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An Impact of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana on Out-of-Pocket Expenditure, A Government-Funded Health Insurance Scheme

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Abstract

India urgently requires a comprehensive healthcare system that is accessible to everybody. Due to budgetary constraints, the deprived population in India has difficulty gaining access to adequate medical treatment. One of the most prominent initiatives, the "Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)," is designed to cover the costs of persons receiving tertiary and secondary treatment. In 2018, the Indian government launched a program named "Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB PMJAY)" to improve access to healthcare. With insurance coverage of up to 0.5 million Indian Rupees per year, this program aims to ensure that those in need never have to choose between paying for medical treatment and meeting other basic needs. This study aims to determine how much of an effect the "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana" has on people's out-of-pocket medical expenditures in the Ahmedabad area of Gujarat. To achieve these goals, the study employed both primary and secondary techniques of data collecting. The primary data was gathered through the use of a questionnaire, and a random sample method was employed to choose 350 respondents from the villages located in the Ahmedabad district. Data from secondary sources, such as government websites, newspapers, prior publications, and so on, were collected. According to the results, the "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana" significantly impacts the beneficiaries' Out-of-Pocket Expenses.

Keywords: AB PMJAY 1; Government initiative 2; Health Insurance 3; Out-of-Pocket expenditure 4

1. Introduction

The Indian healthcare system is an intricate combination of commercial companies, non-governmental organizations, and several levels of government that make decisions and deliver services (Patel et al. 2015). The availability of adequate medical care has become a significant issue in recent years in India. The great majority of Indians do not have access to any kind of health insurance, which means they must pay extremely expensive out-of-pocket costs for medical care (Nandi et al. 2017). Those in need who are unable to meet their medical bills are in an extremely precarious position. In September 2018, the "government of India introduced the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)" to try to solve this problem.

In addition to covering up to “Rs. 5 lacks per family per year” for secondary and tertiary hospitalization treatment as well as pre-and post-hospitalization costs, the program offers participants at empanelled institutions cashless and paperless access to healthcare services. The “out-of-pocket expenditure (OOPE)” for medical treatment has been a significant barrier that the Indian healthcare system has needed to overcome for some time, and one of the key goals of the AB-PMJAY plan is to minimize this barrier (Mukhopadhyay, K. et.al. 2019).

As of the 14th of June 2024, a total of 34.58 crore Ayushman cards have been generated against the verified beneficiaries, and over 6.86 crore hospital admissions have been authorized through a network of 29,984 empanelled healthcare providers, which includes 12,957 private hospitals (Update on AB-PMJAY, 2024).

As a result of the inadequacy of the existing prepayment and risk pooling systems in India, individual households are forced to shoulder a considerable portion of the financial burden associated with the cost of medical care. At the moment of service delivery, "out-of-pocket expenditure (OOPE)" accounts for more than three-quarters of all healthcare expenses. The single greatest portion of these expenditures, or around 63% of the total, goes toward the purchase of medications (NHSRC 2014). This is a result of the fact that household healthcare demands are not being met by government financing or social health insurance payments. By lowering the out-of-pocket costs associated with medical treatment, the program has significantly improved the quality of life for many of its beneficiaries. According to the “National Health Authority (NHA),” the organization tasked with carrying out the scheme’s implementation, AB-PMJAY, has brought about a considerable reduction in the “out-of-pocket expenditures (OOPE)” associated with hospitalization care.

The AB-PMJAY program has a major influence on the lives of many beneficiaries by lowering the “out-of-pocket expenditures (OOPE)” associated with healthcare, increasing the number of people who use healthcare services, and enhancing the overall quality of healthcare services. A significant contribution made by the program has been in the area of providing disadvantaged segments of the population with financial protection against catastrophic health costs. Notwithstanding this, there is still room for advancement in how the program is being implemented, particularly regarding assuring the quality of healthcare services and resolving geographical inequities in the provision of healthcare services (Bala et al. 2021).

