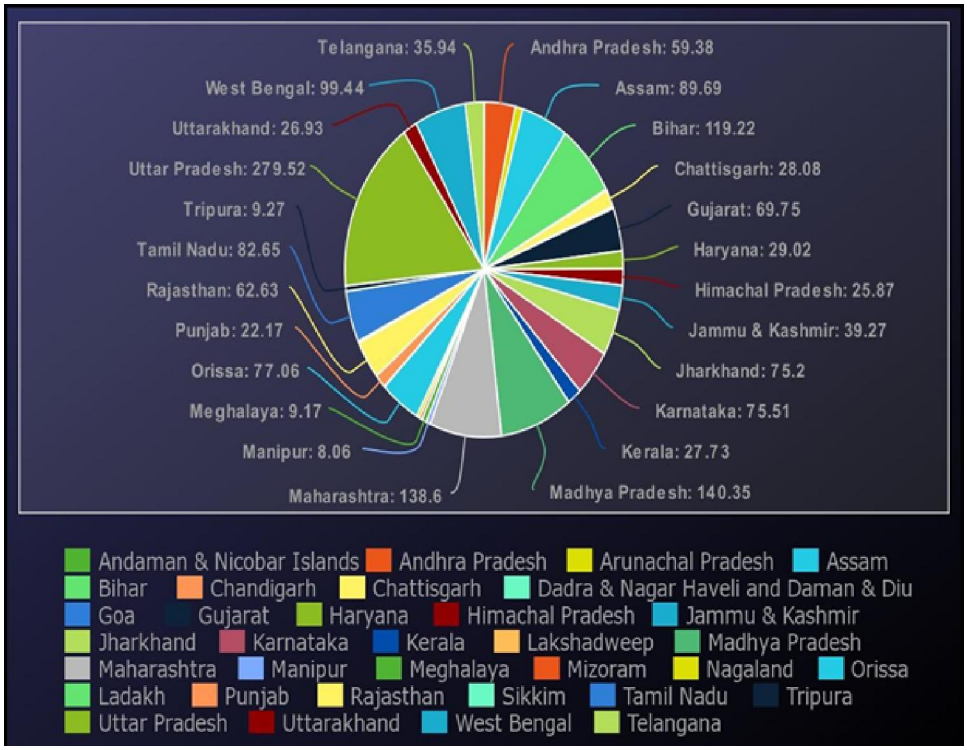

Fig. 4: State wise Funding for year 2020-2021 in crore[17]

According to the analysis from Figures 2 to 4, funding for the Ayushman Bharat programme has increased in most states, but decreased in a few. It has been noticed that in 2020-2021, Ladhak has also received funds worth 7.36 crore for the first time under the Ayushman Bharat program.

Since the program's inception, Uttar Pradesh has received the most funding.

Analysis of Functional HWCs

The detailed analysis of total functional health and wellness centers in different Indian states has been presented in figure 5. Uttar Pradesh has the most number of HWCs (8723). On the other hand, Nagaland (223) and Maghalaya (279) have the least number of functional HWCs. Each state in India has functional health and wellness centers, and this number is expected to grow in the future.

