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EXPLORATORY LITERATURE REVIEW ON THE HEALTH CARE SCHEMES OF INDIA: A WAY TOWARD UNIVERSAL HEALTH CARE

Dr. Suresh Kumar, Assistant Professor
Department of Commerce, ICDEOL, HPU Shimla
suresh.commerce@gmail.com
AmitKumar, Research scholar
Department Of Commerce, HPU Shimla
Ak4909747@gmail.com
RekhaKumari, Research scholar
Department Of Commerce, HPU Shimla
Rekharaghuvanshi55@gmail.com
Rajneesh Kumar, Research scholar
Department Of Commerce, HPU Shimla
Krajneesh170@gmail.com
Yashpal, Research scholar
Department Of Commerce, HPU Shimla
Yashpal1307506@gmail.com

Abstract

The healthcare schemes are the one of the key strategies for expanding access to universal healthcare. This could be accomplished through boosting the citizenry's exposure to healthcare and financial assurance. India is currently experiencing an epidemiological health transition in which non-communicable diseases are replacing communicable ones.3.2% of Indians experience poverty each year, while 34% of Indians allocate their entire income to buying for prescribed medication and associated treatment**(Online, I. T. 2011).** The central and state governments have introduced various health care schemes like; Ayushman Bharat, Janani Suraksha Yojana, Mahatma Jyotiba Phule Jan ArogyaYojna etc. The current work is a review paper, and the literature review was purposefully used as the study's technique. The study aim at the combining the significant theoretical works on the various health care scheme started by the centre government and state government before 2017. The current study try find out the awareness level and impact of these health care scheme on the health care service availability to the citizen of the country. The findings of the study include that the people were only moderately aware about the scheme, **Dutta, B.S., & Barman, M.P., (2017)**revealed the 30% of the study participants were found to be fully aware about the scheme and the (p value = 0.002) showed the difference in awareness between different social classes of the society.According to **Prinja el. At. (2017),** the beneficiary's out-of-pocket expenses did not reduce 69% of respondents experienced no change as a result of enrolling in this scheme**.**Findings of **Soumitra et al., (2017)** found out the low enrollment problem in these scheme as only 11% of people were enrolled in health care scheme.

Keywords: Health insurance, Ayushman Bharat, Universal health coverage, National health insurance, Healthcare expenditure

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INTRODUCTION

India is a country that is quickly developing. The persistence of widespread poverty in our nation is one of its paradoxes. Also, it appears that the vulnerable population has become increasingly exposed to it. The national priority has included reducing poverty for more than a few years.According to the Census Report, 27.5% of people live below the poverty level**(Justice, S. (2005)**. The primary causes of poverty in India include the population explosion that followed the country's rapid population growth, which also raised the unemployment and underemployment rates, as well as the inflation rate and level of food costs. Rising food prices force people to expand a considerable amount of their earnings on the consumption of foods to meet the basic requirements of their lives. In addition, inflation has also put a significant negative impact on peoples' savings and wallets.In addition to this The impact of medical bills on households due to lack of health insurance policies and high spending on medical expenses from their earnings and savings puts immense financial pressure on the households. This is one of the main causes for rapidly spreading poverty. The poor mainly spend disproportionately enormous amounts of their earnings as out-of-pocket expenditure on the hearth related issues and treatments that drive people to poverty and hindered the country's overall social and economic growth.

