

Exploring the Degree of Awareness of Medical Insurance and AB-PMJAY within Blue Collar Workers in Gurugram

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ABSTRACT

Globally, Healthcare is recognized as a human right, either directly, or as a part of the broader right to life. Therefore, healthcare systems of most countries strive to ensure universal access to healthcare. The Public Healthcare system of India has undergone multiple reforms to achieve this. The most recent development was Ayushman Bharat and the National Health Policy of 2017, which sought to prioritize Universal Health Coverage. Most of the research in this field had been centered on national-level analysis on the feasibility, efficacy, and implementation of PMJAY and thus, there is a glaring need to examine the specific awareness, accessibility, and availability of Public Healthcare to the financially weaker sections of the society. The present study aims at examining the awareness and experiences with PMJAY, Medical Insurance, and the Public Healthcare system. A mix of qualitative and quantitative approaches were used to examine Public Healthcare, Medical Insurance, and Ayushman Bharat, including a survey and a qualitative schedule. The sample for the survey consisted of 48 blue-collar workers in Gurgaon. The data was interpreted through graphical representation and thematic analysis. It was found that migrants are less likely to be aware of Ayushman Bharat and that education level has a significant impact on the knowledge of the term medical insurance itself. Moreover, those with PMJAY cards had significantly lesser out-of-pocket expenditure. To address the issues found, awareness drives and camps specifically in the migrant communities as well as the utilization of social service infrastructure like Community Service Centers was suggested.

Introduction

Globally, Healthcare is recognized as a human right, either directly, or as a part of the broader right to life. As such, the healthcare systems of most countries strive to ensure access to healthcare for all. Healthcare itself has an impact on life expectancy, productivity, and the prevalence of disease amongst communities (Riley, 2012) and as such, the quality of healthcare is also a crucial component in determining the efficacy of a healthcare system.

The development of healthcare into its various forms has led to various socio-economic disparities in the utilisation, awareness, and accessibility of healthcare services. A primary line of divide is of economic class, both in terms of the financial ability to pay for healthcare, and in the form of any insurance coverage - both private and public (Riley, 2012).

The Public Healthcare system of India has undergone a myriad of reforms throughout its history as the country has continued to evolve. The most recent development came in the form of Ayushman Bharat and the National Health Policy of 2017 which sought to prioritize Universal Health Coverage. Most of the research in this field had been centered on national-level analysis on the feasibility, efficacy, and implementation of Ayushman Bharat (National Health Authority, India, n.d.), and as such, there is a glaring need to examine the specific awareness, accessi-

bility, and availability of Public Healthcare to the least financially prudent sections of the society, which were ultimately the primary focus of these Healthcare reforms. Further, the COVID-19 Pandemic has highlighted the importance of Public Health Infrastructure and the increased demands which the pandemic yielded.

India's Public Healthcare system is based on a web of "Health and Wellness Centres", which have varying levels of specialization, capacity, and coverage. There are three core designations for facilities serving Primary Healthcare needs: Sub-centres, Primary Health Centres (PHCs), and Urban Primary Health Centres (UPHCs). The UPHCs are the most advanced of the three, whereas Sub-Centres are the least advanced. These designations were largely created to address the specific demand requirements for the various socio-economic environments in India. Gurgaon, the focus district for this research paper, has a total of 60 Health and Wellness Centres, which includes 19 UPHCs, 10 PHCs, and 31 Sub-Centres (Government of Haryana, n.d.). It has an additional 8 Facilities designated for Secondary and Tertiary Healthcare under PM-JAY. In addition to these providers, it has approximately 100 more healthcare facilities of varying sizes and specialties in the private domain. In total, these facilities serve a total population of more than 1.51 million People (Census, 2011).

Most research thus far has examined Ayushman Bharat and PM-JAY from a nation-wide, macro view rather than its implementation in a particular region. An essay published in PLOS Medicine in 2019 examined the lack of preparedness of the Indian Healthcare system to effectively implement Ayushman Bharat. Another research paper examined the role of Private Healthcare providers within Ayushman Bharat and similar state-run schemes, again on a macro level (Choudary & Datta, 2019). Another article published in the International Journal of Advanced and Innovative Research analyses the infeasibility of the scheme at a financial level (Pareek, 2018).