1.1 Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

The "Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (PM-JAY)" was introduced at the end of 2018 and is India's most recent publicly funded national-level health insurance plan. To increase annual family coverage to about USD 7,000, PM-JAY is replacing the previous "Rashtriya Swasthya Bima Yojana (RSBY)" and increasing coverage for secondary and tertiary care as a result. About “500 million” people from the lowest socioeconomic strata are expected to be eligible for the scheme's benefits now that the previous limit on the number of family members who may avail themselves of the scheme's advantages has been eliminated (Furtado et al. 2022).

The National Health Policy of the Indian government includes this means-tested scheme. “The Ministry of Health and Family Welfare unveiled it in September 2018.” That ministry subsequently formed the National Health Authority to handle program administration. The federal government and the individual states contribute equally to this program. It is the largest government-sponsored healthcare program in the world, serving 50 crores (500 million) people. (Economictimes.Indiatimes. Com). Users of the program

have modest incomes in India, making it a means-tested service.

1.2 Out-of-Pocket Expenditure

An “out-of-pocket expenditure” must be paid upfront and may or may not be covered by insurance or another type of reimbursement program. When the cost of a healthcare product or service is not fully covered by insurance, the patient is responsible for paying the remaining balance out of pocket. Some examples of these costs include when people split the bill or pay for their medications. Both the percentage of household income and the percentage of household consumption can be used to assess the financial toll of out-of-pocket health care costs.

The out-of-pocket cost of medical care borne by individuals and families is a standard component of healthcare delivery systems across the globe. In addition, policymakers have a challenge when crafting healthcare systems and insurance mechanisms: how those systems will affect the well-being of families, especially low-income households (Xu et al. 2003). Healthcare financing models that rely on individuals making out-of-pocket payments are widely acknowledged to be demeaning, humbling, and ultimately unsustainable. The most common factors contributing to catastrophic out-of-pocket medical costs are unstable financial status and substandard housing conditions (Vahedi et al. 2020).

1.3 Impact of AB-PMJAY on out-of-pocket Expenditure

The AB-PMJAY is a once-in-a-generation chance to alleviate a significant cause of poverty in India and enhance the health of hundreds of millions of people. High personal healthcare costs are a major issue for health policymakers in India. Households' OOPE accounted for 63.2% of total healthcare spending in 2016, per the most recent “National Health Accounts (NHA)” Report (National Health Systems Resource Centre 2019).

The decrease in healthcare-related out-of-pocket costs is a significant benefit of AB-PMJAY. Hospitalization, surgical procedures, and medication for a variety of diseases and conditions are all included in the program's scope of coverage. Beneficiaries have been able to receive high-quality medical treatment without bearing the financial burden of doing so. This shifts the financial burden away from individuals and their families, lowering out-of-pocket costs and protecting against the kind of catastrophic medical bills that may put a whole household into poverty.

An additional effect of AB-PMJAY is a greater need for medical treatment. Many people who were previously unable to get the treatment they needed owing to financial difficulties are now able to do so. Because of this, more people are using healthcare services, including preventative care and early interventions, which can save money in the long run. Beneficiaries may now get the care they need when they need it, without having to postpone or reject treatment because of cost, thanks to the rise in healthcare service consumption.

1.4 Rashtriya Swasthya Bima Yojana

To help low-income families (also known as "Below Poverty Line" households), the "Indian Ministry of Labour and Employment (MoL&E)" created the RSBY in April 2008. Participants in RSBY must live in one of the low-income families included on a state's BPL list (compiled by a census). Any family that signs up for the program will be issued a smart card that can be used at any of the thousands of partner hospitals nationwide. Insurance companies receive a flat charge per household registered and are required to make all claims settlements with hospitals at rates determined centrally.