"Health is wealth," and a nation's capacity to sustain top health is a valuable resource for the country. Each country or state's capacity to produce human capital depends on its ability to sustain good health, and it is the responsibility of the state health care system to provide its people with improved services and facilities to increase their standard of living. A fraction of the almost completely tax-funded public hospitals in India are part of a multi-payer universal health care system that is supported by both public and private health insurance funds. Apart for minor, usually symbolic co-payments for specific procedures, anybody living in India has access to the public hospital system for free. The Indian healthcare system is decentralised and structured by a complex network of public and private healthcare providers spread out across the state. For providing the better link between two the ministry of health and family welfare and state health department collaborated to provide various health care scheme for the citizen such as National Health Mission started in the year 2005, National Urban Health Mission, Reproductive-Maternal-Neonatal-Child and the Adolescent Health scheme. The main aim of these health care schemes is to reduce the expenditure on health care service on the one hand and on the other hand, to provide the financial protection to the citizen by making the availability the health care treatment.In India before any of these health care programmes, disease directly increased the risk of loss of life due to its high treatment costs and was negatively affect the wellbeing of the individuals because there were no insurance options available, especially in the rural sector, where health care financing is largely based on out-of-pocket expenses and lacks advance payment options like healthcare coverage**(Baisil, S., 2017).**For obtaining the objectives of the universal health care coverage at the affordable rates various schemes were launched by the government they are:

(1) Ayushman Bharat: This is a national health insurance scheme, was introduced by the Indian government's ministry of health and family welfare in 2018. The PM-JAY will currently offer free healthcare services to more than 40% of the nation's citizens. The programme offers a five rupee health insurance for the Pharmaceuticals, medical attention, diagnostic costs, and pre-hospitalization charges are also covered by this programme. **(2)**

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Pradhan Mantri Surksha Bima Yojna It attempts at giving an Indian citizen adequate accident insurance coverage. Anybody with any bank accounts who are between the ages of 18 and 70 are eligible for the initiative. This policy offers a 2 lakh rupee compensation for total impairment and a 1 lakh rupee payment for partial disability for the insured person.**(3) Aam Adami Bima Yojna:**This scheme was launched in the 2007. It mostly applies to those between the ages of 18 and 59. 30,000 rupees as a financial cover are given to the family in the case of a natural death under this scheme and the family is given 75000 rupees as compensation in the event of a death brought on by a permanent impairment. **(4) Central Government Health Scheme**: Launched in 1954, this initiative offered comprehensive health care options to metropolitan area central government employees and pensioners. Cities like Kolkata, Mumbai, Lucknow, Delhi, Nagpur, and Pune are in which this programme is in existence. **(5) Employees State Insurance Scheme:**The core objective of the Indian government in introducing the ESI programme is to protect employees from certain health uncertainties. This programme is applicable to all long-term contracts with more than ten employees as well as different identities with more than twenty employees. **(6) Mahatma JyotibaPhule Jan Arogya Yojna:**This is a programme run by the Maharashtra government to offer health insurance to residents of the state. This programme is for Maharashtra's BPL residents and farmers. It offers a family health insurance up to Rs. 1.5 but does not cover any specific conditions. This policy's strongest feature is that there is no waiting time and that claims may be made immediately on the first day.In order to assess the effect of these initiatives on the government's health initiatives to provide every citizen with elevated, reasonably priced health facilities, notably for the underprivileged section of society, the current study attempts to bring together the most pertinent literature on the multiple healthcare schemes provided by the various authors.

RATIONALE BEHIND THE STUDY

The health insurance is the main tool in the hand of government for providing the universal health care for the every person of the country. The main aim of these insurance policies is to reduce the financial burden of the people for availing the health services. The current study's objective is to know how different health schemes of central and state governments affect coverage, satisfaction and the infrastructure of the healthcare system and to evaluate the level of awareness regarding them through the systematic literature review of the available work of different author.

