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Studio/28-10-49,A28a(i) A doctor examining a child in the Co-operative Health Centre, Delhi, run by the Ministry of Relief and Rehabilitation.
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Government-funded Health Insurance: Does Coverage Mean Care?

The Indian healthcare system has long faced poor public investment and high out-of-pocket expenditures (OOPE). From 2005 onwards, many state governments initiated government-funded health insurance schemes (GFHIs) towards improving access to healthcare and reducing OOPE. This culminated in the launch of the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) in 2018, a central scheme providing insurance coverage of up to ₹5 lakh per household per year for hospitalisation expenses for the bottom 40 per cent of the population. Existing evidence points to several limitations of GFHIs, including the persistent burden of OOPE, exclusions, induced demand, inequitable access and shift of public resources to the private sector. Given that insurance schemes are rife with market failures, expanding and strengthening the public health system for universal and equitable access to healthcare should be the priority.

CHAPTER 10

Government-funded Health Insurance: Does Coverage Mean Care?

Indranil and Richa Chintan

The history of post-independence health policy-making in India has been marked by the retention of elite interests alongside attempts to address the health needs of the majority. Until the 1980s, while the publicly provided health system remained urban-biased and tertiary care-oriented, there was a gradual expansion of primary and secondary care in rural areas through public investments. Formal, market-based provisioning through western medicine could not penetrate beyond metropolitan cities due to limited purchasing power and the reluctance of the elite medical fraternity to serve rural India. The private sector was largely characterised by unskilled or semi-skilled informal providers and practitioners of Indian systems of medicine. The social health insurance programme, the Employees' State Insurance Scheme (ESIS), despite a strong beginning, could not expand significantly, as most of the workforce remained in the informal sector.

Thus, for the overwhelming majority, the tax-funded and publicly provided system remained the only viable option. Although there were efforts to expand

public healthcare delivery, this expansion remained skeletal, underfunded, poorly governed and largely unaccountable to people. The state continued to serve elite interests while promoting market penetration through measures such as subsidised medical education, tax exemptions and concessional land allocation for private providers. Neo-liberal reforms, strongly promoted by multilateral institutions and wholeheartedly supported by ruling elites, advocated reductions in public health expenditure (Indranil 2024; Duggal 1997). This led to a decline in the quality of care in public systems and pushed the middle classes towards private healthcare, thereby creating further space for private sector expansion. As a result, costs increased and inequalities in access to care widened.

The consequences of these neo-liberal reforms were clear: growing inequities in access, rising out-of-pocket expenditure (OOPE), weakening public provisioning and the expansion of an organised healthcare market (Indranil 2024). Globally, it became evident that healthcare markets fail to deliver affordable healthcare for all (Sen 2002). Even multilateral institutions formally recognised these market failures. In response, the World Health Organisation (WHO) advanced the concept of Universal Health Coverage (UHC) (World Health Assembly 2005), placing emphasis on financial risk protection and expanded risk pooling. Efforts to ensure financial protection require progressive health financing arrangements with three core elements: risk pooling, prepayment and cross-subsidisation. Since healthcare needs are uncertain and often associated with high costs, leaving households to manage expenses independently leads to under-consumption of care, delayed treatment, avoidable mortality and financial distress.

Risk pooling and prepayments are effective mechanisms to protect individuals from catastrophic health expenditure, while cross-subsidisation introduces progressivity into financial arrangements (Culyer and Newhouse 2000). Risk pooling—the aggregation of individuals with varying levels of health risk— constitutes the core 'insurance' function. Financing mechanisms like social health insurance (SHI) and private health insurance (PVHI) explicitly operationalise this function by pooling risk across enrolled populations. However, contrary to the common perception that risk pooling is limited to formal insurance models, tax-funded systems that provide healthcare directly to all citizens also inherently incorporate risk pooling and cross-subsidisation (Roberts et al. 2008). Government-funded health insurance schemes (GFHIs), such as Pradhan Mantri Jan Arogya Yojana (PMJAY), represent a hybrid model combining tax-based financing with insurance mechanisms. These schemes are funded through general revenues and operate by reimbursing healthcare providers—primarily in the private sector—for predefined 'care packages'. While most GFHIs are targeted at poorer and vulnerable populations, some states have extended coverage to broader populations, often with contributory elements.

This chapter begins with a discussion of market failures in healthcare, given their relevance to GFHIs. It then traces the historical trajectory of the health insurance schemes in India, with a particular focus on GFHIs. The subsequent sections critically examine their impact on access, financial protection and potential health system outcomes.

10.1 Market failures in healthcare

Market failure is the norm in healthcare rather than the exception. Significant uncertainties surround illness episodes, the nature of treatment required and treatment outcomes. As a result, individuals tend to under-save for future health events and prioritise current consumption. When healthcare is left to the market, it leads to under-consumption and substantial inequities (Arrow 1963). Insurance mechanisms emerge as the market response to such uncertainty. By pooling individuals with varying levels of risk through prepayment mechanisms, insurance ensures access to care without immediate financial burden. However, the insurance function is not confined to formal insurance schemes; prepayment and risk pooling are also embedded in tax-funded, publicly provided systems. When insurance functions are left to the market, new forms of market failure arise, most notably moral hazards and adverse selection. In voluntary insurance schemes, individuals with a higher probability of falling ill are more likely to enrol. However, for such schemes to remain viable, risk pools must include a substantial proportion of healthy individuals. To attract healthy individuals into pools with higher-risk members, premiums must remain affordable. Yet healthier individuals are often unwilling to pay higher premiums and instead prefer less comprehensive, lower-cost plans. Thus, what is desirable from the perspective of those most in need is often not realised.

Insurance providers, in turn, have incentives to enrol healthier individuals and exclude high-risk populations. This results in suboptimal plans and the systematic exclusion of those with greater need. This phenomenon is referred to as adverse selection, or 'crème skimming' (Culyer and Newhouse 2000). Insurance is also expected to bring down the price of direct healthcare consumption. If demand for healthcare is elastic,[1] a decline in price leads to higher consumption. In health economics, this phenomenon is described as 'moral hazard', though Pauly (1968) argued that it reflects normal consumer behaviour rather than an aberration (Arrow 1963). However, increased utilisation may include unnecessary care, leading to welfare loss.