Hospitalization costs for some ailments are paid up to INR 30,000 (about US$500) annually for RSBY households. Insurance does not cover outpatient care. Pre-existing conditions, however, are not covered. Up to five immediate family members can be included. The annual registration cost for beneficiaries is INR 30 (about USD 0.50) per family. Donations from the federal and state governments support the program. It is run by public and private insurance firms chosen through a competitive tendering process. Hospitals selected under the program provide covered services under RSBY (Johnson & Krishnaswamy 2012).

Since April 1, 2015, the "Ministry of Health and Family Welfare" has been responsible for the "Rashtriya Swasthya Bima Yojana (RSBY)" program. The government is administering and executing the program through a decentralized implementation structure at the State level to safeguard low-income families from medical disasters by reducing their out-of-pocket expenditures and boosting their access to excellent treatment in the unorganized sector.

1.4.1 Impact of RSBY on Out-of-Pocket Expenditure

Regardless of the coverage provided by various health insurance plans, the "Indian National Health Account 2017 states that OOP (out-of-pocket)" health costs for inpatient treatment account for around 32% of the entire OOP health expenditures (National Health Accounts: Estimates for India 2014–15 2017). The program was successful enough that it spread to around 26 or 27 states and was recognized internationally. Coverage under RSBY was capped at Rs 30,000 per year per family. The government of India has also become increasingly concerned about rising OOP healthcare costs among the country's poor and marginalized (Karan et al. 2017).

Standard household utility-maximization models, which consider the pricing of healthcare services and other items, help to understand the anticipated effects of RSBY on healthcare usage and out-of-pocket expenses. The hypothesis is that households will increase their usage of inpatient care as a result of the price reductions afforded by RSBY. The cost of hospitalization is also expected to be lowered due to RSBY. Patients' out-of-pocket hospital costs may decrease if families are encouraged to go beyond the RSBY-approved cap of INR 30,000 on inpatient care. However, the impact of RSBY on outpatient service usage and out-of-pocket costs for outpatient treatment is not evident in any way. The extent to which outpatient treatment supplements or replaces hospitalization is an important consideration. However, the utilization of outpatient treatment is predicted to decrease if outpatient care is used as a substitute for inpatient care. Since RSBY is not intended to pay for outpatient treatment, it will have the same negative impact on outpatient out-of-pocket costs that it does on outpatient care utilization (Karan et al. 2017).

1.5 Launch of State-Level Government Insurance Program:

Modern healthcare is expensive due to new and better treatments. The cost of treatments, drugs, and hospitalization has skyrocketed, making it harder for low- and middle-income people to afford adequate healthcare in a medical emergency. To meet everyone's healthcare needs, the Indian government has created many health insurance plans. Many of these health schemes are government-sponsored group health insurance plans. People can get coverage without paying a premium.

In contrast, other plans need minimal payment. Government health insurance programs attempt to offer inexpensive coverage to people with low incomes. The following are different types of Government health schemes that are available in different states –

1.5.1 Mukhyamantri Amrutum Yojana (Gujarat)

The government of Gujarat launched Mukhyamantri Amrutam Yojana in 2012 to help the state's low-

income residents. Those who fall between the middle class and the poverty level are eligible to apply for the program (Bhatt & Rana 2019). It's a health insurance policy for the whole family, and it covers medical expenses up to Rs 3,00,000. The insured has access to all hospitals, including public and private, as well as those operated by charitable organizations. The program's ultimate goal is to increase the likelihood that low-income families would have access to the necessary hospitalization, surgical procedures, and therapeutic interventions for the treatment of specific diseases.

1.5.2 Chief Minister's Comprehensive Insurance Scheme (Tamil Nadu)

The "Government of Tamil Nadu offers the Chief Minister's Comprehensive Insurance Scheme. The United India Insurance Company, Ltd." collaborated with them on the project's debut. It's a group health insurance plan for the whole family, and it's meant to cover high-quality medical treatment. This plan covers more than a thousand different medical interventions. Up to Rs 5 lakh can be claimed for medical care under this coverage. Under this program, the recipient can use either public or private healthcare facilities. Residents of Tamil Nadu whose annual income is less than Rs 75,000 are welcome to apply for this program (Selvavinayagam 2017).

