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Pradhan Mantri Jan Arogya Yojana (PM-JAY) and its Impact on Healthcare Inequalities in India

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ABSTRACT

This article is about the healthcare inequalities that are persistent in the Indian healthcare system, and how effectively the Ayushman Bharat policy limits these inequalities. Ayushman Bharat, also known as Pradhan Mantri Jan Arogya Yojana (PMJAY), is a health initiative launched by the Government of India in 2018. This policy seeks to provide accessible and affordable healthcare to the economically disadvantaged and vulnerable sections of Indian society, aiming to mitigate healthcare inequalities. Despite the policy's many successes, its aim has not been completely achieved due to shortfalls in the policy's implementation paired with societal inequalities (especially persistent in the marginalized communities). Therefore, this paper shows and addresses these inequalities, with policy recommendations on how to develop the implementation of the policy to further limit inequalities in the Indian healthcare sector.

Keywords: Healthcare, India, Inequalities, Ayushman Bharat, Public Policy

1. Introduction

There is no doubt that India, as a developing nation, has made significant strides in healthcare over the past few years. With the introduction of policies such as the Ayushman Bharat scheme and the enhanced access to healthcare services for the most vulnerable populations, India has succeeded in improving the quality of life for many of its citizens. However, as a country characterized by diverse social structures and entrenched hierarchies, India continues to struggle with achieving equitable healthcare and efficient access for all. This ongoing challenge is evident in the effects of the caste system, the urban-rural divide, inter-state disparities, and economic inequalities.

While a subset of the broader spectrum of social inequalities, the healthcare sector in India plays a pivotal role in sustaining these disparities. Marginalized communities often face systemic

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

discrimination and neglect within this industry, leading to significantly limited access to quality healthcare services and poorer health outcomes. The supply of healthcare services varies distinctly between states and urban and rural areas, worsening these inequities. Individuals from lower castes and lower wealth quintiles particularly struggle to afford the high costs of quality healthcare in the private sector. Hence, the Indian healthcare system is entrenched in inequalities that pose substantial challenges to equitable health access and outcomes.

The Indian government aims to mitigate these healthcare disparities, resulting in the creation of the Ayushman Bharat scheme. Ayushman Bharat, also known as the Pradhan Mantri Jan Arogya Yojana (PM-JAY), represents a landmark initiative launched by the Government of India in September 2018. The scheme aims to provide accessible and affordable healthcare to the most vulnerable segments of the Indian population to achieve universal health coverage and relieve the financial burdens associated with medical expenses.[1] Despite its numerous successes, the policy has not yet fully achieved its goal of universal healthcare. The persisting inequalities within Indian society—rooted in the caste system, urban-rural divides, inter-state differences, and wealth disparities—pose significant challenges. This paper aims to discuss the effectiveness of the Ayushman Bharat Policy and explore potential changes to make it more effective in overcoming healthcare inequalities in India.

2. Literature Review

India has been labeled the second most unequal country after Russia, when looking at income inequalities.[2] The country's transition to becoming a more free market economy since the 1990s has resulted in substantial growth (7%); however, this growth has also increased inequality. Increasing inequality has made a significant portion of the population vulnerable to exploitation and discrimination from the elite. The unorganized sector, which provides daily wage labour in the agriculture and manufacturing sectors, holds the highest proportion of the labour market and remains mainly unregulated, consequently harboring the most considerable amount of hierarchical discrimination. While Article 15 of the Indian Constitution - the prohibition of discrimination on the grounds of religion, race, caste, sex, or place of birth - prevents the discrimination of marginalized communities, the implementation of the law is lacking, which makes it easier for industries like healthcare services to disfavour people from these communities. [3] Many of the factors that result in healthcare inequalities don't always stem from

[1]National Health Authority, (PM-JAY), (2019), About Pradhan Mantri Jan Arogya Yojana

[2] Verma, N. M. P., & Srivastava, A. (Eds.). (2020). "Introduction" in *The Routledge handbook of exclusion, inequality and stigma in India.* Taylor & Francis Group.

[3]Ministry of Education Government of India, (2024), *Constitutional Provision Article 15.*

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

stigma towards marginalized groups; in fact, unequal allocation of resources and inadequate human resources result in healthcare inequalities as well. Misallocating resources can result in a difference in healthcare quality between states and urban-rural locations. According to the latest statistics, southern states like Kerela have a much more developed healthcare system than northern states like Uttar Pradesh. India's healthcare services have been developing and improving in quality as the nation continues to develop; however, as healthcare grows, so does the Gini coefficient - a statistical measure of the degree of variation or inequality represented in a set of values, used especially in analyzing income inequality- . From having a value of 35.7 in 2010/2011 to a current value of 45, resulting in a steeper Lorenzo curve. [4]This widening gap between the population ensures a difference in healthcare services, especially in the private and public sectors, where wealthier parts of the population are able to afford better healthcare services than the poorer sections.