The provision of unnecessary care is further reinforced by information asymmetry—another core feature of healthcare markets. Patients typically lack adequate information about their condition, the appropriate treatment and

1 Elasticity of demand refers to the change in demand in response to a change in prices. It is measured as the percentage change in demand divided by the percentage change in price.

expected outcomes. Consequently, they rely on healthcare providers, who act as agents in decision-making. As healthcare becomes more complex, this information gap widens, granting providers considerable power in the patient-provider relationship. When provider incentives are aligned with increased service provision, there is a risk of 'induced demand', whereby patients are encouraged to consume more care than necessary (Rice 1998). Under insurance arrangements, this tendency is amplified. Since patients bear only a portion of the cost, providers face fewer constraints in recommending additional care. Given that many treatment decisions rely on clinical judgement, unnecessary interventions may be justified in the name of improved outcomes or patient safety. Consequently, the boundary between essential care and induced demand gets blurred. In contexts where regulatory mechanisms are weak, these dynamics can also give rise to fraudulent practices.

The following sections examine the extent to which GFHIs in India address these market failures.

10.2 Historical trajectory of health insurance schemes in India

India has implemented mainly two SHI schemes: ESIS and the Central Government Health Scheme (CGHS) (apart from schemes implemented separately by the defence and railways). India has also witnessed a proliferation of GFHI schemes at both the national and state levels since 2003. The Yeshasvini scheme, introduced in 2003 in Karnataka, was designed for worker cooperatives, including members of rural co-operative societies, self-help groups (*stree shakti* groups) and their families (including joint families). The Rajiv Aarogyasri Scheme (RAS), specifically targeting the below poverty line (BPL) population in Andhra Pradesh, was introduced in 2007. The scheme became popular and was soon extended to almost the entire population. A snapshot of these schemes across states has been compiled by Vahab and Drèze (2025).[2] Many of these schemes, some of which were introduced as early as 2007, continue to operate alongside the Centre's PMJAY. In several cases, state schemes offer provisions and coverage that go beyond those under PMJAY.

The Rashtriya Swasthya Bima Yojna (RSBY), launched in 2008, represents a different approach. It was initiated by the Union government (Ministry of Labour and Employment) as a national health insurance scheme targeting the BPL population, with voluntary enrolment. Other notable state-sponsored schemes include the Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS)[3] in Tamil Nadu (2009) and Vajpayee Arogyashree (2009–10) in Karnataka.

PMJAY builds on earlier schemes and provides coverage of up to ₹5 lakh per household per year for hospitalisation. Introduced in 2018, it merged two

2 Vahab and Drèze (2025), Appendix on State Health Insurance Programmes.

3 Initially launched as *Kalaignar Kaappittu Thittam* in 2009. See Chief Minister's Comprehensive Health Insurance Scheme (CMCHIS).

Scheme Name

Pradhan Mantri Jan Arogya Yojana (PMJAY)

Minimum entitlements

Health insurance of up to ₹5 lakh per year per household for hospitalisation services in empanelled public and private hospitals

Eligibility criteria

12 crore+ poor and vulnerable households based on the deprivation criteria of Socio-Economic Caste Census 2011 (SECC 2011), all senior citizens aged 70 years

Year of introduction

2018

Why this scheme?

To achieve Universal Health Coverage (UHC) and mitigate financial risk caused by the cost of medical treatment

ongoing centrally sponsored schemes: the RSBY and the Senior Citizen Health Insurance Scheme (SCHIS). Many states have integrated their existing schemes with PMJAY, often with enhanced provisions. Under PMJAY, states can choose from three modes of operation: 'insurance mode', 'trust mode' and 'hybrid mode'. In the insurance mode, the primary implementing agency is an insurance company. In the trust mode, the scheme is implemented by a state health agency (SHA), which directly reimburses healthcare providers. The hybrid mode involves a partnership between the SHA and one or more insurance companies.

The following sections assess the effect of GFHIs on the coverage of marginalised populations, OOPE and financial protection and emerging equity concerns. They also identify key design and implementation challenges, along with current theoretical challenges that constrain these schemes.