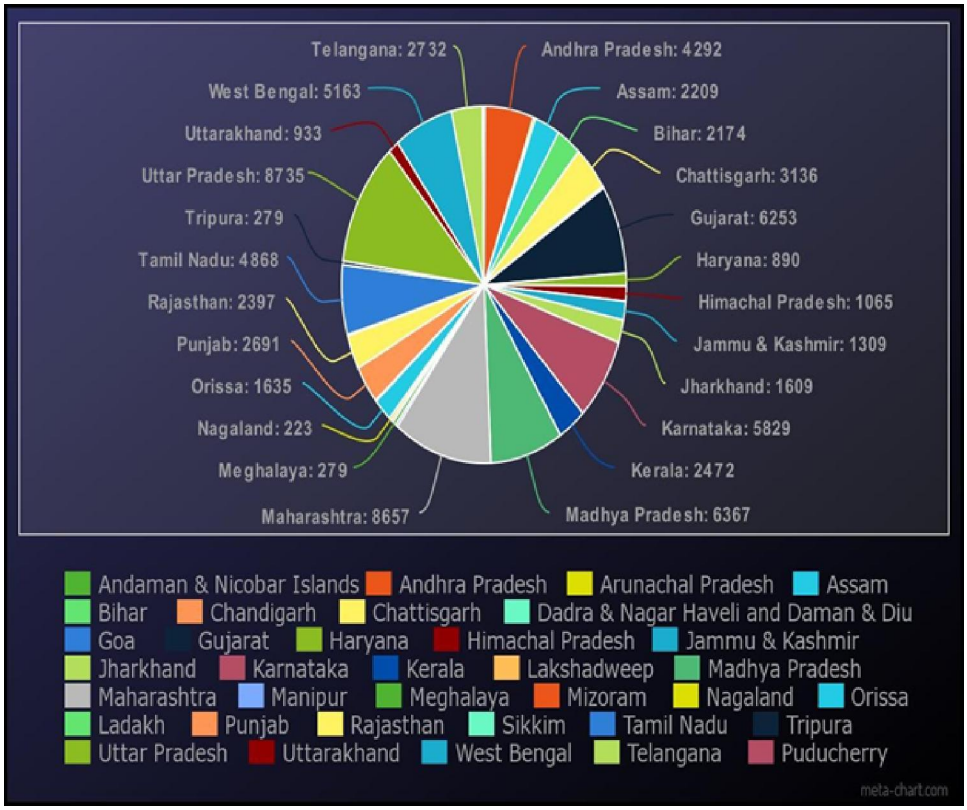

Fig. 5: State wise count of functional HWC till July 2021[17]

Analysis of Authorized Hospital

In this section, the state-wise count of authorized hospitals under the Ayushman Bharat programme has been presented. It has been noticed that Tamil Nadu has the maximum number of authorized hospitals under the Ayushman Bharat programme (3,102,787), and the minimum is in Goa (10282). Otherwise, almost each state in India has authorized hospitals under the Ayushman Bharat program, whose number and functions are supposed to increase in the future.

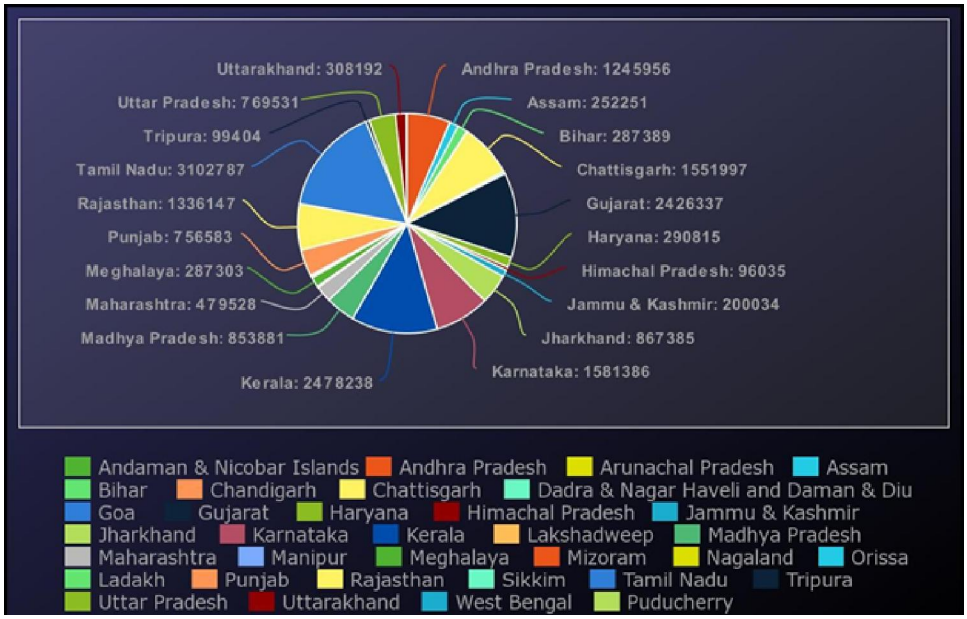

Fig. 6: State wise count of authorized hospital[17]

Challenges Confronting under Ayushman Bharat National Scheme

Either way, under NHP-2017 (the National Health Policy of India), the Ayushman Bharat National Scheme has been launched by the government, which is entirely consistent with the concept of universal healthcare, but there are some areas that raise some particular concerns. Few of that concern has been disused below"

1. For the upgrade of 1,50,000 SC, a fund of Rs. 1200 crores has been provided under the HWC plan[18]. The annual cost per SC estimated to be around of Rs. 80,000. Even if it is a regular grant, the logistical, human resource, and infrastructure requirements to provide the increased variety of services are still woefully inadequate. It should be emphasized that more

than 25% of the operational SCs require building construction. It is necessary to close the gap between policy purpose and financial allocation.