India is a country that suffers from a society of stigma: a mark of disgrace associated with a particular circumstance, quality, or person. From being the country with the highest number of acid attacks on women to having rigid hierarchical structures like the caste system still functioning, India is a country where the delivery of healthcare struggles against societal inequalities, violence, and discrimination that add newer dimensions to the challenges the government must overcome to ensure universal coverage.

Public goods may get severely under-produced without intervention by a government. Since public goods are not adequately provided for by the markets, they must be supplied by the government. Therefore, provisioning of public goods and ensuring their supply represents one of the most important functions of a government. Access to safe drinking water, sanitation, transport, medical care, and schools is essential both as a direct component of well-being as well as an input to enhance productivity. Besley and Ghatak (2004) argue that the rich have the option to seek private alternatives, lobby for better services, or move to different areas.[5] The poor do not have these opportunities, which underscores their deprivation when public goods are not provided for, especially for the vulnerable sections of society. The presence of strong linkages between public goods provision and economic development accentuates the need for the

[4]Adam Heyes, Somer Anderson, David Burn, (2024), *Gini Index Explained and Gini Coefficients Around the World,* Investopedia.

[5]India Budget, (2021 - 2022), Chapter 9, JAY Ho: Ayushman Bharat's Jan Arogya Yojana (JAY) and Health Outcomes/

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

provision of public goods at national, regional, and international levels. Governance, therefore, entails the effective delivery of public goods and services to the vulnerable sections of society.[6]

India bears a significant portion of the global health burden, with 18% of global deaths and 20% of disability-adjusted life-years (DALYs). Chronic diseases are responsible for 53% of deaths and 44% of DALYs in the country, while 36% of deaths and 42% of DALYs are due to communicable diseases, maternal and perinatal conditions, and nutritional deficiencies, indicating a slow transition in disease patterns.[7] India accounts for one-fifth of global maternal deaths and one-quarter of child deaths. The life expectancy at birth is 63 years for males and 66 years for females, and the under-5 mortality rate of 69 per 1,000 births lags behind the regional average for South-East Asia.[8]

However, these overall statistics hide significant differences in health outcomes within India. While health has generally improved, disparities remain based on gender, caste, wealth, education, and geography. For example, in 2005-2006, the infant mortality rate was 82 per 1,000 births among the poorest quintile and 34 per 1,000 among the richest.[9] Similarly, the under-5 mortality rate was 106 per 1,000 births for mothers with no education, compared to 49 per 1,000 for mothers with secondary or higher education. Geographic differences are also pronounced, with life expectancy ranging from 56 years in Madhya Pradesh to 74 years in Kerala—a difference of 18 years, which is greater than the regional differences in life expectancy in China or the interstate differences in the United States.[10] This can be seen in the graph below.

[6] India Budget, (2021 - 2022), Chapter 9, JAY Ho: Ayushman Bharat's Jan Arogya Yojana (JAY) and Health Outcomes/

[7]Y Balarajan, S Selvaraj, Dr SV Subramanian, (2011), Health care and equity in India, National Library of Medicine - National Center for Biotechnology Information.

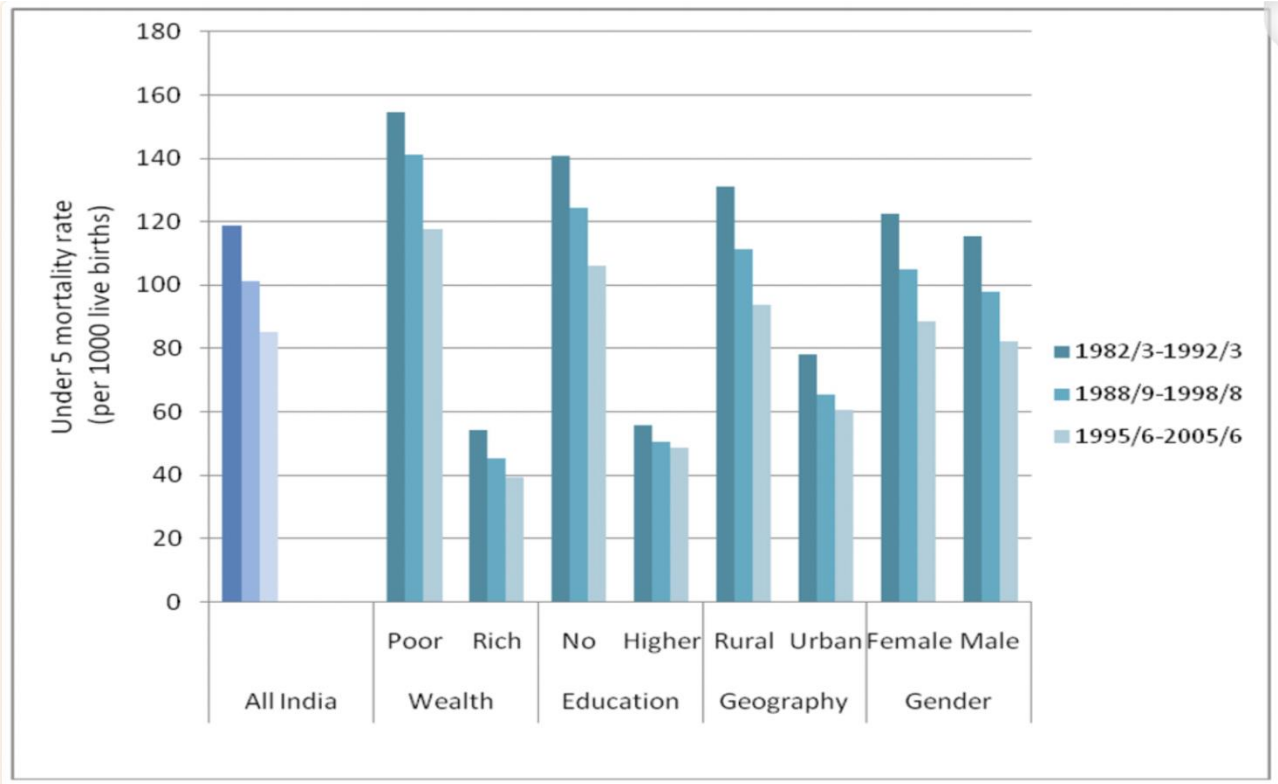
[8]Y Balarajan, S Selvaraj, Dr SV Subramanian, (2011), Health care and equity in India, National Library of Medicine - National Center for Biotechnology Information.