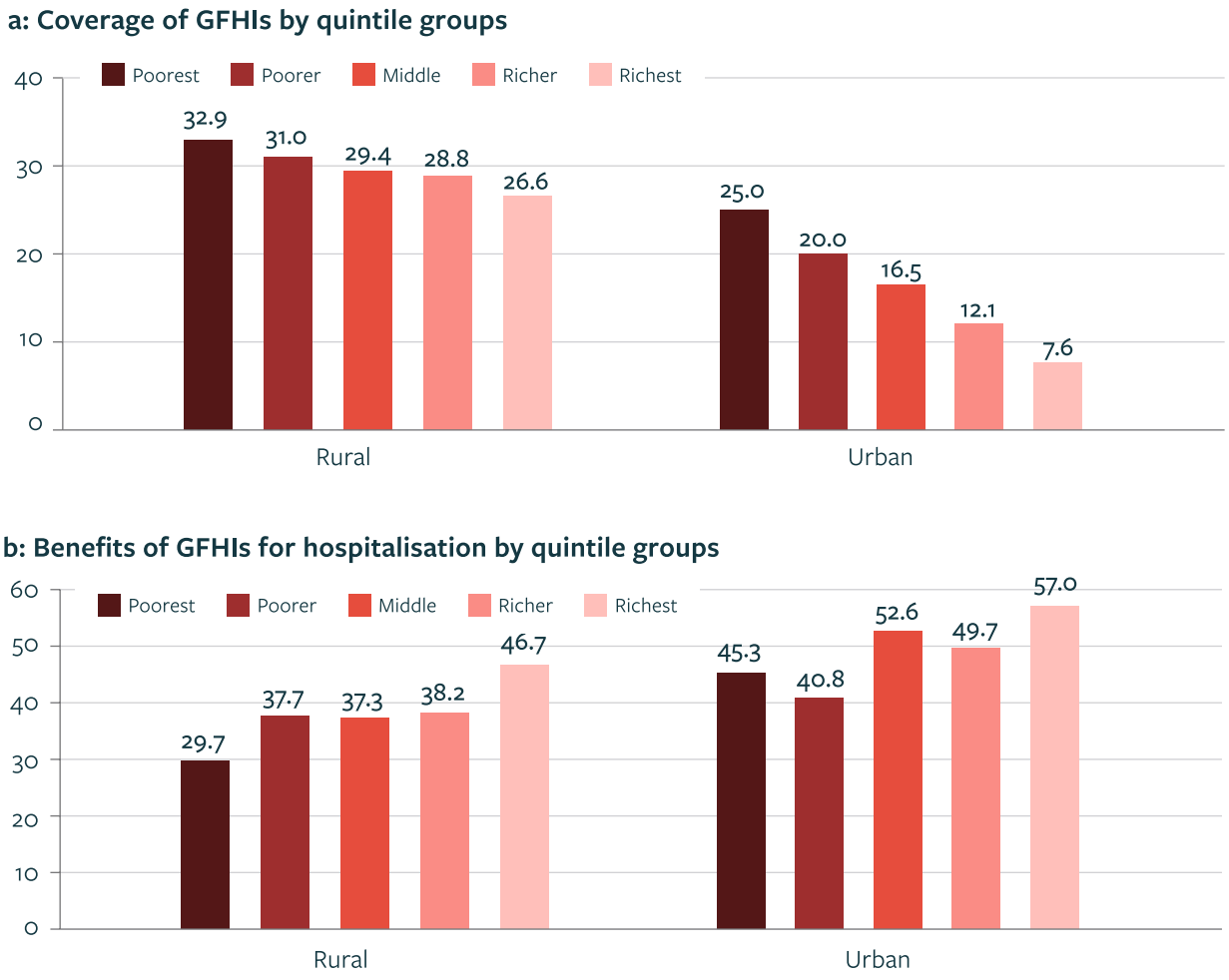
10.3 Notional coverage and exclusion of the needy

GFHI coverage has increased considerably over the last few years, particularly since COVID-19. Around 30 per cent of people in rural areas and 16 per cent in urban areas possess cards. Although official estimates suggest that almost 80 per cent of households are covered, such claims have been subject to scrutiny. The possibility of under-reporting in National Sample Surveys (NSS) cannot be ruled out (Vahab and Dréze 2025). Nevertheless, these schemes exclude a large proportion of the most marginalised sections of society, even though they claim to cover at least the bottom 40 per cent of the population. The NSS Consumer Expenditure Survey (CES) 2023 shows that, among the bottom 40 per cent of the rural population, almost two-thirds are not covered by the scheme (Ministry of Statistics and Programme Implementation 2024). In urban areas, 75–80 per cent of individu-

als in the bottom two consumption quintiles are not covered by GFHIs. Similarly, among *Antyodaya* cardholders, 72 per cent in rural areas and 80 per cent in urban areas are excluded. More than 60 per cent of those with priority ration cards in rural areas and 70 per cent in urban areas are not covered. Although these schemes are intended for individuals working in the unorganised sector, almost 80 per cent of casual labourers in urban areas and 74 per cent in rural areas remain excluded.

Moreover, there are significant variations across states. Coverage exceeds 25 per cent in states such as Jammu and Kashmir (72 per cent), West Bengal (69 per cent), Andhra Pradesh (65 per cent), Chhattisgarh (56 per cent), Odisha (49 per cent), Uttarakhand (40 per cent) and Rajasthan (28 per cent). In contrast, in states like Uttar Pradesh, Bihar, Maharashtra and Jharkhand, less than 5 per cent of the population is covered.

Figure 10.1: Coverage of GFHIs and benefits of the scheme: Rural and urban quintile groups (2022–23)



Sources and notes: Authors' estimation using NSS Consumer Expenditure Survey 2022–23. Figures in panel (b) estimated for those who are covered under GFHI and required hospitalisation

When a population or data set is divided into five equal groups, each group is referred to as a quintile. The first quintile represents the lowest values (0–20%), the next quintile includes the next 20% of values, and so on, with the last quintile representing the highest 20% of values (80–100%). Nomenclature for wealth quintiles here is based on NFHS, with 'poorest' referring to the first quintile and 'richest' to the last quintile.

A History of Social Health Protection in India

1948
Employee State Insurance Scheme (ESIS)
contributory scheme for formal sector workers

1954
Central Government Health Scheme (CGHS)
primarily for civil servants

1986
Mediclaim
started private sector participation in health insurance

2003
Yeshaswini
(Karnataka)

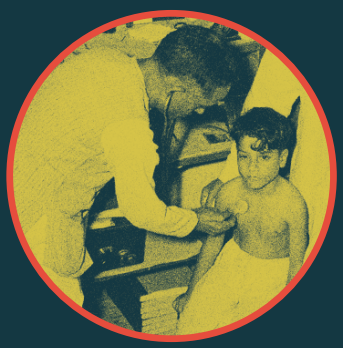
2007
Rajiv Arogyashri
(Andhra Pradesh)

2008
Rashtriya Swasthya Bima Yojana (RSBY) - for below poverty line (BPL) families

2009
Kalaignar Kaappittu Thittam
(Tamil Nadu)

2010
RSBY+ (Himachal Pradesh) and **Vajpayee Arogyashri** (Karnataka)

2010 - 2017
Over twenty state schemes



Studio/28-10-49,A28a(i). A child is being examined by the doctor.
Public Resource via Internet Archive

2018
Pradhan Mantri Jan Arogya Yojana (PMJAY)
- Government-funded
- Purchase healthcare from both public and private institutions
- Mainly limited to hospitalisation expenses
- Packages are identified and have fixed rates
- Managed through insurance agencies, government trusts
- Voluntary participation for marginalised and poorer sections

10.4 Inverse care law: majority with cards do not receive benefits

Despite being covered under GFHIs, only a miniscule proportion of individuals receive benefits at the time of hospitalisation. Among the rural and urban poor, a very small proportion benefits from the scheme. For instance, out of 100 individuals who are covered and require hospitalisation, only around forty benefit in urban areas and thirty-four in rural areas. Moreover, a higher proportion of individuals from better-off quintiles benefit from the scheme compared to their poorer counterparts (see Figure 10.1b). Among the bottom 20 per cent of the rural population, only twenty-nine out of 100 receive benefits, whereas for the top quintile, 47 per cent benefit. In urban areas, among the bottom two quintiles, only one-third of those who are hospitalised and possess cards receive benefits. Details shared by the government in response to a Lok Sabha question show that only 4 per cent of those admitted to private hospitals under PMJAY were Dalits and 1.6 per cent belonged to scheduled tribes (STs) (Chintan 2021). Essentially, a large proportion of the most deprived sections remains disproportionately excluded from the benefits of the scheme.