In order to accomplish the objectives mentioned above, this research paper will analyse the availability, accessibility, and awareness regarding Healthcare through a mixed approach study in Gurgaon, Haryana, which has achieved the goals set out for the district in terms of infrastructure as per Ayushman Bharat, thus making it an ideal candidate to examine the efficacy of the scheme.

Methods

Aim

A mixed approach study was undertaken to determine the degree of awareness of PMJAY, Public Healthcare, and Medical Insurance within blue collar workers, which are all low income professions in Gurgaon, Haryana in India and were confirmed to be through the study itself. The study was utilized to gain the otherwise lackluster primary data on awareness and knowledge of PMJAY, Public Healthcare, and Medical Insurance, and to delve into the perspectives and experiences of these low-income professions which Ayushman Bharat targets in urban areas. (Coverage under PM-JAY, n.d., "Criteria/Coverage" section).

Research Design

The study directly examined the past experiences of participants through a survey and a qualitative schedule which negates the need to make inferences or assumptions over the target demographic of the study. Such a method of research would require the researcher to avoid bias. However, during the interpretation of the findings of the data gathered from research, especially when instances requiring translation, some bias may occur.

Tools Used

The survey was composed of three sections, with the first examining their awareness and usage of Ayushman Bharat and Medical Insurance. The second section examined their experiences with their healthcare provider through the use

of scales, while the last section examined their demographic details. Example questions include “Do you know what PMJAY is?” and “Do you know what medical insurance is?” for the first category, “How far away is the healthcare provider you use?” and “How clean are the healthcare facilities you visit?” for the second category, and “Age” and “Gender” for the third category.

The interview schedule included the following questions: “How smooth was the experience on the Ayushman Bharat Website? Did you face any issues?”, “How smooth was the process of procurement of an Ayushman Bharat Card? Was the institution willing to issue a card or were you redirected?”, “Were you denied treatment within Ayushman Bharat at any empanelled hospital”, “How were you made aware of Ayushman Bharat and where?”, “How much out of pocket expenditure (if any) have you had after getting an Ayushman Bharat card? For what costs?”, “Were your ailments/surgery/treatment covered under Ayushman Bharat?”, and “Was there a difference in your healthcare costs before and after the procurement of an Ayushman Bharat Card?”. This schedule was specifically offered to those who had Ayushman Bharat cards and served to determine the impact the card had on the individuals, as well as their process of procurement.

Sample:

The Sample consisted of 48 participants, of which 16 were female, and 32 male ($n = 48$). Only 12 participants were native to the state of Haryana, while the remaining were migrants (see Table 2). 12 participants were from Uttar Pradesh - a state bordering Haryana - and 5 were from Delhi, the city to which Gurgaon is a satellite to. A significant portion of responses - 7 to be exact - were from those native to West Bengal, a state in Eastern India which rather curiously has rejected the implementation of Ayushman Bharat. The average age of participants was 32.3 (to 3 significant figures), with a standard deviation of 7.20 (to 3 significant figures). However, for certain figures, certain participants may have been excluded for a non-response or an ambiguous response for the data points examined. Additionally, for all figures utilizing medical treatment type, participants citing more than 1 form of treatment were not considered.

Consent and Ethical Issues:

Anonymity was ensured during the data collection process, with no names or personal information being recorded. A note for consent for the utilization of information gathered for research purposes was integrated within the form itself, with additional verbal approval taken. All participants in the study were of the age of consent (above 18).

Data Collection Procedure:

Data was collected in December 2021 and January and February 2022 from gardeners, drivers, maids, and security guards employed in condominiums and gated societies in Gurugram, Haryana, India, as well as at various workplaces and shops in the city. Respondents were included on the basis of being above the age of 18. Other than this, no further exclusionary criteria was maintained. Through convenience sampling, 50 participants were gathered. The participants were either approached directly or conversed with via cell phone. The questions asked revolved around knowledge of PMJAY, Medical/Health Insurance, Expenditure on Healthcare, Interaction with Government Healthcare Providers, and their assessment of certain criteria to gauge their experience with these providers.

For the second phase of the research, 6 individuals who had an Ayushman Bharat card were interviewed. They were chosen on the basis of convenience sampling and conversation occurred in person or over phone.

