



Does Ayushman Bharat Reduce Out-of-Pocket Expenditure?

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Abstract: One of the most important issues facing India's development and governance for a long time has been out-of-pocket health spending (OOPE). The cost of illness continues to force millions of people into poverty year, even in the face of consistent economic development and advancements in health metrics. Launched in 2018, the Ayushman Bharat Programme is the most comprehensive health finance reform in India's history. It combines financial risk protection through the Pradhan Mantri Jan Arogya Yojana (PMJAY) with the development of primary healthcare through Health and Wellness Centers. By offering complete primary care and cashless hospitalization for secondary and tertiary diseases, the program seeks to lower OOPE. This research paper assesses whether Ayushman Bharat has succeeded in achieving this goal. The study concludes that Ayushman Bharat has decreased hospitalization-related financial shocks for covered households, but has not substantially changed the overall structure of OOPE in India. It bases this conclusion on official secondary data from the National Health Accounts (NHA), National Family Health Survey (NFHS-5), and international benchmarks, as well as evidence from recent academic assessments. Furthermore, uneven state-level implementation and reliance on private providers continue to constrain its impact. The paper concludes that Ayushman Bharat has been a step in the right direction but requires expansion, regulation, and integration with universal health coverage strategies to meaningfully reduce OOPE and protect households from impoverishment.

Keywords: Ayushman Bharat, OOPE, PMJAY, NHA

Introduction

In India, the right to health has never been fully codified as a fundamental right, yet it is central to the exercise of basic human dignity. The Bhore Committee of 1946 envisioned a publicly funded health system capable of delivering equitable care, but successive decades of underinvestment and fragmentation left the country heavily dependent on private expenditure. By the mid-2010s, out-of-pocket expenditure (OOPE) accounted for over 60 percent of India's total health expenditure, one of the highest shares globally (Verma & Dhaka, 2019). This financial vulnerability translated into catastrophic spending, debt, and impoverishment for millions of households each year.

Against this backdrop, the Government of India launched the Ayushman Bharat Programme in 2018, framing it as a transformative step toward universal health coverage (UHC). The programme combined the creation of Health and Wellness Centres (HWCs) to provide comprehensive primary healthcare, and the Pradhan Mantri Jan Arogya Yojana (PMJAY) to deliver hospitalization coverage of up to ₹5 lakh per family annually. Ayushman Bharat was presented not only as a health scheme but as a social protection measure, designed to reduce OOPE, prevent catastrophic expenditure, and enhance access to care for nearly 500 million people—making it the largest publicly funded health insurance initiative in the world (Basu, 2024).

The central question, however, is whether Ayushman Bharat has succeeded in achieving its most important financial protection objective: reducing out-of-pocket expenditure. This paper attempts to answer this question by reviewing secondary data, drawing insights from national surveys, and situating Ayushman Bharat within the broader discourse on health policy and governance.

Health Financing and OOPE in India

India's health financing structure has historically been shaped by low levels of public investment. Government health expenditure averaged around 1.2 percent of GDP until the late 2010s, significantly below the global average of 5 percent for low- and middle-income countries (World Bank, 2020). This structural underfunding meant that households were left to fill the financing gap through OOPE. According to the National Health Accounts (2014–15), household OOPE accounted for 64.7 percent of current health expenditure, placing India among the top countries globally in terms of private financial burden (Kamath & Brand, 2023).

The composition of OOPE reveals important dynamics. Nearly two-thirds of household spending on health care is spent on medications and outpatient services. Despite being less common, hospitalization plays a major role in catastrophic shocks; one episode of dialysis, cancer treatment, or surgery frequently results in the sale of assets or the need for high-interest loans (Dhaka, Verma, Agrawal, & Kumar, 2018). Rural households are particularly disadvantaged since they have less access to public facilities and are more likely to rely on private suppliers, frequently at exorbitant prices.

The consequences of this financing structure have been stark. Estimates suggest that around 55–60 million Indians are pushed below the poverty line each year due to healthcare spending (Suheta, Shukla, Chandra, & Kumar, 2020). Catastrophic health expenditure, defined as spending that exceeds 10 percent of household income, remains widespread, particularly among the poorest quintiles. The NFHS-5 (2019–21) reaffirmed these concerns, noting that while utilization of institutional health services has increased, financial hardship remains a defining feature of the health system.