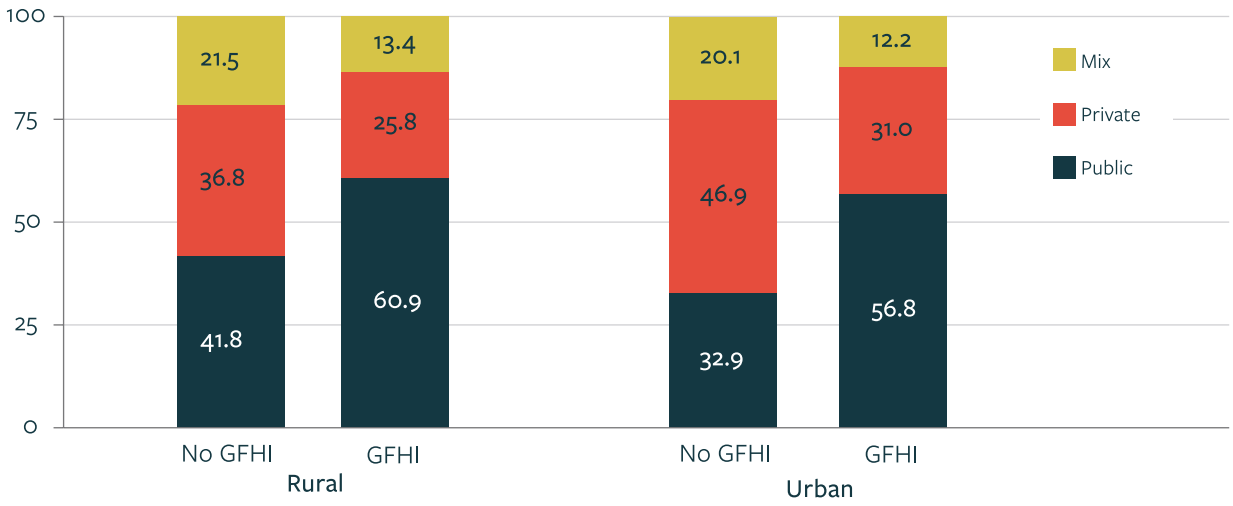
10.5 Crème skimming by the private sector

Another critical element of GFHIs is that a cardholder is entitled to free treatment in both public and private hospitals. Of those who were able to benefit from the scheme for hospitalisation, 26 per cent sought care in private hospitals and a further 13 per cent used both public and private hospitals in rural areas (see Figure 10.2). In urban areas, utilisation of private facilities is higher—around 31 per cent, with an additional 12 per cent using both sectors. An overwhelming majority of those covered by the scheme continue to depend on public hospitals in both rural and urban areas. Marginalised communities, including the poorest quintiles and individuals belonging to scheduled castes (SC) and STs, overwhelmingly seek care in the public hospitals. In fact, utilisation of public hospitals increases among these groups when they possess GFHI cards.

Another important finding is that, when GFHI cardholders seek care in private hospitals, only 29 per cent in rural areas receive benefits; in urban areas, the figure is around 32 per cent. Despite having cards, a large majority in both rural and urban areas are unable to avail themselves of the benefits of the scheme. In contrast, the proportion of patients receiving benefits in public hospitals is significantly higher.

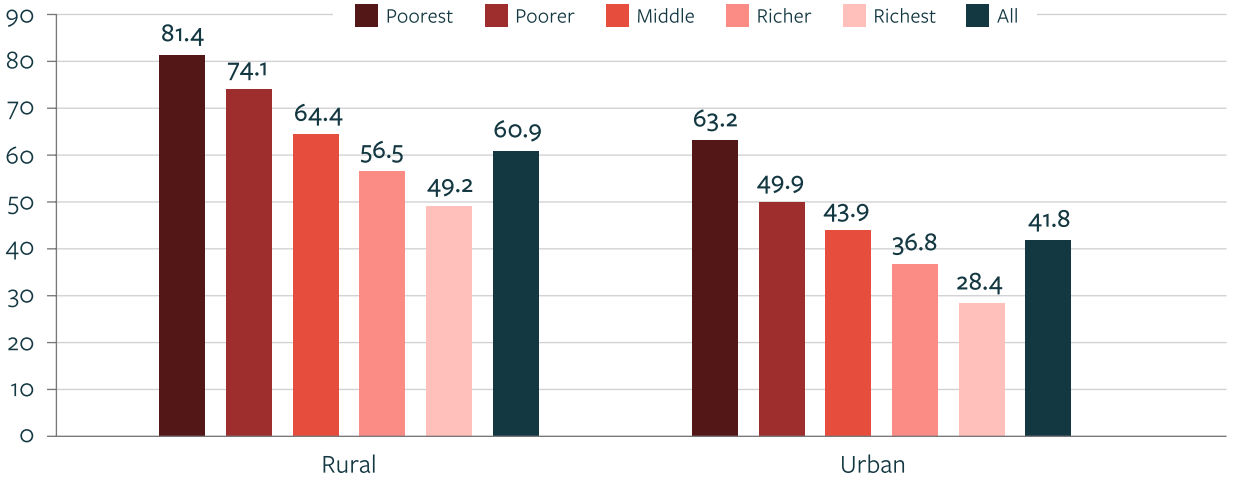
According to the National Health Authority, the technical body responsible for implementing the scheme, most private hospitals are empanelled for surgical packages and are more strongly oriented towards tertiary care (Di Dong et al. 2020). Private hospitals are also predominant in super-specialities such as cardiology, car-

Figure 10.2: Utilisation of public and private facilities among those with GFHI coverage and without coverage



Sources and notes: Authors' estimation using NSS Consumer Expenditure Survey 2022–23

Figure 10.3: Percent of GFHI card holders accessing public facilities for hospitalisation by quintile groups: 2022–23



Sources and notes: Authors' estimation using NSS Consumer Expenditure Survey 2022–23

diothoracic and vascular surgery and neurosurgery. Almost two-thirds of private hospital claims are for surgical packages (Di Dong et al. 2020). These services offer advantages over acute and emergency care due to greater predictability, cost rationalisation and profit margins.