1.5.3 Yeshasvini Health Insurance Scheme (Karnataka)

The "Yeshasvini Health Insurance Scheme is one that the government of Karnataka" is working to spread awareness about. Peasants and farmers, particularly those who are cooperative group members, can benefit from this arrangement. This health insurance plan pays for more than 800 different types of medical treatments, including neurology, orthopedic, angioplasty, and many more. The Yeshasvini Health Insurance Scheme is made more accessible to rural farmers via the assistance of cooperative groups. Beneficiaries can get medical treatment at network hospitals, and family members of beneficiaries are also eligible to receive coverage benefits (sahakarasindhu.karnataka.gov.in).

1.5.4 Mukhyamantri Swasthya Beema Yojana (MSBY) (Chhattisgarh)

Chhattisgarh was India's first state to offer universal healthcare coverage of 50,000 under this program. The Chief Minister's Health Insurance Program provides comprehensive medical protection for the whole family. The MSBY expands upon the RSBY in several ways and is an effort of the state government. The RSBY insurance limit was raised from 30,000 to 50,000. It had a particularly beneficial effect on the lives of women and children in low-income households across the state. The official assessment evaluating RSBY and MSBY in four districts of Chhattisgarh found that the primary reasons for nonenrolment were that potential beneficiaries were either absent in the village, did not apply, or faced long waiting periods (Shirisha 2020).

2. Review of literature

The purpose of the literature review for the present study is to determine which areas of research are lacking and which difficulties already exist by analyzing works written by a wide range of authors. A review of the relevant literature should begin with the aspects mentioned below as its foundation:

2.1 Evolution of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

The largest health insurance program in the world, the "Pradhan Mantri Jan Arogya Yojana (PM-JAY) in India, offers a family's health coverage for 500,000 INR (about USD 6,800) each year." Treatment is given by governmental and commercial empanelled providers, and over 500 million of India's poorest households receive financial aid for hospitalization bills as a result of various insurance arrangements. **Joseph, J., et al. (2021)** outlined the process of Ayushman Bharat PM-JAY provider empanelment, a vital component of the program's success. However, the study also showed that while empanelment has the

potential to help with the inclusion and regulation of the private sector, the public sector's role is still critical, especially in underserved parts of India. Focusing on the universal quality health care system. **Amit, K., & Madhushree, B. (2020)** highlighted the difficulties that are currently being encountered in the implementation of AB PMJAY based on the experiences gained during the field tour that took place in May 2018 in three blocks of the Gaya District of Bihar from the standpoint of conventional medical practices. Researchers revealed that persons who have acquired a PMJAY letter are members of the Dalit community but that the quality of care they are receiving is inadequate. **Naaz, N., & Nigudgi, S. (2022)** evaluated the number of patients who signed up for the PM-JAY health insurance program at the "Basaveshwar Teaching and General Hospital in Kalaburagi, Karnataka." The study found that between January and October of 2021, 1791 patients registered for PM-JAY benefits. In April, when the second wave of COVID-19 hit, 327 people filed for PM-JAY insurance, the highest monthly total to yet. Only a handful of claims were ultimately denied. Incidence of NCDs was observed during the study. Key trends in the use of cardiac care packages under the Ayushman Bharat AB PM-JAY were examined **by Naib, P. et al. (2021).** In their study, all cardiac claims processed through PM-JAY over 17 months (from the scheme's inception in September 2018 to February 2020) were examined. The data revealed that claims from the cardiac (cardiology, cardiothoracic, and vascular surgery) speciality contributed to the total claim volume but only made up 5% of the entire PM-JAY claim volume. It was much higher at 26%, showing that a sizable amount of the program was used to offer free cardiac treatment to users who were among the poorest members of society.