These structural challenges explain the urgency behind Ayushman Bharat. The initiative was started as a national commitment to health security rather than just as a sectoral reform. Its policy framework clearly acknowledged that lowering OOPE is essential to social fairness and economic growth, and that financial protection is a requirement for equitable health outcomes.

Ayushman Bharat: Policy Design and Objectives

The launch of Ayushman Bharat in 2018 was a defining moment in India's health policy, signifying a shift from piecemeal welfare schemes to a structured approach to universal health coverage. The programme was announced in the Union Budget with two interlinked pillars: Health and Wellness Centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PMJAY). Together, they were meant to represent a continuum of care that could address preventive, promotive, curative, and rehabilitative needs, while also providing a safety net against catastrophic health expenses (GOI, 2018; Lahariya, 2018).

The first component, the Health and Wellness Centres, aimed to upgrade 150,000 existing sub-health centres and primary health centres into comprehensive primary care units. These centres were designed to deliver an expanded package of services that included screening for non-communicable diseases, mental health

care, palliative and geriatric services, oral and ophthalmic health, reproductive and child health, and basic diagnostics (Dhaka et.al., 2018). The logic behind HWCs was that by strengthening primary care, the system would reduce unnecessary hospitalizations and provide early interventions, which in turn could limit OOPE on expensive tertiary care. The underlying rationale was that strengthening primary care would reduce unnecessary hospitalizations, promote early interventions, and in turn help limit out-of-pocket expenditure (OOPE) on expensive tertiary care (Prinja et al., 2019).

The second component, PMJAY, was designed as a publicly funded health insurance scheme that provided coverage of up to ₹5 lakh per family per year for secondary and tertiary hospitalization. The scheme targeted 10.74 crore vulnerable families, identified through the Socio-Economic Caste Census (SECC) 2011, thereby covering nearly 40 percent of India's population (Dhaka, Verma, Agrawal, & Kumar, 2018). The insurance covered pre-existing conditions, did not impose a cap on family size, and was portable across states. Services were delivered through empanelled hospitals in both the public and private sectors, with payments made on a cashless and paperless basis (NHA,2020).

The explicit policy objective of Ayushman Bharat was not just to increase access to healthcare, but also to reduce out-of-pocket expenditure. By creating a network of HWCs and simultaneously ensuring financial protection through PMJAY, the government sought to address both the supply and demand-side barriers that had historically kept poor households away from healthcare facilities (Hooda,2020). PMJAY, in particular, was projected as a mechanism to prevent catastrophic expenditure from hospitalization, while HWCs were expected to address the more routine outpatient needs.

Financially, the scheme represented an unprecedented level of government commitment. The estimated cost of implementing PMJAY alone was ₹2,500 billion over the first two years, shared between the central and state governments (Suheta, Shukla, Chandra, & Kumar, 2020). The programme's design also incorporated elements of cooperative federalism, allowing states flexibility in implementation—some chose the trust model, others the insurance model, and still others a hybrid. This flexibility was expected to encourage innovation but also created unevenness in the way the scheme was rolled out across India.

Ayushman Bharat was framed in political discourse as a social revolution, with Prime Minister Narendra Modi describing it as a step towards creating a “new

India” by 2022. Its stated goals aligned with the National Health Policy 2017 and India’s commitment to the Sustainable Development Goals, particularly Goal 3 on health and well-being. The central thrust of the policy design was clear: financial risk protection and reduction of OOPE had to be at the heart of health sector reform.

Review of Literature

The academic and policy literature on Ayushman Bharat has grown rapidly since its inception, and much of it interrogates the scheme’s ability to deliver on its promise of reducing OOPE. Scholars and practitioners have highlighted both the achievements and the persistent limitations of the programme.

Kamath and Brand (2023), in a systematic review of the literature on Ayushman Bharat, identify the issue of OOPE as one of seven major thematic concerns. They argue that while PMJAY has improved access to hospitalization for certain groups, there is limited empirical evidence to suggest that it has significantly reduced OOPE at the household level. They note that the majority of OOPE continues to arise from outpatient care and the purchase of medicines, which remain excluded from the scheme. The review concludes that without expanding coverage to these areas, Ayushman Bharat’s impact on OOPE will remain partial.