[9]Y Balarajan, S Selvaraj, Dr SV Subramanian, (2011), Health care and equity in India, National Library of Medicine - National Center for Biotechnology Information.

[10]Y Balarajan, S Selvaraj, Dr SV Subramanian, (2011), Health care and equity in India, National Library of Medicine - National Center for Biotechnology Information.

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"



Source: NFHS 1992/3, NFHS 1998/9 and NFHS 2005/6

Many health inequalities arise from various social, economic, and political factors that affect the overall health and its distribution within a population. These factors, known as the social determinants of health, are important to address because some health inequalities may be unfair and result from the unequal distribution of essential resources, power, and opportunities. Correcting these inequities should be a key objective of public policies. Health systems play a crucial role in promoting fairness and efficiency in distributing health and reducing people's exposure and vulnerability to poor health.

3. Overview of Key Statistics

3.1. Children's Living Standards and Parental Survival

In India, only 3% of children under the age of 18 live with non-biological parents, while 5% are orphans, having lost one or both parents. The percentage of orphans increases with age, with only 0.9% of children under two years old being orphans compared to 9% among those aged 15-17. Geographically, the north-eastern region of India has the highest percentage of orphans, with 6% of children living without one or both parents. This results in several children being left

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

without care, impacting their overall health and accessibility to quality healthcare. This also results in several unaware of the policies placed which could benefit them.

3.2. Schooling and Education

Educational attainment in India exhibits significant differences across gender, location, wealth, and social status. Approximately 72% of females and 87% of males have spent some years in school. However, 31% of females and 34% of males have completed only seven or fewer years of schooling. There is a noticeable difference between urban and rural areas; urban females have a median of 7.5 years of schooling compared to 4 years in rural areas, while urban males have a median of 8.8 years compared to 6.5 years in rural areas.

Household wealth strongly influences educational outcomes. Females in the lowest wealth quintile have a median of just 0.4 years of schooling, whereas those in the highest wealth quintile have a median of 9.3 years. For males, the median schooling years range from 3.7 years in the lowest wealth quintile to 10 years in the highest. Additionally, individuals not classified within the Scheduled Castes (SC) or Scheduled Tribes (ST) communities tend to have higher median years of schooling—7 years for females and 8.5 years for males.

The percentage of the population with no schooling is higher in rural areas compared to urban areas, with 33% of rural females and 16% of rural males having no formal education, versus 17% of urban females and 8% of urban males. School attendance is highest among children aged 6-10, with 95% attending school, but this drops to 70% for those aged 15-17. Notably, SC and ST children have the lowest Gross Attendance Ratios (GARs) and Net Attendance Ratios (NARs) at the secondary school level.

These educational inequalities prevent vulnerable parts of society from accessing knowledge, which has a detrimental effect on accessing healthcare facilities. Not only would one not know when to seek healthcare, but one would also not understand how to. This prevents the PM-JAY from being fully effective.

3.3. Infant and Child Mortality

In India, one in 24 children dies before reaching the age of five, with 83% of these deaths occurring during infancy. Despite a general decrease in child mortality, from 109 deaths per 1,000 live births in 1998-1999 to 42 per 1,000 in 2019-2021, there are significant disparities within this. Infant mortality has decreased by 63% over the past 28 years, yet rural areas still report higher rates (46 per 1,000) compared to urban areas (32 per 1,000). State-level differences are stark, with Uttar Pradesh having an infant mortality rate of 60 per 1,000, compared to just 4 per 1,000 in Kerala.