2.2 Impact of AB-PMJAY on Out-of-Pocket Expenditure

"Out-of-pocket expenditures (OOPE)," also known as direct and indirect expenditures, are borne by patients and cause them to become impoverished. As a consequence of this, patients who have life-threatening illnesses and require tertiary care frequently do not receive treatment, even though they are aware that high-quality services are available to them. Patients receiving AB-PMJAY benefits had no reduction in catastrophic health spending or distress finance **(Khan, A., et al. 2021)**. The Ayushman Bharat program guaranteed coverage for all preexisting diseases and offered 1,350 unique medical packages, some of which comprised surgical procedures, pharmaceuticals, diagnostic tests, and even childcare. In Sirsi and Madanpur, two villages in the Indian state of Haryana, not a single policyholder has reported receiving any kind of medical aid from the program. Families of sick people need greater education, and the barrier to obtaining the card has to be removed. All severity levels (from mild to severe) must be risk-free for the claim to be valid **(Bala, R., et al. 2021)**. In their study, **Prinja, S., et al. (2019)** determined the average cost per patient treated for valvular heart disease at a major hospital in India. This encompassed in-office consultations, hospital stays, emergency treatment, some operations, and diagnostics. One hundred individuals who had heart valve replacement or balloon valvotomy had their out-of-pocket expenses assessed. All price ranges were for the 2016-2017 fiscal year. Outpatient cardiac consultations in cardiology and "cardio-thoracic and vascular surgery (CTVS)" were predicted to cost the healthcare system 182.4 Indian rupees (US$2.8) and INR 334.8 (US$5.2), respectively. **Kaur, A., et al. (2021).** determined the average amount spent by patients' healthcare systems and their own pockets on each "Pediatric Intensive Care Unit (PICU)" stay. The per-patient and per-bed-day expenses of care were calculated from both the healthcare system's and the individual patient's perspectives. The costs incurred by a family when caring for a child who required mechanical ventilation were twice as high as those of a family whose child did not require mechanical ventilation.

2.3 Awareness among the Public regarding AB-PMJAY

Prasad, S. S. V., et al. (2023) investigated AB-PMJAY's level of awareness and usage in a particular rural region of Bihar. Two-thirds of rural residents and three-quarters of eligible participants were acquainted with the "Ayushman Bharatiya Jan Arogya Yojana (AB-PMJAY)" scheme, but only 1.3 per cent used it. This suggested that regular training of frontline healthcare workers like "Accredited Social Health Activists (ASHA) and Angan Wadi Workers (AWW)" is necessary to strengthen community ties and increase AB-PMJAY participation. The impact of AB PM-JAY on controlling and reducing the virus's spread in India was studied by **GOGOI, H., et al. (2022)**, who found that it helped Indians during the Covid-19 epidemic. In addition, the study offered analysis-based perspectives to help policymakers and healthcare stakeholders better prepare for future crises of this nature. To assess "healthcare workers' (HCWs)" awareness of and readiness to implement the PMJAY, **Nirala, S. K., et al. (2022)** conducted a study. The analytical, cross-sectional study was conducted at hospitals with a target sample size of 411. Participants included "treating faculty, resident doctors, and nursing officers." The doctor averaged just over 50% of the possible maximum score in awareness. Faculty members had a greater understanding of the system than residents and nursing officers. As knowledge of PMJAY has grown, so has preparedness for its implementation. For greater preparedness, stakeholders should attend regular PMJAY sessions.

3. Objectives and Methodology

The study aims to determine the "impact of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana on out-of-pocket expenditure, a government-funded health insurance scheme." Following are some of the objectives that are pursued by this research:

1. To examine the evolution of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in India.
2. To ascertain the benefits of the AB-PMJAY scheme.
3. To determine the impact of the AB-PMJAY scheme on the out-of-pocket expenditure of beneficiaries.

The study used both primary and secondary sources to gather the information needed to reach its goals. The primary data was collected through the questionnaire using a random sampling technique from 350 respondents from villages of the Ahmedabad region of Gujarat. Secondary data was collected from government websites, newspapers, previous articles, etc. The statistical tools used are "Excel and SPSS (Statistical Package for the Social Sciences)." The statistical techniques used in this study are mean, standard deviation, correlation, and regression.