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LITERATURE REVIEW RELATED TO THE VARIOUS HEALTH CARE SCHEMES

Krishnan T.N., (1994) has brought up the crucial problem of the financial burden of treatment on those in lower socio-economic strata. He views the topics of healthcare financing and delivery to include both access to care and the standard of care. In addition, he emphasized the significance of capital development, cost-effectiveness, and the influence of technology in deciding the cost of healthcare.**Vilas Gaikaris (2000)** examines health public health initiatives in Maharashtra. The study's conclusions demonstrated that public spending on various health programmes had grown gradually, reducing the state's health issues. The recent study offered several suggestions for enhancing Maharashtra's health. First, there needs to be much promotion if the needy and the impoverished are to benefit from various programmes. Second, the correct implementation and supervision of ASHA, ANUSH, and other programmes are required. Third, the accountability of the health plans needs to be investigated, and the hospital should have the necessary infrastructure to deliver the health programmes. Fourth, the National AYUSH mission must be implemented correctly. **Gumber & Kulkarni (2000),** attempted to examine some critical concerns about the availability and need for health insurance coverage for the poor, particularly women in the informal sector, in their paper on. 1,200 families were included in the study's sample size in the Gujart district of Ahmedabad.The study's findings indicate that the more about 92% of insured families in both rural and urban regions are ignorant of the prevailing health insurance programme.Moreover, it says that the responder is willing to spend 13 to 25% more for the premium in order to receive greater advantages under this arrangement.The study also emphasised the importance of considering the coverage of illnesses, While deciding whether or not to get insurance, consider the coverage of services, the cost of the premium, and administrative issues like submitting claims. The study also emphasised the need for effective informational, organizational, and promotional methods to promote general public insurance literacy and broaden the market for medical insurance.In order to gauge the effectiveness of the plan, supplementary benefits coverage receives the highest ratings in both the rural and urban sample result areas, scoring 20.07% overall.**Sodani, P.R. (2001)** evaluated the community's preferences relating to the health insurance scheme. The study reveals that quality of care and cost are the two vital influencers determining the public's decision to buy any health scheme. The work also suggested that there is a vital quest for a health insurance scheme which is designed following the needs of the informal sectors' needs. **Sara Bennett (2004)** has investigated how various components of a healthcare funding system interact with community-based health insurance (CBHI) programs. The study emphasizes the necessity for additional research on financial institutions and interactions and community-based insurance programmes as solutions for providing medical care to the populace of low-income nations. **Ahuja Rajeev (2004),** Analysis revealed that health insurance was becoming a crucial funding source for addressing the poor's medical requirements. According to the survey, households with higher health expenses and income are more likely to renew their health insurance coverage. Therefore, the report recommends raising the standard of healthcare services supplied to the underprivileged. **Rajeev Ahuja and Narang (2005),** in their study, gave a summary of the current situation of health insurance in India and the new trends that are emerging in the market for low-income individuals. In the paper, the authors list three prerequisites that