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

Social and economic factors also play a critical role. Infant mortality is higher among lower social status groups: 50 per 1,000 for STs, 49 per 1,000 for SCs, and 41 per 1,000 for Other Backward Classes (OBCs), compared to 33 per 1,000 for those not belonging to these communities. Additionally, infant mortality decreases as household wealth increases, with rates of 59 per 1,000 in the lowest wealth quintile and 20 per 1,000 in the highest.

3.4. Perinatal Mortality

Perinatal mortality, which includes stillbirths and neonatal deaths, is closely linked to maternal age, first-time pregnancies, and socio-economic factors. The highest rates of perinatal mortality are found among younger mothers (aged 20-30) and first-time pregnancies. The perinatal mortality rate is higher in rural areas (34 per 1,000) than in urban areas (25 per 1,000), and it varies significantly across states, being highest in Uttar Pradesh and Bihar (44 per 1,000) and lowest in Goa (2 per 1,000).

Education and household wealth also influence perinatal mortality. Rates decrease as maternal education increases and are inversely proportional to household wealth, with 41 per 1,000 in the lowest wealth quintile versus 17 per 1,000 in the highest. The SC and OBC communities experience the highest perinatal mortality rates, with around 700 stillbirths and 1,300 neonatal deaths among SCs, and more than 1,000 stillbirths and 2,000 neonatal deaths among OBCs between 2019-2021.

3.5. Wealth Quintiles and Social Stratification

Wealth distribution in India is heavily skewed, particularly among SCs and STs. About 25% of those in the SC community and 46.3% of those in the ST community fall into the lowest wealth quintile, while only 12.3% of SCs and 5.4% of STs are in the highest quintile. This indicates a significant concentration of poverty within these communities, with the wealthiest individuals often being self-employed or living in urban areas where educational attainment is higher.

This shows that those in marginalized communities, like those in lower castes, suffer from a lack of accessibility to essentials due to poverty. One of these essentials is education, especially in parts of India that discriminate against those from scheduled castes in the world of education. In parts of Jharkhand and Bihar, schools that don't permit admission to those from lower castes still exist[11]—this lack of education results in a lack of knowledge of healthcare.

3.6. Wealth Quintiles by State

[11]Manu Kumar, (2022), *Cast System in Jharkhand,* International Journal of Enhanced Research in Educational Development (IJERED) ISSN: 2320-8708, Vol. 10 Issue 6, Impact Factor: 7.326

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

Wealth disparities are also pronounced across different states. Jharkhand and Bihar are the poorest states, with 46% and 43% of their populations in the lowest wealth quintile, respectively, and only 7.5% and 5.4% in the highest quintile. In contrast, Punjab and Delhi are among the wealthiest states, with 61% and 68% of their populations in the highest quintile and less than 1.1% in the lowest. Chandigarh, the wealthiest part of Punjab, has 79.4% of its population in the highest wealth quintile. In contrast, southern India has a more even distribution of wealth across quintiles.

The difference in the development levels between states results in a vast difference in the implementation strategies of the PM-JAY between different states. This makes the policy more effective in some states than in others, causing the inequalities in healthcare to be evident. Despite the availability of government healthcare, many people hesitate to use it, particularly due to perceptions of poor facilities and long waiting times. The highest utilization of government healthcare services is in Bihar (80%) and Uttar Pradesh (79%), mainly because a significant portion of the population in these states belongs to the lowest wealth quintile. However, 48% of households report poor conditions in government healthcare, and 46% cite long waiting times as a major deterrent.

4. Ayushman Bharat Policy

Ayushman Bharat, also known as Pradhan Mantri Jan Arogya Yojana (PMJAY), is a health initiative launched by the Government of India in 2018. This policy seeks to provide accessible and affordable healthcare to the economically disadvantaged and vulnerable sections of Indian society, aiming to mitigate healthcare inequalities.