Dhaka, Verma, Agrawal, and Kumar (2018) similarly highlight the inadequacy of financial protection before the launch of Ayushman Bharat. Their analysis underscores that three-quarters of Indians were spending their entire income on healthcare and drug purchases, with 3.2 percent of the population pushed below the poverty line annually due to medical costs. They present Ayushman Bharat as a necessary intervention, but caution that its success would depend on effective implementation and the ability to overcome systemic weaknesses in health governance.

Suheta, Shukla, Chandra, and Kumar (2020) frame Ayushman Bharat as a “healthcare revolution,” noting that it provides insurance cover to more than 10.74 crore families. Their review emphasizes the scheme’s inclusiveness—covering pre-existing conditions and offering benefits without age or family size restrictions. They acknowledge, however, that the reliance on empanelled hospitals, particularly private ones, creates risks of overcharging and exclusion, which can erode the financial protection the scheme is meant to provide.

Basu (2024) takes a governance perspective, pointing out that India’s heavily privatized health system poses structural challenges to Ayushman Bharat. With

nearly 75 percent of outpatient consultations and 65 percent of hospitalizations occurring in the private sector, the scheme must engage with private providers, but this engagement also opens up avenues for fraud and informal payments. Basu argues that Ayushman Bharat has increased access and utilization but has not fundamentally altered the imbalance between public and private healthcare, thereby limiting its ability to reduce OOPE.

Taken together, the literature presents a nuanced picture. Ayushman Bharat has been successful in expanding coverage and raising awareness of entitlements. It has also reduced hospitalization costs for certain beneficiaries. However, its effect on overall OOPE remains modest, constrained by design exclusions, weak regulation of private providers, and uneven state capacity. Scholars consistently emphasize that without expansion to outpatient care and stronger regulation, the scheme cannot achieve its full potential in reducing OOPE.

Analysis of Impact on Out-of-Pocket Expenditure

The stated objective of Ayushman Bharat was to provide financial risk protection and reduce the dependence of households on out-of-pocket expenditure. To evaluate whether this has been achieved, it is necessary to examine official data sources on health financing, trends in catastrophic expenditure, and evidence of household-level financial burden.

National Trends in OOPE

India's National Health Accounts (NHA) provide a clear picture of the changing share of OOPE in total health expenditure. In 2010, households accounted for over 64 percent of the country's health spending, a figure that remained stubbornly high throughout the decade. By 2014–15, the share of OOPE was 62.6 percent of current health expenditure, one of the highest in the world for a large lower-middle-income country (Kamath & Brand, 2023). This burden translated into catastrophic financial shocks, with an estimated 55–60 million people falling below the poverty line annually due to medical costs.

Following the launch of Ayushman Bharat in 2018, there has been a modest but notable decline in the OOPE share. According to NHA 2019–20, household spending as a proportion of current health expenditure dropped to **48 percent**, marking the first time in decades that OOPE had fallen below half of the total (Government of India, NHA 2022). Figure 1 illustrates this trend, showing a gradual

but uneven reduction in OOPE over the past decade. While Ayushman Bharat cannot be credited as the sole driver of this decline—state-level free medicine schemes and increased government spending have also contributed—the scheme’s role in providing hospitalization coverage is an important factor.