4. Measurement of Tools Used in the Study

4.1 Data Collection

The study utilized a close-ended questionnaire to determine the impact of the "AB-PMJAY scheme" on the out-of-pocket Expenditure of beneficiaries. The targeted population completed the questionnaire after obtaining consent through the consent application form. The questionnaire data were filled by 350 respondents from the Ahmedabad district, Gujarat. The first page of the questionnaire had the consent application form, and then from the next page questionnaire started. The questionnaire used a 5-point Likert scale, "5 points to fill, related 5 = Strongly Agree, 4 = Agree, 3 = Neutral, 2 = Disagree, 1 = Strongly Disagree."

4.2 Analysis of Data

The study analyzed the responses that were obtained using the questionnaire from the participants mentioned above. Various tools and techniques can be used to analyze and interpret the data obtained

through various methods. However, the study utilized few of the tools and techniques mentioned. The statistical tools used are "Excel and SPSS (Statistical Package for the Social Sciences)." The statistical techniques used in this study are the regression model and descriptive technique.

Table 1: Research Metrix

Objective	Statistical Tests	Description
To examine the evolution of "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in India."	Descriptive	The method of doing descriptive analysis is by comparing current and old data to establish connections and patterns.
To ascertain the benefits of the AB-PMJAY scheme	Descriptive	The method of doing descriptive analysis is by comparing current and old data to establish connections and patterns.
To determine the impact of the AB-PMJAY scheme on the out-of-pocket Expenditure of beneficiaries	Regression	The analysis of the relationship between a "dependent variable and a set of independent variables," including the direction and magnitude of the relationship.

5. Data analysis

This section outlined the data analysis and results. The results have been divided based on objectives. Inside the objectives, the result has been shown with the use of a table and their explanation.

- **Demographics of the respondents**

Table 2: Demographic profile of the respondents

S No.	Demographic Characteristics	Category	N	%
1.	Gender	Male	258	73.70%
		Female	92	26.30%
2.	Age Group	16-25 Years	73	20.90%
		26-35 Years	102	29.10%
		36-45 Years	97	27.70%
		46-59 Years	78	22.30%
3.	Marital Status	Married	219	62.60%
		Unmarried	131	37.40%

"Table 1 shows the Demographics of the respondents in the context of their gender, age, and marital status. According to Table 1, out of 350 respondents, 73.70% are male, and 26.30% are females, out of which 20.90%of the respondents are aged between 16-25 years, 29.10% of the respondents are aged between 26-35 years, 27.70% of the respondents are aged between 36-45 years, and 22.30% of the respondents are aged between 46-59 years."

Objective: To examine the evolution of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana in India

The Government of India introduced the "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)" in September 2018 as its flagship health insurance plan to provide financial security and inexpensive healthcare to millions of underprivileged households across the country. Since it was first implemented, the plan has changed to better meet the requirements of those who receive its benefits. In comparison to the sectoral, segmented, and fragmented approach to service delivery employed by previous national and state programs, "Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY)" is a radical improvement (pib.gov.in).

In the fight against the COVID-19 epidemic in India, AB-PMJAY was a key player. The program was extended in April 2020 to include the expense of detecting and treating COVID-19, which includes hospitalization and isolation. This enlargement lessened the financial strain on families by making sure that even the neediest people could afford treatment throughout the epidemic.

To bring healthcare closer to the community, the component entails the construction of 1,50,000 "Health and Wellness Centers (AB-HWCs)" by modernizing rural and urban "Primary Health Centers (PHCs) as well as Sub Health Centres (SHCs)." To provide "Comprehensive Primary Health Care (CPHC)," these facilities enlarge and improve their current "reproductive and child health (RCH)" and communicable disease services, adding services for "Non-Communicable Diseases (common NCDs like hypertension, diabetes, and the three most common cancers of the oral, breast, and cervix), and gradually increase their primary healthcare offerings for mental health, ENT, ophthalmology, oral health, geriatric, and palliative care" (pib.gov.in).