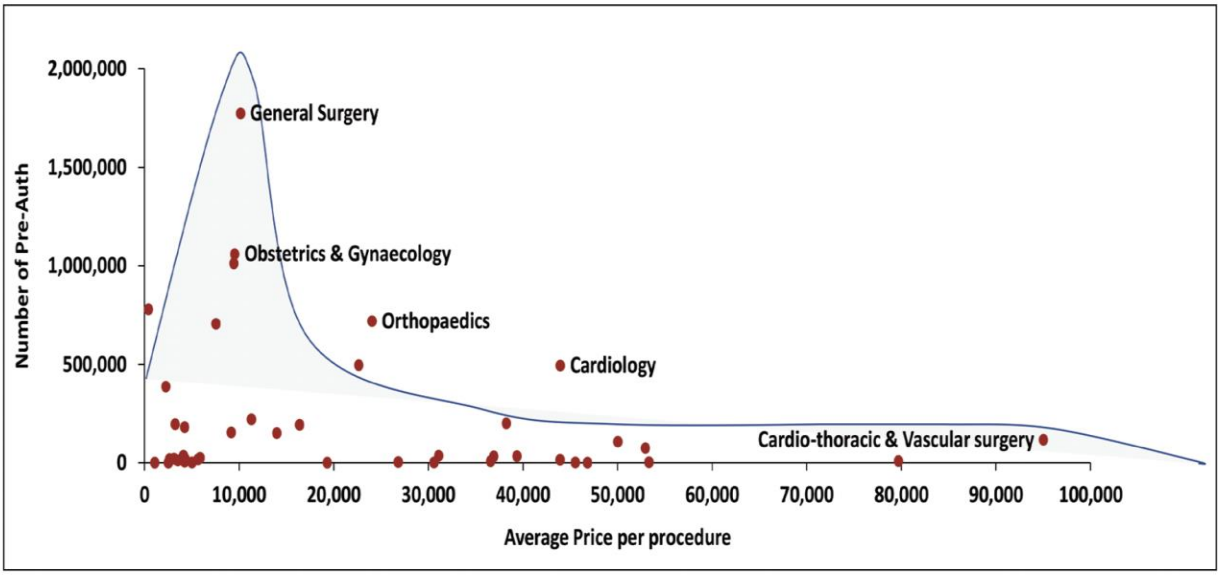
The policy consists of two components; The first focuses on the establishment of Health and Wellness Centers (HWCs) across the country, and the second, Pradhan Mantri Jan Arogya Yojana (PMJAY), is a health insurance scheme that aims to cover over 500 million people. With a target of setting up 150,000 centers, HWCs are designed to be the primary points of contact for people seeking medical care. They offer primary healthcare services, including maternal and child health, treatment for non-communicable diseases, and free essential drugs and diagnostic services. The PMJAY is one of the largest government-funded healthcare programs in the world. Under PMJAY, permitted families receive health coverage of up to INR 5 lakh per year for care and hospitalization. The scheme targets poor and vulnerable families identified through the Socio-Economic Caste Census (SECC) data, ensuring that it is given to those who need it most. The families that are permitted to receive the PMJAY can access cashless treatment at various public and private hospitals across India. The coverage includes more than 1,500 medical procedures, providing a broad range of services. Importantly, there are no restrictions on family size or the age of family members, ensuring comprehensive coverage for all.

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

Ayushman Bharat's objectives are to provide universal health coverage, reduce the financial burden of healthcare expenses on the poor, and mitigate healthcare inequalities in India. Moreover, Ayushman Bharat is also expected to generate significant employment opportunities within the healthcare sector and related services. [12]

Since its introduction in the Indian healthcare sector, this policy has had numerous successes. Thirty-two states and UTs have implemented the scheme, and 13.48 crore E-cards have been issued. Treatments worth INR 7,490 crore have been provided (1.55 crore hospital admissions), 24,215 hospitals have been equipped, and 1.5 crore users have registered on the scheme's website. [13]



Source: NHA data secured from PMJAY

Figure 1 plots the number of PM-JAY pre-authorization claims for a procedure against the average price of the procedure from September 2018 through January 2021. As shown in the figure, there were relatively fewer claims for expensive procedures, and the higher number of claims for lower-cost procedures can be an indicator of the PM-JAY as a delivery channel for primary healthcare services.

[12]National Health Authority, (PM-JAY), (2019), About Pradhan Mantri Jan Arogya Yojana

[13]India Budget, (2021 - 2022), Chapter 9, *JAY Ho: Ayushman Bharat's Jan Arogya Yojana (JAY) and Health Outcomes/*

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

Additionally, to compare the health indicators measured by the National Family Health Survey-4 and the National Family Health Survey 5 and undertake this analysis, two surveys provide before-after data to assess the impact of PM-JAY on states that implemented it and did not in 2018. West Bengal, as a state that did not implement PM-JAY, can be compared (using its before-after difference in health outcomes) to its neighboring states that have implemented PM-JAY – Bihar, Sikkim, and Assam.

After the Ayushman Bharat program was implemented, efforts have been made to enhance Sub Centres and Primary Health Centres by transforming them into Health and Wellness Centres. These centres are being developed in phases to provide comprehensive primary healthcare services.