This pattern reflects crème skimming–a practice in which private hospitals provide services only for more profitable conditions, while critical cases are refused and relatively low-risk patients are admitted (Zweifel 2009). This shifts critical and end-of-life care to the public sector. Under PMJAY, the private sector predominantly handles surgical packages such as cataract procedures, single-stent angioplasty and hip fracture treatment. A substantial share of life-saving, critical and cost-inten-

sive care continues to be provided by public hospitals. Despite this, nearly 75 per cent of the total claim value under PMJAY accrues to the private sector (Di Dong et al. 2020). Over time, these dynamic risks push the public health system towards non-profitable, cost-intensive care, thereby weakening it further.

10.6 Chimera of financial protection

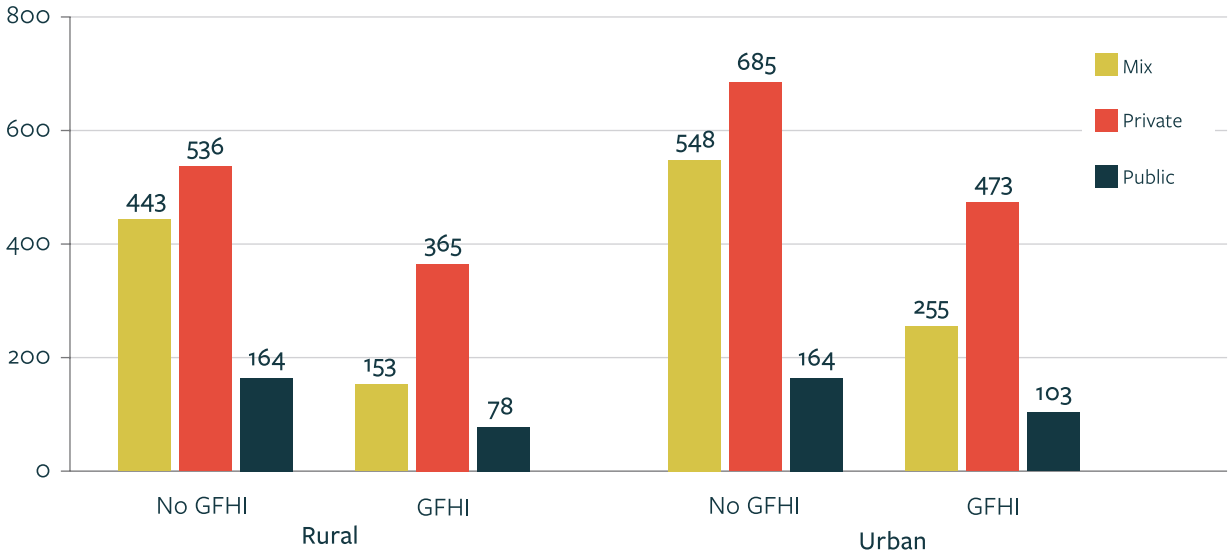
There is a plethora of evidence that GFHIs have limited or no effect on financial protection. Several studies on GFHIs in India, including those on the centrally funded RSBY, show that cashless insurance mechanisms have failed to reduce OOPE (Selvaraj 2012; Ranjan et al. 2018; Nandi and Schneider 2020). A systematic review by Reshmi et al. (2021) examines the impact of GFHIs on financial risk protection and healthcare utilisation. The review finds inconclusive evidence regarding financial risk protection, which is one of the stated objectives of GFHIs. It also reports limited evidence of any reduction in OOPE. A critical analysis of PMJAY by Kamath and Brand (2023) concludes that multiple impact evaluation studies of the RSBY and state GFHIs show little or no reduction in OOPE. GFHIs are also prone to double-charging, whereby hospitals charge patients for services, medicines or diagnostics that are already covered under the scheme, while simultaneously claiming reimbursement. Global evidence similarly suggests that GFHIs operating within private provider-dominated systems fail to reduce OOPE.

According to the NSS 75th round, per-episode hospitalisation expenditure has increased, particularly in the private sector, rather than declining (Indranil 2024). The NSS CES round 2022–23 further substantiates that households with GFHI cards incur higher expenditure than those who do not use them. GFHIs appear to be most effective in controlling OOPE in public facilities in both rural and urban areas. Expenditure incurred in private facilities, even when cards are used, remains significantly higher than in public facilities (see Figure 10.4). A survey commissioned by NITI Aayog reports that, under PMJAY, patients spend around ₹54,000 per episode in private hospitals (Indian Express 2026). In public facilities, patients incur an average OOPE of ₹21,827 per hospitalisation.

As per CES 2022–23, OOPE as a share of household consumption expenditure (HCE) is rising steadily. Between 2011–12 and 2022–23, the share of OOPE in HCE increased from 5.5 per cent to 5.9 per cent in rural areas and from 6.9 per cent to 7.1 per cent in urban areas (Figure 10.5). This indicates that healthcare costs are rising faster than overall consumption expenditure.