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must be met before extending health insurance to those with little financial resources. Three things are necessary for effective implementation: a nodal agency, which could be any public organization, community-based organizations, women's groups, NGOs, microfinance institutions, etc.; the provision of a certain minimum level of affordable quality health care services; the possibility of resource mobilization from the targeted segment**. Pooja Kansraa & Gaurav Pathania (2012**) study was conducted on factors influencing the demand for health insurance in Punjab. It is concluded that the country's economic status is directly connected to the health status of its people. However, the study also revealed that significant bars to the success of health insurance in Punjab are; complex registration procedures, agents-related issues, coverage issues, and awareness among the public. **Priyadarshini, M. (2013)** conducted a descreptive study with the goal of understanding investor investing behaviour about health insurance, their knowledge base and expectation towards it. The data was collected with the questionnaire method from the tamilnadu district of india. 200 respondents form the district were included in the study for collecting the data about the insurance scheme. The data was analyzed through the use of SPSS, and using the chi square and percentage technique. According to the study's findings, the majority of respondents (84.5%) were aware of the different insurance coverage, and 71.2% had invested in one. The findings additionally demonstrated that 55.4% of the respondents had purchased an insurance policy to protect themselves from unanticipatedly large medical costs. The chi square value also indicates that the respondent's income level influences their decision to get an insurance policy (calculated value =20.305 > table value =20.305).**Mallikaruna, K. (2014)** conducted a study evaluating the Rajiv Aarogyasri Scheme in Andhra Pradesh which is implemented to ensure free health checkups by the empanelled hospitals. He cruised that the scope of diseases empanelled under this scheme is narrow because most patients continued to seek help from the Chief Minister's Relief Fund to cure their ailments. As a result, this scheme only assists 500 out of 20000 patients admitted to the empanelled hospitals.. **Borooah et al., (2015)** provided a study on the insurance scheme Rashtriya Swasthya Bima Yojana to access the people's perception toward health protection provided by it and its coverage in various social group. A total of 1500 sample card holder was used by the study for conducting the research collected from the BPL household in utter pradesh and maharashtra. The study's findings include the following: (1). Hindu SC households were more likely to apply for health cards (675) but to not utilise them (48%). (2) Cardholders with higher per capita incomes tended to use their cards more frequently than those with lower incomes (z value =3).(3) it is also found card holder living in the maharashtra state (31%) had claimed more benefits than in UP(18%). **AkashAcharya M Kent Ranson (2015)** examines community-based health insurance as a possible substitute for your for paying medical expenses in Gujarat. The study found the overall schemes financed by NGOs, only a tiny portion of the underserved unorganized sector has been touched thus far. In addition, there is relatively little engagement between the Gujarat and Indian Govt. over the (BHI) schemes implementation in the state. **Azad Bali and M Ramesh (2015)** evaluate India's health policy reforms. The study asserts that the government did not exert the necessary stewardship over the health system, which is why India's healthcare reforms failed to meet their stated objectives. Compared to what the central and state governments delivered, the Health Care sector needed additional intervention. Alok Kumar (2015), in his study on India's approach to Universal Health Coverage, has called attention to the necessity

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for systematic development of health systems and tackling the social determinants of health in India. The author has placed focus on adopting a state-specific strategy for healthcare and modernizing the accountability of the system to give incentives to healthcare providers in the public and commercial healthcare sectors. **Mehtabul Azam (2016)** examined the effect of the RSBY programme on its participants concerning healthcare consumption, per-person out-of-pocket (OOP) spending, and per-patient OOP spending on significant morbidities. The implementation of difference-indifferences with matching, which addresses the issue of non-randomness in enrolment into the scheme, takes advantage of the longitudinal feature of an extensive, nationally representative household survey. In rural India, but not in urban India, the study discovered that RSBY had a beneficial effect on how often RSBY beneficiary households used health services. However, there is no proof that RSBY households in rural and urban areas spent less per person on OOP.. **Mackintosh et al. (2016),** in their study in Lancet 2016, have shown that almost 80% of the reimbursement grants from the RSBY went to private healthcare organizations. The study also noted that one of the highest rates in India was paid out-of-pocket by those seeking medical care. **Mathiraj, D. S., & Devi, R. S. (2016**) Their study of health insurance schemes in India, highlighted the need for the health insurance scheme to provide health care facilities to the underprivileged section of society. The study found that the future of health insurance will advance quickly. However, it also points out the drawbacks of providing better health care coverage at reduced cost without excessive use of technology and producer in healthcare schemes. **R. Nagabhushana (2017)** conducted a study and evaluation of the Yeshasvini Healthcare Scheme in Chamarajnagar Districts to assess assets and the scheme's effectiveness. It shows that the beneficiary is reasonably away from the benefits of the Yeshasvini scheme despite their best efforts; the cooperative societies could not meet the membership target due to financial limitations. **Prashanth (2017),** evaluation of Government Health Insurance schemes for employees in the unorganized sector in Karnataka, investigated in-depth the awareness, enrollment utilization, and satisfaction levels of the state's current Insurance beneficiaries. **Prinja el. At., (2017)** presented a study on the impact of the healthcare programme that was introduced in India on the use of medical services and changes in out-of-pocket spending. the also aimed at analysis the financial risk protection received through the health care schemeThe study made use of a number of research databases found on PubMed, Google Scholar, Ovid, Scopus, and Embase Prior to 2015. The research made use of 1265 articles for analyzing the data for conducting study. the findings of the study include (1) Among the 13 studies that evaluated financial risk protection, 9 (69%) reported no decrease in out-of-pocket spending between enrolled households just after introduction of healthcare insurance. The research additionally showed that upon the implementation of different insurance schemes, more citizens were started using healthcare services. The analysis of the data further revealed that the adoption of such a plan had a favourable impact on citizen health. The author also suggested that health insurance programmes might well be utilised as an opportunity to alter health sector concepts that go beyond the conventional regulatory systems. **Dutta, B.S., & Barman, M.P. (2017)** examine a study, the purpose of the research was to evaluate the extent to which participants knew about maternal and child health care programmes among women of reproductive age and to examine the connection between various socio-demographic characteristics and respondents' knowledge of the topic. 216 women from the Assam area of India were selected as a sample size for this cross-