As of March 31, 2022, India has a total of 161,829 Sub Centres operating across both rural and urban areas, with 157,935 in rural locations and 3,894 in urban areas. There are 31,053 Primary Health Centres functioning nationwide, with 24,935 in rural areas and 6,118 in urban areas. The country also has 6,064 Community Health Centres with 5,480 situated in rural regions and 584 in urban areas. Furthermore, there are 1,275 Sub Divisional/District Hospitals and 767 District Hospitals in both rural and urban parts India. This shows that the Ayushman Bharat scheme has increased the number of health and wellness centers across India, ensuring an equal distribution in rural and urban areas. This shows efficient implementation of the policy. [14]

As of March 31, 2022, there are 157,935 Sub Centres and 24,935 Primary Health Centres operating in rural areas across India. Over the years, many PHCs have been upgraded to Community Health Centres leading to an increase in CHCs. Currently, 5,480 CHCs are functioning in rural areas.

NUMBER OF SUB-CENTRES, PHCs, CHCs FUNCTIONING IN RURAL & URBAN AREAS							
S. No.	State/UT	(As on 31st March 2022)					
		Sub centres		PHCs		CHCs	
		Rural	Urban	Rural	Urban	Rural	Urban
	All India	157935	3894	24935	6118	5480	584

Verma, N. M. P., & Srivastava, A. (Eds.). (2020). "Introduction" in The Routledge handbook of exclusion, inequality and stigma in India. Taylor & Francis Group.

[14] Verma, N. M. P., & Srivastava, A. (Eds.). (2020). "Introduction" in *The Routledge handbook of exclusion, inequality and stigma in India.* Taylor & Francis Group.

ISSN: 2455-8834

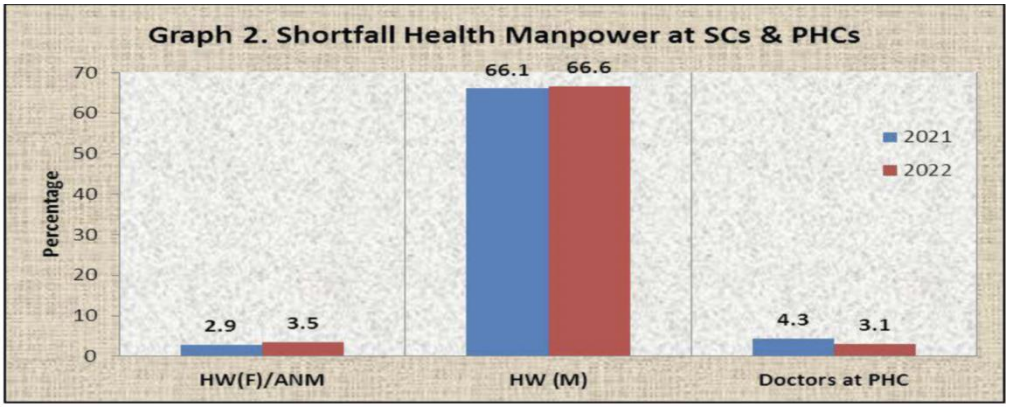
Volume:09, Issue:09 "September 2024"

The number of essential medicines available at PHC-AB-HWCs has increased to 172, with 63 diagnostic services. At the Sub Health Centre level, the number of essential drugs is now 105, with 14 diagnostic services. This approach ensures a steady supply of medicines, helping patients stick to their treatment plans and reducing the need to travel far for care. [15]

The IT system at AB-HWCs has been upgraded with smartphones for ASHA workers and tablets for Multipurpose Workers and Community Health Officers. This technology allows for better tracking of patient services and outcomes, improving quality and accountability. It also enables healthcare workers to follow up with patients in their homes or communities, ensuring they adhere to treatment and monitoring their vital signs.

Teleconsultation services at AB-HWCs allow patients to consult with specialists at higher-level centers without traveling, saving time and money. Additionally, the centers are involved in school health activities, training teachers as Health and Wellness Ambassadors and students as Messengers. This initiative aims to promote healthy habits in young people, helping prevent chronic diseases later in life.

A Primary Health Centre (PHC) is the first point of contact between the village community and a Medical Officer. The staff at a PHC includes a medical officer, who is supported by paramedical staff and other personnel. There is a significant shortfall in Health Assistants, with a gap of 74.2% across the country. For allopathic doctors at PHCs, there's a 3.1% shortage nationwide, with states like Odisha, Chhattisgarh, and Karnataka facing the largest deficits. This can be seen in graph two.