Table 1. Parameters examined for the Study

Demographics	Scales	Objective Questions
Age	Success of Healthcare Treatment	Awareness of Medical Insurance
Gender	Cleanliness of Healthcare Facilities	Source of Medical Treatment
Education	Distance to Healthcare Facility	Awareness of PMJAY
Occupation		Enrolment and Utilization of PMJAY
Family Income and Monthly Healthcare Expenditure		Enrolment in Govt. Schemes
State/Region of Origin		Enrolment/Coverage of Pvt. Insurance

Results and Discussion

Fig 1. shows the distribution of each level of success for each medical treatment type. The results indicate the fact that the quality of the medical treatment available is largely similar across most forms, barring Informal Health Practitioners (IHPs). The fact that 7 respondents even indicate using IHPs highlights possible shortcomings in the capacity or availability of licensed private healthcare or public healthcare providers.

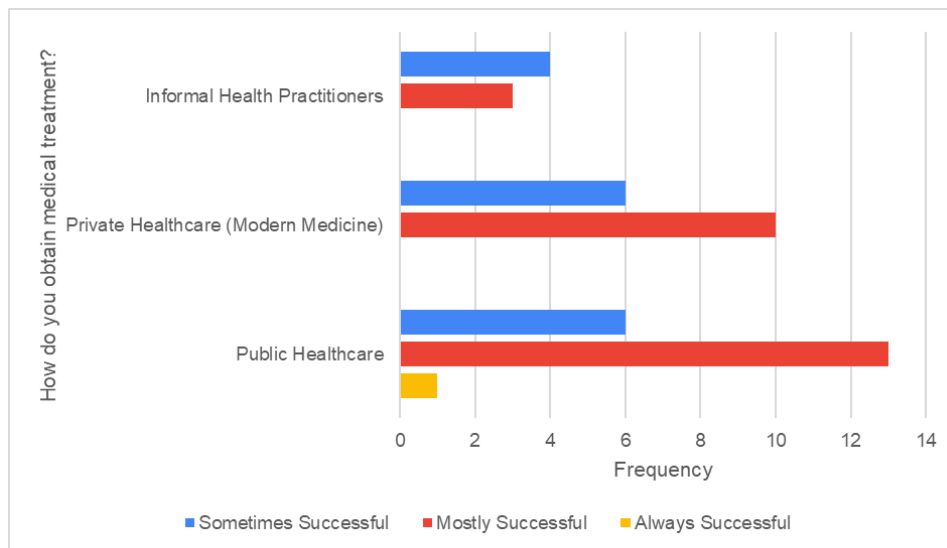


Fig 1. Distribution of each success level of treatment for each treatment type (N = 43)

Fig. 2. shows the distribution of medical treatment types for each family income category. It shows a significant skew towards private healthcare for the more than 30000 INR per month category, indicating that individuals tend to opt for private healthcare as income increases. On the contrary, those in the lower income strata of 10001 - 15000 INR per month primarily opted for Public Healthcare. This pattern however does not exist due to quality of healthcare as indicated by Fig 2, which suggests the fact that Public Healthcare is marginally superior to Private Healthcare in terms of treatment success.

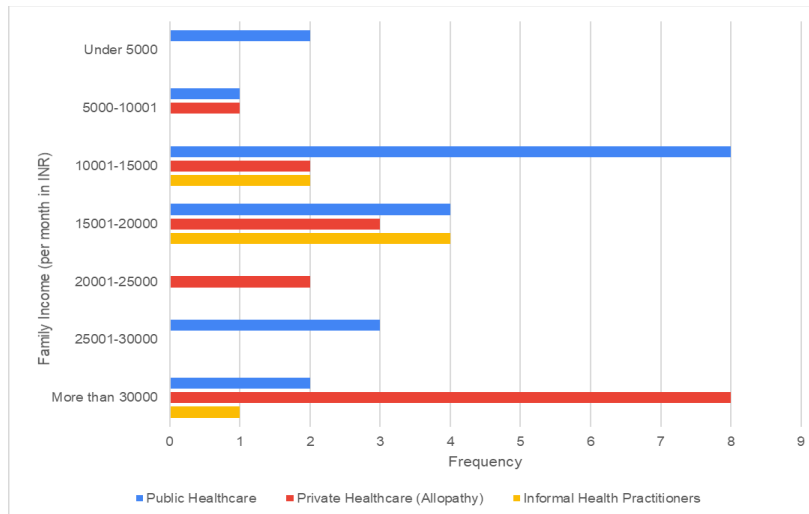


Fig 2. Distribution of treatment type for each family income level (per month, INR) (N = 43)

Fig. 3 shows the distribution of distance to the medical facility for each medical treatment type. Distances are largely similar over all three categories (N = 43).