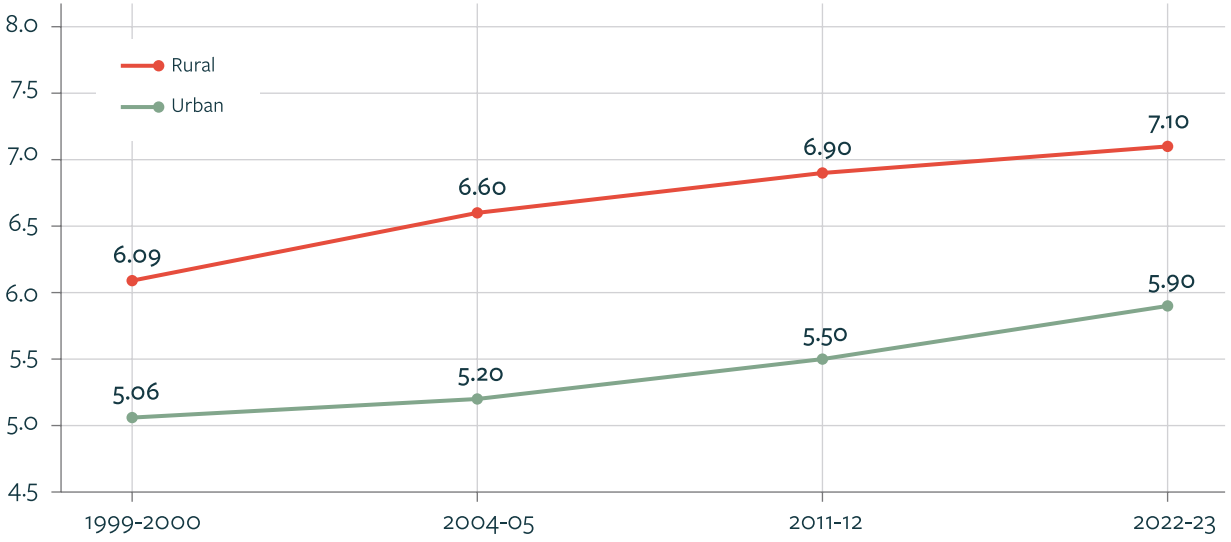
More concerning is the trend in catastrophic health expenditure (CHE), which increases when individuals utilise GFHI benefits. CHE is defined as health expenditure exceeding a specified share of household consumption—for instance, 15 per cent or 10 per cent. Among those hospitalised under the scheme, nearly half in rural areas and 58 per cent in urban areas experience 15 per cent CHE. In

Figure 10.4: Average per capita OOPE (₹) among beneficiaries of GFHIs compared to non-beneficiaries



Sources and notes: Authors' estimation using NSS Consumer Expenditure Survey 2022–23

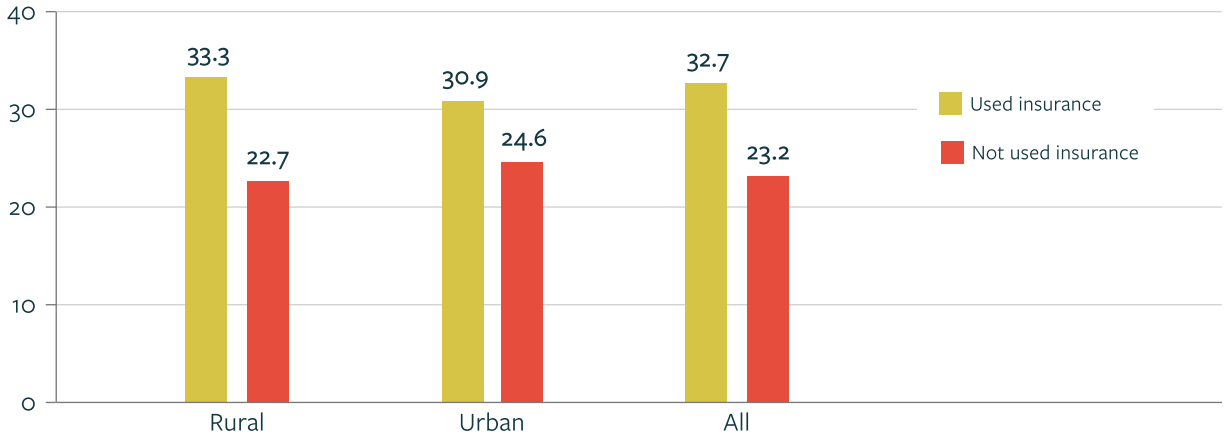
Figure 10.5: Share of medical expenditure in household consumption expenditure (%)



Sources and notes: Reports of NSS Consumer Expenditure Surveys, various rounds

comparison, the corresponding figures for those without cards are 46 per cent and 48 per cent, respectively. CHE incidence is significantly higher in the private sector, where nearly three-quarters of beneficiaries in urban areas and 85 per cent in rural areas experience 15 per cent CHE. By contrast, individuals seeking care in private hospitals without using cards are less likely to face CHE. As expected, CHE incidence remains much lower in public hospitals. These findings indicate that GFHIs fail to provide effective financial protection, particularly when care is sought in the private sector.

Figure 10.6: Catastrophic health expenditure (10% of HCE) for hospitalisation by GFHI usage



Sources and notes: Authors' calculation based on NSO HCE 2022–23 unit records

Reduction of CHE is considered a major sustainable development goal. When measured at a 10 per cent threshold of household spending, CHE remains higher among those who utilise GFHI cards than among those who do not possess or use them (Figure 10.6). CHE incidence at this threshold is also higher in rural areas than in urban areas.

The ineffectiveness of GFHIs in reducing financial hardship is further compounded by their limited coverage of non-hospitalisation expenses, except for short pre- and post-hospitalisation periods. As a result, a large share of chronic and outpatient care remains uncovered. Moreover, when patients are directed to private providers for hospitalisation, they are often channelled back to the same providers for follow-up care, leading to additional OOPE.