2. Grassroots/lower centres must also be aware that providing increasingly more facilities could be harmful because doing so would cause them to fall short of meeting their main goals (promotional and preventive) and inadequately handle the new obligations.
3. NHP 2017 aims to secure UHC and boost public trust in the healthcare system by strengthening and expanding services. By 2025, it seeks to raise federal health spending as a share of GDP from the present 1.15% to 2.5%[19]. This implies that in the following 6–7 years, the financial allocation will practically double. Given that the budgeted allotment for 2018–2019 (Rs. 52,800 crores) is only 2.4% greater than it was the previous year, it appears implausible.[20]. Actually, if inflation is taken into account (4% last year), the allotment has decreased.
4. Cooperative federalism is the foundation of the plan. Thus, unless all the various governments agree to execute the system, it will be difficult to attain the necessary aims. The state is anticipated to contribute about 40% of this, or more than Rs. 4,000 hence it has been found to be difficult to attain the necessary aims.
5. The lack of workers at all levels is the single biggest factor in the unavailability of health care services (especially curative ones) in distant locations. A situational study of the current state of rural healthcare demonstrates that as the degree of treatment increases, the gaps in infrastructure investment widen. According to Census 2011 data on rural population, the overall shortage for rural public hospitals in India is 19% for SCs, 22% for primary health clinics (PHC), and 30% for CHC. People who are ill are overcrowded in urban institutions (mainly private sector) and the OOPE rises as a result of this.

Study of Emotional Tenderness or Compassion of the Scheme's Beneficiaries

Here in this section, studies have been conducted on various cases to understand the emotional tenderness or compassion of the scheme's beneficiaries. This section, based on its theme, has been considering the various cases for the study of the fair evolution of the Ayushman Bharat National Scheme at the Indian level. A detailed study of the different cases has been presented below:

Case 1: Jamuna Kolita

Jamuna Kolita belongs to Kamrup District of Assam. Jamuna was critically ill for six months and did not received any medical attention. As her illness worsened, a villager advised her family members to go to the hospital with her ration card and register for the Ayushman Bharat benefit. On July 24, 2019, the Jamuna with her family reached Guwahati and enrolled herself as a beneficiary and was taken to the hospital for emergency care.

Her partner's monthly salary, as a driver, is roughly Rs. 8,000. Despite having given up, he broke down and said that she might live if medical care was provided to her, even if it was difficult to do so. The family incurred an extra cost of Rs. 2,700 for medications, which was paid back through Ayushman Bharat.

Case 2: Mahindiri Hira

Hira, a 54-year-old patient who had spent more than six months in the hospital and was in extreme pain, was taking a local prescription. The monthly salary earned by her son, a driver, is roughly 7,000 rupees. About eight months prior, she had received the card, but she wasn't sure on how to utilise it until a local doctors recommended that she can receive free treatment at a major hospital. She received an Ayushman Bharat Card from an ASHA employee. On August 5, after the right course of therapy, she was discharged. Commercially, the surgery is anticipated to cost around Rs. 35,000 which was covered under the scheme. This ways the family could save sizeable part of out of pocket health expenditure.

Case 3: Dilip Lohar

Dilip suffered many injuries on his shoulder in a car crash a few years ago. He made a sluggish recovery, but his shoulder weakened. His shoulder dislocated shortly after sustaining another injury. There is no medical facility to remedy this in Meghalaya. A bone graft was performed after the family travelled to Guwahati. If done privately, the cost could have been close to Rs. 100,000. Two of his sons attend a nearby school, and his wife stays at home. He had been in bed for 15 days, during which time the family's income was nonexistent. The fact that there were no medical charges and that the procedure went smoothly, made the family relief from expenses.

Case 4: Promila Doimai

38-year-old Promila is a housekeeper. The lady makes 2,000 rupees a month. Well, before family members decided to take her to the doctor, she had been in discomfort for nearly three years and one month. Due

to a lack of funds, they decided against seeing a doctor. An ASHA employee advised them to visit a hospital and take advantage of the free medical care provided by Ayushman Bharat. The family intended to borrow more money from the local moneylender because they lackedassets. She underwent effective surgery and made a speedy recovery. She was shifted from the intensive care unit to the recovery room after spending a day there, where she recovered enough to resume her daily activities.