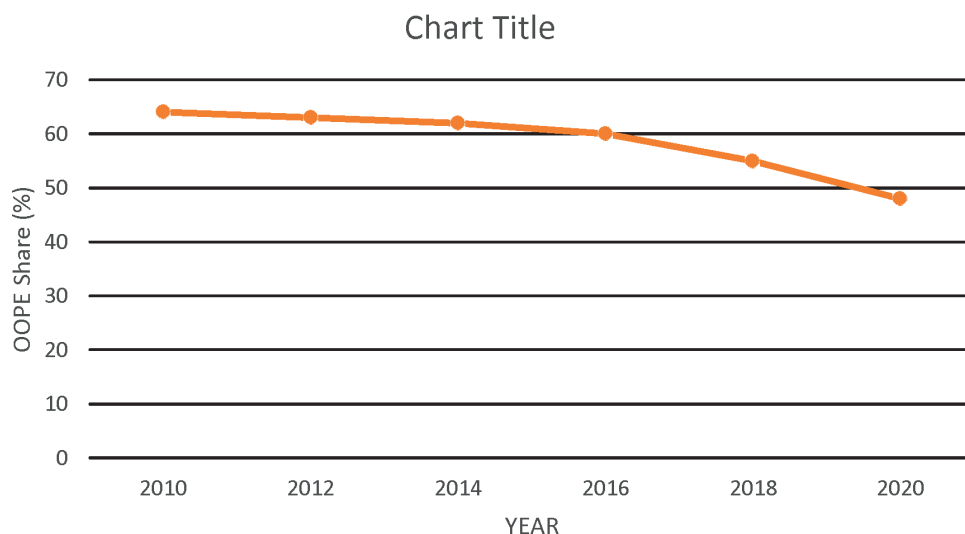


Figure 1: Share of OOPE in Total Health Expenditure, 2010–2020.

Source: NHA

Inpatient and Hospitalization Costs

The most direct impact of PMJAY has been observed in hospitalization costs. Studies and beneficiary surveys indicate that households covered under PMJAY have experienced reductions in catastrophic hospitalization expenses. For example, dialysis, cancer treatments, and cardiac surgeries—previously associated with ruinous costs—are now partially or fully absorbed under the insurance cover. Evidence from Tamil Nadu and Andhra Pradesh suggests that households using PMJAY for hospital admissions reported lower incidence of debt and asset sales compared to non-covered households (Basu, 2024).

However, the reduction is uneven. In states with weaker hospital networks or fewer empanelled facilities, households continue to incur OOPE despite being formally entitled to cashless treatment. Informal charges, medicines purchased outside hospitals, and diagnostic costs continue to burden patients. Table 1 compares catastrophic expenditure levels in selected states before and after PMJAY, showing sharper declines in southern states compared to northern counterparts.

Table 1 : Catastrophic Health Expenditure by State – Tamil Nadu and Andhra Pradesh show reductions from around 18–20 percent to 12–15 percent, while Uttar Pradesh and Bihar exhibit more modest improvements, from 35–38 percent to 32–35 percent.

Table 1: Catastrophic Health Expenditure (Pre- and Post-PMJAY)

State	Pre-PMJAY (%)	Post-PMJAY (%)
Tamil Nadu	18	12
Andhra Pradesh	20	15
Uttar Pradesh	30	32
Bihar	38	35

Source: PMJAY Dashboard

Interpretation: Southern states such as Tamil Nadu and Andhra Pradesh show a sharper decline in catastrophic expenditure compared to northern states like Uttar Pradesh and Bihar.

Outpatient Care and Medicines

The greatest limitation of PMJAY in reducing OOPE is its exclusion of outpatient care. Outpatient consultations and medicines together constitute nearly two-thirds of household health spending. According to NFHS-5, households spend disproportionately on medicines for chronic conditions such as hypertension and diabetes, with women and the elderly bearing the highest costs. Figure 2 demonstrates that while inpatient OOPE has shown modest declines, outpatient costs have remained persistently high, hovering around 58–60 percent of household spending.

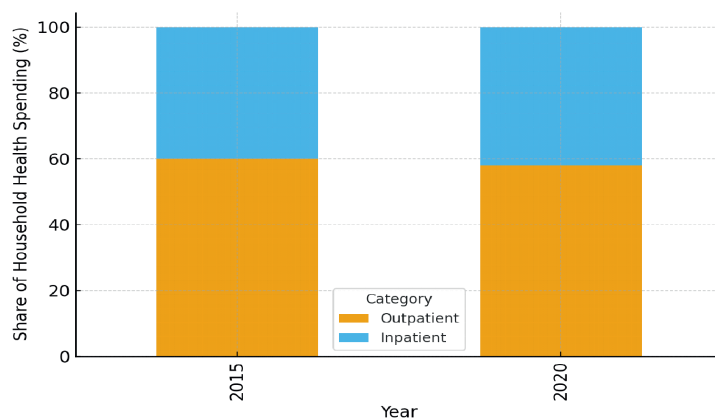


Figure 2: Breakdown of OOPE – outpatient care accounts for 60 percent in 2015 and 58 percent in 2020, while inpatient shares rose from 40 to 42 percent.