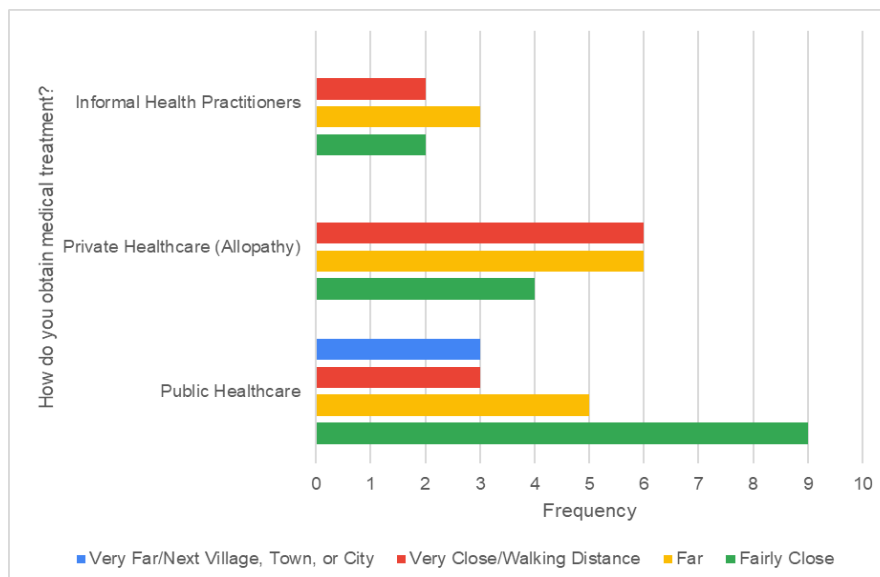


Fig 3. Distribution of each distance level for each treatment type. (N = 43)

Fig 4. shows the distribution of knowledge of the term ‘medical insurance’ for education level, signifying a general trend of a greater likelihood of awareness of medical insurance as literacy increases. The significant presence of those

with bachelor's and master's degrees in the sample sheds light on the lack of skilled employment opportunities in Gurgaon, with overqualification in unskilled or semi-skilled jobs present as a result. Despite improvements as literacy increases, a large segment of even the educated population appears to be unaware of the Medical Insurance, further highlighting the need to raise greater awareness about the idea.

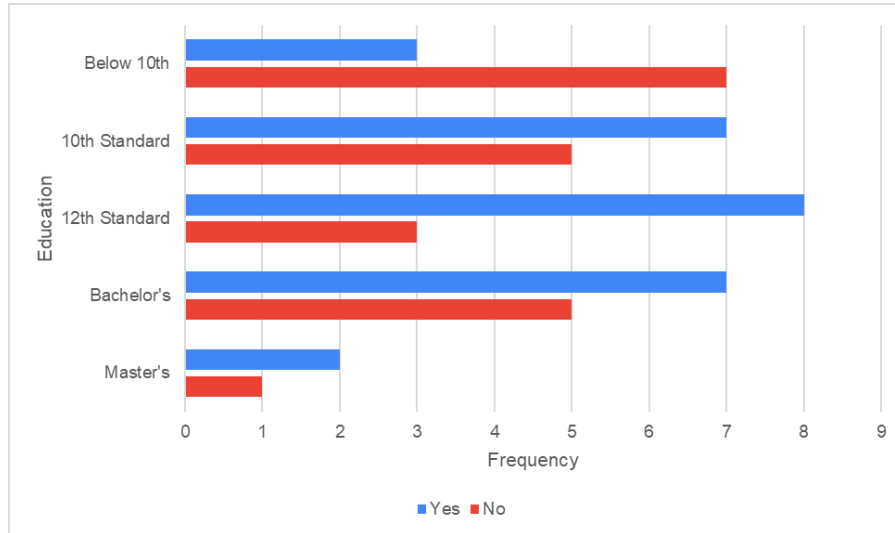


Fig 4. Distribution of knowledge of the term 'medical insurance' for each education level