Case 5: Makibur Rehman

29-year-old Makibur works at a nearby motel. About nine months earlier, the card was issued to the family. This is the second time the family has used the service. His mother received treatment for gallstones first. Makibur was hospitalised on July 26, 2019, after experiencing dull abdominal aches on the right side of his body for a fortnight. He was unable to pay the procedure's above Rs. 30,000 cost with his meagre monthly income of Rs. 8,000. The treatment was successfully completed under Ayushman Bharat, and he promptly returned to work.

Case 6: Jinnat Ara

Jinnat who is 47 years old widow lives with her son, a driver who makes around Rs. 6,000 per month, is the only working member of the family. Jinnat, had abdominal pain for a prolonged period of time and was also prescribed painkillers by the neighborhood doctor. Her village has no ultrasound facility, so no USG could be done to determine the source of the pain. One of her neighbors, who received her regular medical care through Ayushman Bharat, advised her to go to the local government hospital that was emp. She was hospitalized right away and was given all the privileges that she was entitled for under the Ayushman Bharat Scheme, thereafter her condition got stabilized.

Case 7: Johan Barala

Johan, 47, works irregular hours on a tea farm in upper Assam and earns Rs. 3,200 per month. He could never afford medical treatment with his little earnings. As a result, he suffered for more than a year. He found it difficult to seek treatment since he was the only member of the family who worked and had no money to use the medical services at a major hospital. A government delegation that visited the tea estate issued Ayushman cards for each employee. This gave Johan some hope that his pain would end. He underwent surgery after being diagnosed with a kidney stone. The surgery was performed successfully with Yojana covering all expenses.

Case 8: Arabinda Kalita

Arabinda, 63, visited a nearby health centre because he was having

trouble swallowing. Initial medical care was provided, and he was then directed to the Guwahati Medical College Hospital (GMCH). Further recommendations included treatment at the GMC Cancer Institute. He received cancer therapy while undergoing more than a month of hospitalisation. He once became so critical that he had to be admitted to the intensive care unit. He underwent surgery and a radiation chemotherapy. The family could not have imagined receiving such treatment with their meagre daily salary of Rs. 300 from their employment as masons, but the Yoajna helped them save health expenses.

Case 9: Bhandeswari Das

Bhandeswari, who is 69 years old, is being hospitalized for the second time. In the first case, she underwent surgery and received radiation treatment. In that case, a sum of Rs. 50,000 was approved. She waived extradition during her present hospital stay and completed 25 sessions. She was in the hospital for five months, receiving complete care and recovering. This procedure will probably cost about Rs. 3 lakh commercially that will be covered by the scheme.

Case 10: Azizul Hak

Azizul, 48, who earns only Rs. 250 per day, could never afford therapy. He was in tremendous pain and on the verge of giving up. Because this ailment existed before the Ayushmaan Card was created, the family was compelled to sell their agricultural land for Rs. 1.5 lakh in order to pay for his medical care. With the issue of Ayushman Bharat card, a new ray of hope appeared, owing to which Hak is still living. He was admitted for treatment in July 2019, and after recovering, he was released. All his medical expenses after he was issued the card was covered under the Yojana.

Case 11: Niru Begum

Niru, 37, was admitted to a hospital in Guwahati after complaining of a brain haemorrhage. Her spouse earns around Rs. 1,500 per month as a casual labourer at a stone quarry. Because the family does not own any land, the query does not run regularly on wet days, preventing them from receiving money. Niru lost consciousness on July 27, 2019, and was carried to the hospital by a government ambulance with the assistance of ASHA, The Ayushman Bharat Yojana paid all of her bills, and she was promptly released from the hospital after healing.

Case 12: Raj Kumar

Raj Kumar, 46, works as a peon in Gurugram. He'd been suffering from a severe stomachache for at least seven months. He was treated

by a local doctor, who gave him temporary relief. However, this was only temporary, and the misery soon returned. As a result, he had to miss work and was dismissed. He couldn't afford the doctor's recommended therapies, which included USG and other procedures. After discovering that the Ayushman Bharat programme would cover this therapy, he proceeded to Alfaa Hospital. He was diagnosed with kidney stones and had the requisite operation. The Ayushman Bharat Yojana paid all of his expenditures .