This structural exclusion significantly blunts Ayushman Bharat’s impact. While hospitalization shocks are mitigated, the day-to-day financial strain of outpatient care continues unabated, leaving households vulnerable.

State-Level Variations

The impact of PMJAY on OOPE varies considerably across India’s federal landscape. States like Tamil Nadu, Karnataka, and Andhra Pradesh integrated PMJAY with their pre-existing health insurance schemes, leading to higher awareness, enrolment, and utilization. In these states, reductions in catastrophic expenditure are more visible. In contrast, states such as Uttar Pradesh, Bihar, and Jharkhand have lagged behind. Limited hospital empanelment, poor awareness campaigns, and weak administrative capacity have meant that many eligible families remain excluded from benefits (Kamath & Brand, 2023).

Table 2 illustrates this variation by comparing utilization rates and self-reported OOPE across selected states. While Tamil Nadu reports utilization rates above 25 percent of eligible families and significant declines in hospitalization costs, Uttar Pradesh records utilization below 10 percent, with only marginal reductions in OOPE.

Table 2: PMJAY Utilization and OOPE Reduction by State – Tamil Nadu and Andhra Pradesh show high uptake and measurable declines, while Uttar Pradesh and Bihar show lower usage and persistently high OOPE.

State	Utilization Rate (%)	OOPE Reduction Reported
Tamil Nadu	27	Significant
Andhra Pradesh	22	moderate
Uttar Pradesh	9	Low
Bihar	8	Low

Source: WHO

Interpretation: Utilization rates of PMJAY are highest in Tamil Nadu and Andhra Pradesh, which also report more substantial reductions in OOPE. In contrast, states like Uttar Pradesh and Bihar lag in both utilization and financial protection.

Public–Private Dynamics

A further dimension of Ayushman Bharat’s impact relates to the dominance of the private sector in service delivery. Nearly 70 percent of PMJAY empanelled hospitals are private (Suheta et al., 2020). While this expands geographical access, it also creates vulnerabilities. Reports indicate cases of overcharging, upcoding, and

unnecessary procedures, which partially offset the scheme's financial protection benefits. Informal payments continue to be demanded in some facilities, and medicines are often prescribed outside the package rates, requiring households to pay out of pocket. This dynamic reinforces the structural imbalance between public and private healthcare in India: Ayushman Bharat has expanded access but has not fundamentally shifted the reliance on private providers, which undermines its OOPE reduction objectives.

Challenges and Policy Gaps

While Ayushman Bharat has brought health financing into the mainstream of India's public policy, its ability to reduce out-of-pocket expenditure is constrained by several structural and governance challenges. The first and most fundamental limitation is its design focus on hospitalization. As earlier sections have demonstrated, outpatient consultations and medicines account for nearly two-thirds of household health spending. By excluding these components, the scheme leaves the largest driver of OOPE untouched. Households continue to bear the routine costs of chronic illness management, diagnostics, and follow-up visits, which erodes the financial protection promised by the scheme.

A second challenge lies in the uneven implementation across states. India's federal structure allows states flexibility in adopting the scheme under different models—trust, insurance, or hybrid. While this cooperative federalism is designed to encourage local innovation, it has also generated stark disparities. States such as Tamil Nadu, Andhra Pradesh, and Karnataka, which already had established insurance schemes, integrated PMJAY more smoothly and witnessed reductions in catastrophic expenditure. In contrast, states like Uttar Pradesh, Bihar, and Jharkhand have struggled with awareness campaigns, empanelment of hospitals, and administrative capacity. As a result, eligible households in these states either remain excluded or encounter barriers in accessing cashless care.

Third, the reliance on private providers creates vulnerabilities. With nearly 70 percent of empanelled hospitals belonging to the private sector, there is an inherent tension between expanding access and regulating costs. Instances of upcoding, overcharging, unnecessary procedures, and even outright denial of treatment have been reported in some states (Suheta et al., 2020).

Finally, the evidence base for evaluating Ayushman Bharat remains limited. Most available studies are either descriptive or based on small-scale surveys.

Rigorous longitudinal evaluations of OOPE reduction are scarce, making it difficult to isolate the impact of Ayushman Bharat from other concurrent reforms, such as free medicine programmes and state-level schemes. Without systematic monitoring and independent evaluation, the policy debate risks being guided more by political narratives than by evidence.