The implementation procedures for AB-PMJAY have also been refined and made more efficient. *

The initiative has been executed utilizing a paradigm that does away with cash and paper altogether, with the use of technology playing an important part in streamlining operations. Several different technical interventions, such as the development of information technology systems for beneficiary identification, hospital empanelment, and claims processing, have been brought into the program to increase its effectiveness and openness of the program (National Health Authority, 2021). This has reduced fraud and abuse, increased monitoring and assessment of the program, and speedier processing of claims.

Objective: To ascertain the benefits of the AB-PMJAY scheme

The PMJAY program offers benefits that cover all medical costs up to Rs 5 lakh. For a year, the sum is set aside for each qualifying household. For instance, a family floater option is offered for the cover. It is open to one or all family members, unlike other plans. Women, children, and the elderly are among the beneficiaries. As a result, for support, one might go to secondary and tertiary healthcare facilities in your region. The fact that users of this program can access services throughout India is its most significant advantage. The following elements are available to all beneficiaries:

1. Examination, treatment, and consultation in medicine
2. Pre-hospitalization
3. Medicines and medical supplies
4. Services for both non-intensive and intensive care
5. Investigations that are diagnostic and laboratory
6. Services for medical implantation (where necessary)
7. Accommodations advantages

8. Food delivery
9. Problems that develop during therapy
10. Follow-up treatment after hospitalization for up to 15 days

The benefits of 500,000 Indian Rupees are provided on a family floater basis, which dictates that it can be utilized by either one family member or all family members simultaneously. There was a limit of five people per family who may participate in the RSBY. On the other hand, to take advantage of the lessons learned from previous programs, PM-JAY was developed so that neither the number of members in a family nor their ages are subject to any restrictions. Additionally, coverage for pre-existing conditions begins on day one of the plan's effective date. This means that as of the day of enrollment in PM-JAY, any qualified individual who was already experiencing any medical disease would be entitled to seek treatment for all of those challenges, as well. Mental health care is included in this.

Objective: To determine the impact of the AB-PMJAY scheme on the out-of-pocket Expenditure of beneficiaries

Table 3: Model Summary

Model Summary				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.112[a]	.013	.010	2.94592
a. Predictors: (Constant), AB-PMJAY scheme				

Table 3 defines the model summary, indicating a significant degree of connection. The R-value for the simple correlation is 0.013, which reflects 0.013 of the dependent variables (out-of-pocket Expenditure of beneficiaries) is explained by the independent variable (AB-PMJAY scheme).

Table 4: ANOVA

ANOVA[a]						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	38.433	1	38.433	4.429	.036[b]
	Residual	3020.107	348	8.678		
	Total	3058.540	349			
a. Dependent Variable: Out-of-pocket Expenditure						
b. Predictors: (Constant), AB-PMJAY scheme						

Table 4 is an ANOVA table that shows how well the data is fit by the regression equation (i.e., predicts the dependent variable). This table shows that the regression model accurately predicts the dependent variable. The above table 4 shows that 'there is a significant impact of the AB-PMJAY scheme on the out-of-pocket expenditure of beneficiaries,' as the significance value is 0.036, which is smaller than 0.05.

Table 5: Coefficients

Coefficients[a]				
Model	Unstandardized Coefficients	Standardized Coefficients	t	Sig.

		B	Std. Error	Beta		
1	(Constant)	18.322	.955		19.191	.000
	AB-PMJAY scheme	-.144	.069	-.112	-2.104	.036
a. Dependent Variable: Out-of-pocket Expenditure						

Table 5 is the coefficient table. Table 4, the Coefficients model demonstrates how effectively the AB-PMJAY scheme created an impact on the out-of-pocket Expenditure of beneficiaries. The table highlights that the regression model shows a significant value (the significance value is less than 0.05).