Fig 5. shows the distribution of awareness of the term 'PMJAY' for each state of origin. The graph illustrates the lack of penetration of the scheme amongst migrants. Those local to the state of Gurgaon (Haryana) showed significant awareness of the scheme, with a majority of respondents indicating awareness of Ayushman Bharat. However, those from states at a great distance from Gurgaon, such as West Bengal, showed little or no awareness of the scheme. Those from neighbouring states or Union Territories like Uttar Pradesh and Delhi still indicated awareness of Ayushman Bharat, though not at the percentage of Haryana. The case of West Bengal in particular may be explained by its rejection of Ayushman Bharat.

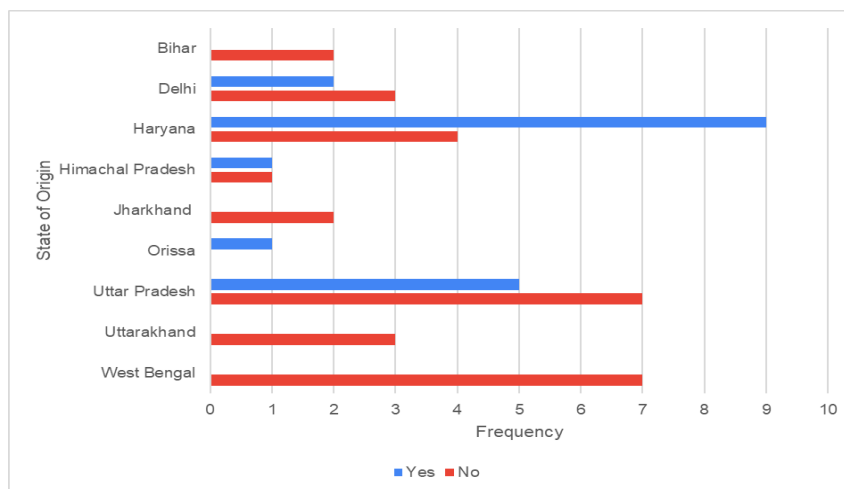


Fig 5. Distribution of awareness of the term PMJAY for each state of origin

Further, education and awareness of medical insurance and by extension Ayushman Bharat had a significant correlation, with those with lesser education showing lesser awareness. The origin of state also had a significant impact, with those from Haryana having a higher likelihood of being enrolled in Ayushman Bharat (33.3%) vs. migrants (15%). Awareness about Ayushman Bharat also often did not translate to enrolment (approx. 40% of respondents indicated awareness of Ayushman Bharat).

The second phase of research indicated a mixed response with regards to their experience with Ayushman Bharat. The experience on the website was coded, as 2 of the 3 respondents who used the website indicated difficulties with finding their name in the Am I Eligible Section. 3 of the 6 respondents had their cards made at a government camp, in which case they reported no difficulties. The other 3 respondents had their cards made at an empanelled hospital, however 1 was redirected to a civil hospital despite visiting an empanelled hospital. 2 of the 6 respondents were denied treatment at an empanelled hospital, with 1 respondent citing capacity constraints. The 3 respondents who were facilitated by the government camps were also originally made aware of the scheme at the camps, while 2 respondents were made aware of the scheme by friends or neighbours, and 1 received information via a Village Panchayat (table 2). The 4 respondents who had received treatment under Ayushman Bharat all had out of pocket expenditure, however the costs for their procedure was reduced in 3 of the 4 cases. 1 of the 4 respondents who had received treatment under Ayushman Bharat had costs reduced for a heart stent surgery from 80000-90000 INR (figure cited to the respondent at a private hospital) to 3000 INR for treatment through the scheme. All the 4 respondents who had received treatment under Ayushman Bharat indicated that their surgery/treatment was covered under the scheme.