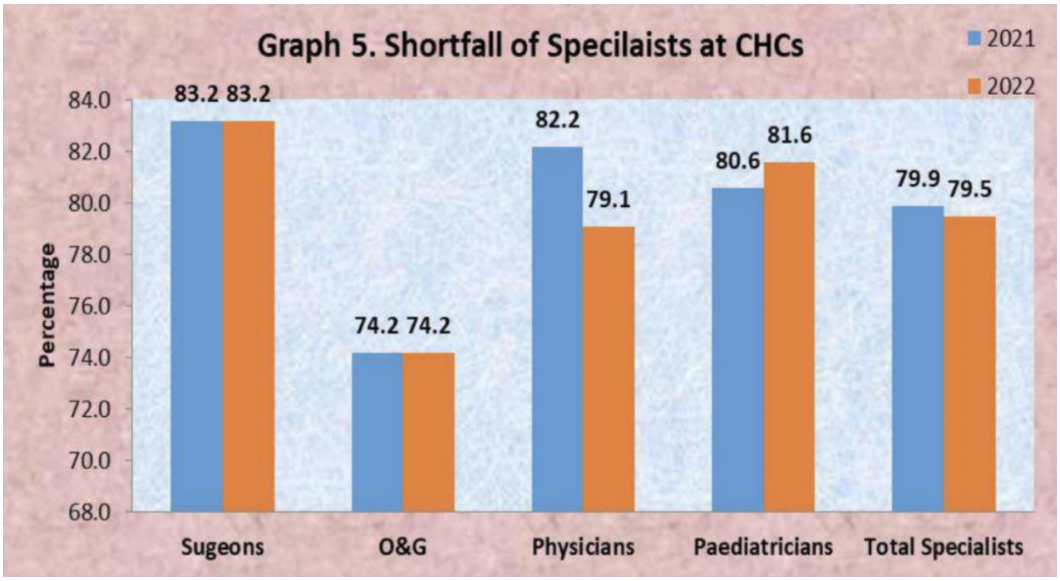
Verma, N. M. P., & Srivastava, A. (Eds.). (2020). "Introduction" in The Routledge handbook of exclusion, inequality and stigma in India. Taylor & Francis Group.

[15] Ministry of Family and Wellfare, National Health Mission, (2021), Chapter 3.

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

Furthermore, Community Health Centres provide specialized medical care, including surgeons, obstetricians & gynecologists, physicians, and pediatricians. As of March 31, 2022, a large percentage of these specialist positions are vacant: 71.9% of surgeon posts, 63% of obstetricians & gynecologists, 67.5% of physicians, and 69.7% of pediatricians. Overall, 67.8% of specialist positions at CHCs are vacant. Additionally, there is a significant shortfall compared to the existing infrastructure needs, with an 83.2% shortage of surgeons, 74.2% shortage of obstetricians & gynaecologists, 79.1% shortage of physicians, and 81.6% shortage of pediatricians, resulting in an overall specialist shortfall of 79.5%. This can be seen in graph five.



Verma, N. M. P., & Srivastava, A. (Eds.). (2020). "Introduction" in The Routledge handbook of exclusion, inequality and stigma in India. Taylor & Francis Group

5. Conclusion

Despite the implementation of the PM-JAY being successful in numerous areas, benefiting the overall healthcare sphere in India, inequalities in health remain persistent in India. This undermines the implementation of the PM-JAY as a scheme due to the inability to meet its aim. This is due to the numerous inequalities enduring in Indian society, creating several marginalized communities that are vulnerable to poor healthcare conditions. Additionally, as a developing nation, India has a significant wealth inequality, resulting in a large number of people being in poverty and unable to access quality healthcare. Lastly, differences in states' development levels impact the PM-JAY's effectiveness, resulting in inter-state inequalities as well. Here are a few recommendations on how the policy may be improved and supported to better address healthcare inequalities in India.

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

5.1. Proactive Outreach Campaign

As shown above, one problem consistent with all vulnerable parts of Indian society is a lack of education and knowledge. This limitation prevents people from knowing when seeking healthcare is necessary and how to seek it when needed. Moreover, this could also result in people being unaware of the specifics of the PM-JAY scheme. Additionally, as shown in the schooling inequalities, women within households in vulnerable parts of society tend to be neglected from education past a certain point; this results in males within a household being responsible for the healthcare, which could result in some women being denied sufficient healthcare. Therefore, the PM-JAY should be advertised and advocated to the most vulnerable and marginalized parts of society in order to ensure optimum knowledge is conveyed. This could be done by sending representatives to spread information on the policy at each household physically; this way, females within households and those neglected from schooling can understand the policy and what it has to offer. Therefore, the government should introduce awareness campaigns that are especially targeted towards women and marginalized communities, and these campaigns should be structured in a way that these communities understand their message sufficiently.

5.2. Increasing Accessibility

India suffers from inequalities in many ways, excluding healthcare (wealth, inter-state, etc.). Accessibility to hospitals and doctors is a consistent obstacle to limiting healthcare inequalities. While affordable healthcare to vulnerable parts of society is available, access can often be a larger issue. For example, Bihar has a total of 10,399 health centers and a shortfall of 1492 doctors for a population of 125532000, whereas 219 health centers and no shortfall of doctors for a population of 1569000. This can cause overcrowding, a lack of space, and large distances in hospitals/clinics within underdeveloped states like Bihar. Moreover, those from lower wealth quintiles - that also tend to be from marginalized communities like the scheduled caste/tribe community - don't have access to sufficient/regular transportation in order to access these centers efficiently. Underdeveloped states like Bihar and Uttar Pradesh have an area of 94,163 m^2 and 240,928 m^2, indicating the large distances that need to be traveled in order to access these centers. Unlike wealthier states like Delhi which have a sufficient transportation system and urban areas, Bihar and Uttar Pradesh don't offer transportation opportunities to those from lower wealth quintiles. This limits the ability to mitigate healthcare inequalities. Therefore, I would recommend the introduction of a daily bus system that covers a certain mile radius so that people can use the bus for transportation to clinics and hospitals. This would introduce a direct transportation system between rural areas that are more accessible and healthcare facilities, removing the obstacles of accessibility and transportation costs. Moreover, I would recommend fund allocation for the PM-JAY to be state-dependent: the government should allocate funds