Policy Recommendations

If Ayushman Bharat is to realize its goal of reducing OOPE, several reforms are urgently required. The most pressing reform is the expansion of coverage to include outpatient care and essential medicines. International experience, particularly from Thailand and Mexico, demonstrates that universal health schemes reduce OOPE most effectively when they cover both inpatient and outpatient services. For India, this would mean integrating outpatient consultations, diagnostic tests, and a comprehensive list of essential drugs into the PMJAY benefit package. By addressing the day-to-day financial burden, such an expansion would significantly improve household-level financial protection.

Equally important is the strengthening of primary healthcare infrastructure through Health and Wellness Centres. For HWCs to function as effective gatekeepers, they must be adequately staffed, stocked with medicines, and equipped with basic diagnostics. Currently, many centres remain underutilized due to shortages of doctors, erratic drug supply, and weak referral linkages. Investing in HWCs would not only reduce OOPE by cutting down avoidable hospitalizations but also build public trust in the health system.

The regulation of private providers must be tightened. At present, package rates are often circumvented, and informal charges are levied on patients. Introducing stronger accreditation requirements, periodic audits, and strict penalties for non-compliance is essential. Furthermore, empanelment criteria should prioritize quality, equity of access, and geographical distribution. Strengthening grievance redressal mechanisms at the district and state levels would empower beneficiaries and improve accountability.

State-level capacity building is another critical reform area. Lagging states require targeted fiscal transfers, technical assistance, and administrative support to strengthen their health systems. Tailoring the scheme's implementation to state-specific needs, rather than adopting a uniform model, would ensure more equitable outcomes. Encouraging innovation in community mobilization, digital tracking, and beneficiary outreach can improve awareness and utilization.

Finally, institutionalizing robust monitoring and evaluation mechanisms is indispensable. Independent impact assessments should be conducted regularly, focusing on OOPE reduction, equity of access, and quality of care. Linking evaluation findings to policy recalibration would ensure that Ayushman Bharat evolves based on evidence rather than political expediency.

Conclusion

Ayushman Bharat represents a historic step in India's health policy trajectory, reflecting both the aspirations of universal health coverage and the recognition of healthcare as a pillar of social protection. The scheme, through its twin pillars of Health and Wellness Centres (HWCs) and the Pradhan Mantri Jan Arogya Yojana (PMJAY), has expanded the scope of government intervention in health financing to unprecedented levels. By targeting 500 million people, it has become the world's largest publicly funded health insurance programme.

In assessing whether Ayushman Bharat has reduced out-of-pocket expenditure, the evidence presents a nuanced picture. On one hand, hospitalization-related financial shocks have been mitigated for covered households, particularly in states with robust insurance integration and a stronger health infrastructure. National Health Accounts data confirm that the share of OOPE in total health expenditure has declined from over 60 percent before 2018 to around 48 percent in 2019–20. This suggests that Ayushman Bharat has contributed to an important structural shift, even if it is not the sole driver of the change.

On the other hand, the scheme's exclusion of outpatient care and medicines—the largest component of OOPE—means that households continue to shoulder a significant financial burden. NFHS-5 data reinforce this point, showing that medicines for chronic diseases remain a major source of impoverishment, particularly for rural and low-income families. The heavy reliance on private providers, coupled with weak regulation, has created additional challenges such as informal payments and overcharging. Moreover, uneven implementation across states has produced highly variable results, with southern states demonstrating tangible reductions in OOPE while northern states continue to lag behind.

Ultimately, Ayushman Bharat has laid a foundation but not completed the edifice of financial risk protection. Its contribution to reducing catastrophic expenditure for hospitalizations is undeniable, yet its limitations constrain its transformative potential. The way forward requires bold reforms: expanding coverage to outpatient

services and essential medicines, strengthening HWCs as credible first points of care, regulating private providers more rigorously, and tailoring support for weaker states. Above all, the scheme must be guided by continuous monitoring, evaluation, and evidence-based recalibration.

If these reforms are pursued with seriousness, Ayushman Bharat can move beyond being the world's largest insurance programme in scale to becoming a model in substance—one that genuinely reduces OOPE, protects vulnerable households, and advances India's commitment to universal health coverage.

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