6. Discussion

The primary focus of the research was on the "Impact of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana on Out-of-Pocket Expenses." In this study, every facet of these schemes was explored, including their inception, their execution, their advantages, and their influence on out-of-pocket expenses, among other topics. The study began by presenting the framework and its variables' key components. After that, the research looked at relevant existing literature written by a variety of writers on the topic of "an impact of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana on out-of-pocket expenditure, a government-funded health insurance scheme." For this reason, the subject matter of the study was broken up into three sections, which are as follows: the evolution of the “Ayushman Bharat Pradhan Mantri Jan Arogya Yojana;” the impact of AB-PMJAY on out-of-pocket expenditures; and awareness among the general population regarding AB-PMJAY. Some of the investigation done by previous authors is summarized below, including the following:

The “Pradhan Mantri Jan Arogya Yojana (PM-JAY)” insurance program was evaluated by **Naaz, N., and Nigudgi, S. (2022)** in Basaveshwar Teaching and General Hospital in Kalaburagi City, Karnataka. 1791 participants enrolled in PM-JAY between January and October of 2021. In April, when the second wave of COVID-19 hit, 327 people filed for PM-JAY insurance, the highest monthly total to yet. While empanelment can aid in the inclusion and regulation of the private sector, the public sector's involvement is still crucial, especially in underserved portions of India, as **Joseph, J., et al. (2021)** showed. Paying close attention to the health care system for all people.

Patients who are aware that they have access to tertiary care for potentially fatal conditions often choose not to access these facilities. Patients who were eligible for AB-PMJAY benefits saw no reduction in out-of-pocket medical expenses or financial hardship **(Khan, A., et al. 2021)**. The study by **Kaur, A., et al. (2021)** found that the OOP spending of a ventilated kid was double that of a non-ventilated child during their "Pediatric Intensive Care Unit (PICU)” stay and that the health system cost per patient was also estimated. To understand the significance of AB PM-JAY, **GOGOI, H., et al. (2022)** assessed the function of AB PM-JAY in not only controlling but also containing the virus epidemic in India and how it assisted Indians in weathering the COVID-19 storm. In their study, **Prasad, S. S. V., et al. (2023)** discovered that while 1.3% of eligible participants and two out of three rural residents were aware of the AB-PMJAY scheme, training of healthcare workers at the community level, such as “accredited social health activists (ASHA) and Anganwadi workers (AWW),” should be done regularly to strengthen ties in the neighbourhood and for efficiency.

7. Conclusion

India's most significant move in promoting, preventing, curing, soothing, and rehabilitative parts of univ-

sal health coverage has been the AB-PMJAY program. The largest publicly sponsored health protection program in the world, AB-PMJAY, serves 50 crore people. In the Ahmedabad district of Gujarat, this study assessed the effect of the "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana on out-of-pocket" spending. The outcome (Table 4) demonstrated that the AB-PMJAY program significantly affects recipients' out-of-pocket expenses. Before the adoption of AB-PMJAY, many Indian families experienced financial hardship as a result of unforeseen medical costs, sometimes necessitating the sale or borrowing of assets to pay for medical expenses. Instead of paying for treatment up front and then requesting reimbursement, beneficiaries may now get cashless care at hospitals that have been empanelled thanks to the launch of AB-PMJAY. Beneficiaries' out-of-pocket expenses have been greatly decreased as a result of their ability to get healthcare services without concern about the cost. Additionally, AB-PMJAY has developed a reliable IT system to implement the plan.

The success of a massive program like AB-PMJAY relies heavily on careful monitoring and evaluation to achieve the desired outcomes. By providing financial security, expanding access to healthcare services, and standardizing treatment fees, "Ayushman Bharat Pradhan Mantri Jan Arogya Yojana" has significantly contributed to lowering out-of-pocket healthcare expenditures in India. The initiative has guaranteed that low-income families have access to timely, high-quality medical care without suffering financial ruin because of their treatment.

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