10.7 Drain on public resources for private profit

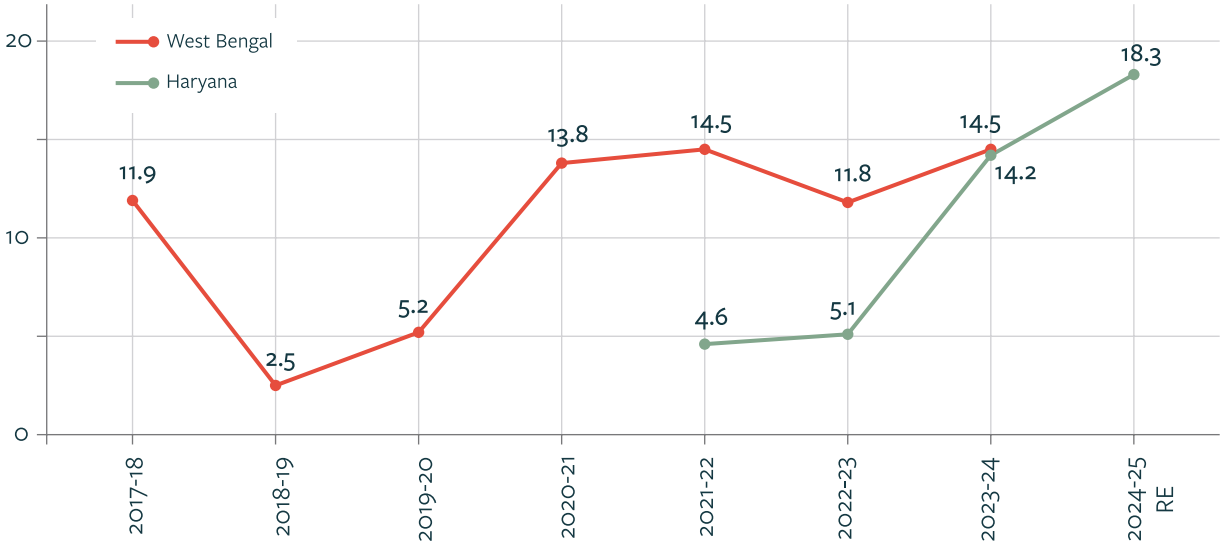
The Union government's prioritisation of Ayushman Bharat PMJAY (AB-PMJAY) is evident in its spending patterns. Between 2014–15 and 2019–20, expenditure in real terms almost doubled, growing at an average of 18 per cent per annum, with much of this increase borne by states. The Union government continues to promote GFHIs at the cost of programmes such as the National Health Mission (NHM), which have strengthened the health system, especially at the primary level of care. In contrast, spending on the NHM has declined in real terms by an average of 5.5 per cent since 2019 (Jan Swasthya Abhiyan 2026). Although PMJAY is the flagship scheme of the Union government, a larger share of spending is incurred by states. Some states have launched their own GFHI schemes, while others have introduced additional features to AB-PMJAY.

Earlier studies show that the RAS in Andhra Pradesh consumed more than one-fifth of the state's total health budget and diverted resources away from pre-

ventive and primary care programs (Mukhopadhyay 2017). The West Bengal government did not adopt AB-PMJAY and instead designed its own GFHI scheme. The Swasthya Sathi scheme, launched in 2016, covers all permanent residents of West Bengal who are not already enrolled in other government health insurance schemes, such as the West Bengal Health Scheme or the CGHS. As a result, the scheme extends coverage beyond poorer populations to include non-poor households. Budgetary allocations for the Swasthya Sathi scheme have increased significantly, from 2.5 per cent of the total public health budget in 2018–19 to 14.5 per cent in 2023–24 (budget estimates) (Figure 10.7).

Similarly, in Haryana, the budgetary allocation for GFHI schemes has increased from 4.6 per cent of the total public health budget in 2021–22 to 18.3 per cent in 2024–25. In 2022, Haryana launched its state-specific Ayushman Bharat Scheme, CHIRAYU (Comprehensive Health Insurance of Antyodaya Units Scheme), for families with annual incomes above ₹1.80 lakhs. In 2023, the state government extended CHIRAYU for families whose annual income is greater than ₹1.80 lakh and up to ₹3 lakh, through a nominal contribution of ₹1,500 per family per year. In both West Bengal and Haryana, the government expenditure on GFHI schemes is increasing. As discussed above, a large proportion of this expenditure is directed towards the private sector. In both states, it is not only the poorest or the most marginalised sections of society that benefit from these so-called 'cashless' schemes. As the data indicate, most of the poorest sections continue to rely on public facilities to meet their healthcare needs, while better-off groups increasingly utilise private facilities, thereby driving up the overall budget.

Figure 10.7: States' budgetary spending on GFHIs as a share of total spending on medical and public health: West Bengal and Haryana (%)



Sources and notes: Detailed demand for grants, Department of Health and Family Welfare, Department of Finance, Government of West Bengal and Government of Haryana, various years.
For Haryana, the figures include allocations for CHIRAYU, Mukhya Mantri Muft Ilaj Yojana, Ayushman Bharat Haryana Health Protection Mission and other cashless medical transfers.

10.8 Induced demands and frauds: Blurring boundaries

The field of medicine and healthcare is characterised by significant information asymmetry between providers and patients. One consequence of this asymmetry is induced demand, whereby providers may encourage patients to consume more care than necessary. Insurance mechanisms can further amplify this distortion. Evidence from research suggests that GFHI coverage is associated with an increased demand for surgical interventions (Singh 2024). Care provided by the private sector under GFHIs may often be unnecessary and induced. For instance, data from NFHS-5 show that caesarean-section rates are much higher in private hospitals than in public facilities. Among those without insurance coverage who seek care in private hospitals, around forty-one out of 100 deliveries are conducted via caesarean section. Among those with GFHI coverage, more than 54 per cent of deliveries are conducted in this manner. It is reasonable to infer that a proportion of these procedures may be medically unnecessary. Thus, these schemes not only fail to ensure free care but may also incentivise unnecessary interventions.