Table 2. Frequency Distribution for the Qualitative Schedule

Criteria	Yes	No	Unsure/Not Applicable/Don't Know
Issues with the AB-PMJAY Website	2	1	3
Issues with Procurement	1	5 (3 Govt. Camp, 2 Hospital)	0
Denial of treatment at an empaneled hospital	2	3	1 (Not attempted to Use the Card)
Source of Awareness as Govt. Camp	3	1 through Friends, 1 through Panchayat, 1 through neighbors	0
Reduction in costs through the usage of AB-PMJAY	3	0	2 Not Used, 1 Unsure

The results indicate a general lack of awareness of Ayushman Bharat, with a majority having no knowledge of the scheme. As the flagship healthcare scheme of India, further collaboration between the State Governments and the Central Government will be crucial in increasing the outreach of the scheme to migrants, who are disproportionately neglected under the scheme currently, especially as the website interface relies on documentation from their native state. Given the old reference database for determining eligibility (SECC 2011), a requirement to conduct a new survey is also highlighted. However, this would only be a short-term solution given that these surveys are updated on

a 10-year basis, and therefore, might grow outdated towards the latter half of the decade. An alternative path to enrolment in PMJAY can be made available to remedy any shortcomings in the survey through Community Service Centers, allowing individuals to prove their eligibility.

Certain states like West Bengal, which have rejected to implement Ayushman Bharat, also negatively impact their migrant communities, as the results indicate that the primary source of enrolment is government outreach. The highly developed, urban landscape of Gurgaon would also negate the significance of distance of healthcare facilities to a large degree, which would otherwise limit choice of empaneled hospitals or facilities in rural regions of India.

Further, the lack of participation of private hospitals reduces the penetration of the scheme in urban regions, where private healthcare may account for the vast bulk of treatment. Out of India's estimated 69264 hospitals, 43486 are private (Kanwal, 2022). This, compared with the approximately 23000 empanelled hospitals (Ministry of Health and Family Welfare, 2021) including public ones, indicates a fairly small adoption of PMJAY in the private sector. Moreover, access to tertiary and super-specialised healthcare would be vastly restricted without adequate participation from stakeholders in the private domain, as the capacities for the same within the public healthcare setup are highly limited, often being restricted to medical institutes or hospitals in tier 1 cities. The primary roadblock to the implementation of Ayushman Bharat in large-scale private hospitals is simply the infeasibility of the package rates set by the government, as well as nonpayment of dues in certain situations (Mander, 2022). An alternative to increase capacity through private engagement may be encouraging private hospitals to create centers in semi-urban and tier 3-4 cities of India, which will both increase outreach of the organization and allow Ayushman Bharat to be implemented without the constraints of higher overheads in Tier 1 Cities and the operation of a large establishment. This would also deflect traffic from the main establishment to the smaller centers, allowing for a further emphasis on high-margin treatment for the hospitals. Moreover, this would also offer an affordable alternative to the overburdened public healthcare system in semi-urban regions.

Limitations

The study is limited by its small sample size, as well as the sample itself - which disproportionately included migrants. Certain respondents were also confused between different government schemes or questions, and as such, certain responses could not be included when examining certain data points. There was also a skew towards males, especially in ages above 25. This may partially be explained through India's low female participation rate of 22.8% (Sharma, 2022). Moreover, there was a skew towards the above 30000 INR per month segment in the sample. The sample was also not uniform, with a heavy skew towards West Bengal in particular (7 Responses). More specific and relevant responses could have been elicited through better question formation, as certain questions such as "Generally, how aware do you find yourself to be with regards to healthcare and healthcare facilities?", which are highly subjective or vague. The sample was also concentrated in certain areas of Gurgaon, which may not be representative of the entire city.

Conclusion

The paper has gone on to highlight the shortfalls in awareness of the general concept of Insurance, upon which PMJAY is created. Through a mixed approach of both qualitative and quantitative techniques, it was determined that education, state of origin, and Insurance as a concept has been largely alien to the healthcare field, which has hamstrung the adoption of Ayushman Bharat. The decentralization of the scheme to the individual states has also adversely impacted the migrant communities, as indicated by both awareness and usage data on the scheme. To remedy this and other issues with the scheme, measures such as the creation of centres by leading private hospitals in semi-urban and tier 3

cities and awareness drives focused on migrant communities. Also, the usage of Community Service Centers for enrolment and the usage of the SECC 2021 data (when completed) has also been suggested to allow for greater penetration and adoption of the scheme.

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