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

based on the population figures in a particular area, like a designated amount per person, meaning less developed states like Bihar and Uttar Pradesh's healthcare systems can be developed and increased to a larger extent than the healthcare systems in states like Kerela and Goa.

5.3. Multi-Modal Assessment of Inequalities

One of the most effective ways to limit the inequalities in Indian healthcare is through the limitation of the inequalities within Indian society, especially in marginalized communities. Marginalized communities like the scheduled caste/tribe communities in India often suffer from neglect in society, reflected in the education and healthcare systems. When working with the Mitr Trust NGO in Sitapur, New Delhi, I conducted a survey for those in the transgender community in this area. This Survey included questions about their current experiences with governmental healthcare and what they were looking for in healthcare. A large majority of the respondents in this survey conveyed that they often dealt with stigma when using public healthcare, discouraging them from going to hospitals and clinics. This can reduce the impact of the PM-JAY as a scheme.

Additionally, the desire to increase equality tends to be more prominent in urban areas and southern states. Therefore, equal and empathetic views being advertised and promoted in parts of India where the marginalized experience most discrimination could help limit neglect, making the healthcare system a more inviting place for marginalized communities. This could be done through a mandatory change in the public school syllabus and stricter consequences for discriminating behavior. In addition, certain states, particularly in North East India, that tend to have more stringent social hierarchies should have clinics specific to marginalized groups so that people from these communities feel more secure and will be more likely to maintain their healthcare. For example, the introduction of scheduled caste/tribe or LGBTQ++-only clinics.

5.4. Alleviating Staff Shortfalls

One of the main limitations of the PM-JAY scheme, especially evident in certain states, is the shortfall of doctors, surgeons, nurses, and other healthcare staff. This can result from the 'manpower' idea - as discussed above. Statistics show that certain states suffer to a smaller extent from this problem than others, indicating another cause for the inequalities in the healthcare sphere in India. In order to limit the effects of the issue, there should be a system that influences and encourages healthcare staff to fill these vacant positions—for example, introducing a reward system for healthcare staff in states like Uttar Pradesh - such as higher salaries and frequent bonuses. This would not only influence more people to enter the healthcare field for an occupation but would also influence doctors from other states to move to these

ISSN: 2455-8834

Volume:09, Issue:09 "September 2024"

underdeveloped states so that they can enjoy the benefits. Additionally, if the government does not have enough financial flexibility to implement this system, it could position healthcare staff in specific locations that have more vacant positions, like the idea of posting. This would create a more equal distribution of healthcare staff relevant to the state population and needs.

In summary, The Ayushman Bharat scheme has made commendable strides towards introducing greater access to healthcare services. However, while the scheme has undoubtedly expanded coverage and reduced financial barriers for many, its implementation still faces significant challenges, particularly in fully addressing the disparities caused by discrimination against marginalized communities, wealth inequalities, and inter-state differences. Through specific reforms that focus on removing these obstacles, the effectiveness of the PM-JAY will develop much further. This would facilitate the limitation of the inequalities in the Indian healthcare system, achieving the goal of the PM-JAY.

References

Adam Heyes, Somer Anderson, David Burn, (2024), *Gini Index Explained and Gini Coefficients Around the World*, Investopedia.

India Budget, (2021 - 2022), Chapter 9, *JAY Ho: Ayushman Bharat's Jan Arogya Yojana (JAY) and Health Outcomes/*

Manu Kumar, (2022), *Cast System in Jharkhand*, International Journal of Enhanced Research in Educational Development (IJERED) ISSN: 2320-8708, Vol. 10 Issue 6, Impact Factor: 7.326

Ministry of Education Government of India, (2024), *Constitutional Provision Article 15.*

Ministry of Family and Welfare, National Health Mission, (2021), Chapter 3.

National Health Authority, (PM-JAY), (2019), *About Pradhan Mantri Jan Arogya Yojana.*

Verma, N. M. P., & Srivastava, A. (Eds.). (2020). "Introduction" in *The Routledge handbook of exclusion, inequality and stigma in India.* Taylor & Francis Group.

Y Balarajan, S Selvaraj, Dr SV Subramanian, (2011), *Health care and equity in India*, National Library of Medicine - National Center for Biotechnology Information.