In addition, some studies suggest that fraud contributes significantly to high OOPE and poor-quality healthcare. In the US and Europe, health insurance fraud is estimated to account for around 10 per cent of total health-care spending; in India, estimates suggest that it may be as high as 35 per cent (Kamath and Brand 2023). For the period from September 2018 to March 2021, the Comptroller and Auditor General of India (CAG) conducted a performance audit of AB-PMJAY. The audit highlighted several implementation issues. In six states and union territories, ineligible households were registered as PMJAY beneficiaries, with expenditure on such beneficiaries reaching ₹22 crore in Tamil Nadu. There were also instances of multiple beneficiaries being registered against the same or invalid mobile numbers. The audit further found very low availability of empanelled healthcare providers (EHCPs) per lakh beneficiaries in several states and union territories: Bihar had 1.8 EHCPs per lakh beneficiaries, Maharashtra had three and Uttar Pradesh had five (Government of India 2023).

10.9 Discussion

India's policy response to high OOPE and poor healthcare access has increasingly emphasised insurance-based schemes; however, the preceding discussion suggests these schemes have had limited success in addressing the core market failures they seek to redress. The roots of such design can be traced back to the 'Medicaid' scheme in the US, introduced during the 1960s, where the government provided subsidies to enrol the poor into private health insurance schemes. Early initiatives in the late 1990s and early 2000s—especially in Latin America, where reforms were based on GFHI schemes—shaped the UHC agenda globally. Mecha-

nisms adopted in Chile, Colombia and Mexico shared certain key features: increases in national healthcare expenditures, both public and private and a market logic centred on 'individual care' conceived as a 'private' good. Notably, the World Bank played a key role in building consensus around reforms that later became precursors to UHC, well before the WHO formally adopted it as a policy plank (see Kutzin 2001), although there is limited evidence that these schemes improved financial protection or health system efficiency.

GFHIs in India can be understood as a response to the problem of crème skimming n private insurance. To address adverse selection and crème skimming, the government subsidises more comprehensive insurance plans to make them accessible to high-risk and low-income populations. However, the evidence presented here suggests that GFHIs in India have not effectively addressed adverse selection. GFHIs also promote a tendency towards tertiarisation of healthcare, contributing to rising costs. As healthcare becomes more complex, information asymmetry widens, creating conditions for providers to exercise monopoly power. Care that could be delivered in low-resource settings by general practitioners is often shifted to specialists. Conditions that could be treated with medication or simpler interventions are redirected towards complex surgical procedures, and patients requiring only day-care services are induced into hospital admissions. Providers competing with one another introduce newer technologies and a growing reliance on technological innovations further escalates costs.

Managing healthcare costs has become a challenge in most market-based systems, including the US. Some studies argue that regressive financing mechanisms, combined with higher expenditure and longer survival among wealthier beneficiaries, have resulted in net transfers from poorer to richer populations under Medicare (McClellan and Skinner 1997). Market responses to moral hazard and induced demand often involve the introduction of co-payment mechanisms to increase the cost burden on patients and thereby restrain utilisation. Consequently, policyholders frequently incur substantial out-of-pocket payments even when insured. Under GFHIs, co-payments often occur through informal arrangements, as reflected in NSS data. As a result, the objectives of financial protection and rationalisation of care remain unmet under both PVHIs and GFHIs.

The root cause of the problem lies in the commodification of healthcare, which makes demand responsive to price. When healthcare is provided on a non-commercial basis, the demand curve becomes inelastic[4] to prices and depends on clinical needs rather than patients' ability to pay. Even in developed systems like the US, significant resources are devoted to detecting fraud and induced demand. In India, in addition to induced demand, patients are often subject to informal co-pay-

4 An inelastic demand curve represents a situation where a change in prices does not lead to a significant change in demand.

ments in the private sector. Since these payments are lower than prevailing market prices, patients may be incentivised to pay out of pocket even when services are nominally covered. Many states in India have replaced insurance companies with state-managed agencies in an attempt to address fraud and exclusion. However, success has been limited, as indicated by media reports and CAG assessment. In the absence of a comprehensive regulatory framework and with continued emphasis on market expansion, such piecemeal reforms have failed to curb malpractice.

One reason for such practices in the private sector is the inability to achieve economies of scale in capital-intensive investments in equipment and diagnostics. Providers also face pressure from financial investors to generate rapid and high returns. In an effort to differentiate services and offer state-of-the-art technologies, there is a tendency to oversupply high-end services such as computed tomography (CT) scans and magnetic resonance imaging (MRI). However, adherence to standard treatment protocols would often result in lower utilisation rates and higher returns relative to investment (Indranil and Chintan 2025).

The healthcare industry is undergoing rapid transformation, characterised by growing partnerships between hospital chains and insurance companies, evolving relationships between individual practitioners, small nursing homes and corporate chains, and increased foreign investments, including speculative capital (Chakravarthi et al. 2017; Roy, Sebastian and Mukhopadhyay 2026). Networks linking political actors, real estate interests, the liquor industry and religious institutions are increasingly shaping health policy and practice. Although corporate hospitals are relatively few in number, they wield considerable influence over market behaviour and policy decisions. These entrenched power structures, combined with the rise of business lobbies and the active role of the state in promoting markets, help explain the emergence of a medico-industrial complex in India.

Analyses of actors such as Pratap Reddy and the Apollo Hospitals Group demonstrate how the state facilitated the growth of corporate healthcare through subsidies and tax concessions for high-end medical equipment during the 1980s (Nundy and Baru 2008). At the same time, the corporate sector aligns with the aspirations of elite medical professionals, including those within the public system. One consequence is the continued underfunding and declining quality of public hospitals, reflecting a disconnect between elite professional interests and the needs of the wider population. Schemes such as CGHS and GFHIs have further contributed to market consolidation, with increasing lobbying for higher insurance premiums. Experiences from countries like Japan and Germany suggest that healthcare markets must be regulated to limit excessive profit. However, in India, where unbridled profit and unconditional impunity are norms, establishing effective regulatory mechanisms remains politically challenging.

An alternative approach would be a tax-funded, publicly provided system, based on principles of trust, solidarity and accountability. Such a system could deliver quality care at an affordable cost, with a strong emphasis on comprehensive primary care. It would also enable economies of scale through epidemiological planning and coordinated service delivery across providers. Publicly managed district health systems, with clear referral linkages, offer a viable pathway adopted by several countries. In contrast, continued reliance on demand-side financing of private providers risks foreclosing this possibility.

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