Case 13: Komal

Komal, 24, is a 24 year old LLM student at a Dehradun institution. She felt unwell after returning to her hometown last week. As her condition deteriorated, she was taken to the hospital. The family was already enrolled in Ayushman Bharat, and all medical care was provided at no expense to the family. She compared her current predicament to one from a few years ago, when she was hospitalised for a physical ailment and had to pay $23,000 for her medical bills.

Case 14: Surjit Singh

Surjit Singh experienced problems with urinary discharge for over 5 years. Surjit, a farmer by trade, was 52 when he began taking medicine from a neighbouring doctor. He was later notified by the government that the Ayushman Bharat programme covered all members of his family and that all hospital treatments were free of charge. When he went to Alfaa Hospital a few months ago, he was hospitalised.But lately, the problem came again, so the patient had to go back to the hospital for another operation to finally address the problem. All his medical expenses were covered under Ayushman Bharat programme relieving him of medical expenses.

Case 15: Jaibir

Jaibir, 23, was sent to the hospital after complaining of vomiting, diarrhoea, and stomach pains caused by food poisoning. He was sent to the hospital with his younger sister, who also had a food allergy. His mother, who was caring for her two children in the hospital, breathed a sigh of relief because the entire medication was covered by Ayushman Bharat and she would not have to pay for medical expenses.

Case 16: Bharath Kumar

Bharath Kumar, 22, was admitted to the hospital on August 2nd due to severe stomach ache. This had happened before when he had taken local anaesthesia and found momentary relief. The pain was caused by kidney stones, according to tests. The surgery was carried out the next day. He was unaware of the benefits of Ayushman Bharat

prior to obtaining assistance from Ayushman Mitra. However, the monetary help offered to him through the Yojana was a welcome respite

Case 17: Jeevan US

Jeevan first had stomach issues when he was ten years old. Because his family lacked the financial means to seek treatment at a big hospital, the family turned to a nearby dispensary. After two years the family acquired an Ayushman Bharat card, reigniting their desire to aid Jeevan in resolving his problem. On August 1st of this year, he was brought to the hospital and had surgery. Both the patient and his family were relieved as all the expenses were covered under the Yojana.

Case 18: Kushal Gowda

Kunal Gowda, five years old, was taken to KC General Hospital's emergency room in the middle of the night with an uncommon case of appendicitis. The hospital summoned the expert since the patient required an urgent treatment due to his excruciating pain, and the surgery was done in two hours. Kunal's life has been saved. The hospital did not solicit an advance payment from the family and instead informed them that Ayushman Bharat would cover the treatment at no cost.

Case 19: Sheria

Sheria, who is nine months old, was born with a congenital heart condition. Her dad is the only earner in the family; he works as a washerman and makes about Rs. 10,000 each month. He was appealing with God for help since it was practically impossible for him to have her treated at any hospital. When the Ayushman Card was issued for him, he was notified that he was entitled to get treatment for his daughter. He rushed to the Sri Jayadeva Institute of Cardiovascular Science & Research, registered his daughter, and then got her operated.

In continuation of this, numerous other families were also benefited by Ayushman Bharat. Case of Geetha, Tumkur from Karnataka, Pavan Kumar from Chitradurga District, Karnataka, Bindhu Y Kottukal from Thiruvananthapuram, Vishnu S Aryanad, from Thiruvananthapuram, Kala Venganoor from Thiruvananthapuram, Thankapdan Vellanad, from Thiruvananthapuram and Shaiju T. Keezhayikonam from Thiruvananthapuram are some other example of scheme's beneficiaries.

Conclusion

The AB-PMJAY is a rare opportunity to enhance the health of hundreds of millions of Indians and eradicate a major factor contributing to the nation's poverty. A detailed study has been conducted in order to investigate and visualize the impact of this programme before and

after its implementation on health governance. The study has also included studies on the emotional tenderness or compassion of the scheme's beneficiaries as well as the scheme's impact based on secondary data. From the various studies, it is evident that the Ayushman Bharat Program seems to be a balanced strategy that combines the delivery of comprehensive primary healthcare (via HWCs) with secondary and tertiary care hospitalization (through PM-RSSM). Nevertheless, there are significant obstacles that must be removed in order for the Indian people to experience these benefits and for the programme to sustainably advance India's pursuit of Universal Health Coverage.

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