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sectional research during 2016. According to the study's findings, respondents had a moderate degree of knowledge about the various insurance plans. 30% of the study participants were found to be fully aware of the strategy. The research also found a strong correlation (p value = 0.002) between respondents' caste and their awareness of the different features of the plan. the respondents of sc and st categories was less aware about the scheme. The author further said that in order to maximise the usage of the benefits of the programmes, efforts must be made to raise the level of knowledge among reproductive women in rural regions like Majuli concerning the various free concessions of National rural health mission. **Sriraman et al., (2017)** examined the study In order to evaluate the awareness, use, and advantages of the Bal Sanjeevani Program in a State District Hospital. 100 BPL parents who had admitted their children for treatment of ailments covered by the BSP health care programme made up the study's sample population. According to the study's findings, 86% of respondents were very impressed with the procedure for subscribing for the program. 60% of respondents were comfortable with the monetary compensation offered for treatment under the plan, while 78% of respondents were satisfied with the waiting period before accessing the programme. The study also found the significant relationship (p=0.001) between the child's age and the use of the programme. Moreover, it stated that the study's 100-person sample size may not accurately reflect the population as a whole, and that changes in the socioeconomic environment might have an impact on the study's findings. **Karan et al., (2017)** investigated at a research on the Rashtriya Swasthya Bima Yojana, an Indian healthcare programme. ed The study's goal is to assess how the program affected the expenses that residents spend for their health. The researcher used secondary data collected from the National Sample Survey Organization to carry out the investigation. Using the descriptive statistics approach, the data was examined. The study's conclusions demonstrated that RSBY has not significantly increased the financial security of low-income households. Also, it was discovered that as a result of this scheme, more citizens had recourse to medical services. the result of the data showed that the OOP expenditure has increased by 22% in group 1 and 28% in group 2 despite using such scheme. In addition, the study also states some limitation that RSBY status is not determined at the household level and that systematic state disparities may prove detrimental in the study result. **Soumitra et al., (2017)** examine a study on the on the Rashtriya Swasthya Bima Yojana a health care scheme in india. The objective of the research was to evaluate how using this system will affect residents' access to health care services and financial protection. The researcher used the current National Sample Survey data available to carry out the investigation. The survey includes 37,343 homes from the 18 states. According to the study's findings, approximately 11% of people were enrolled in this programme. This show that only a few individuals were using this scheme in general. According to study, the program was more widely used in rural regions where the enrollment rate was higher (11.51%) than in urban areas (9.81%).The study also found that this scheme had no impact on the providing the financial protection (p value =0.097) to the citizen. The article makes recommendations including utilising international insurance knowledge, comprehending the challenges of controlling the private health insurance sector, and enhancing financial security. **Baisil, S., (2017)** In their cross sectional research attempted to find out if individuals in different level of health care settings in coastal Karnataka district had health insurance. The author further was interested in discovering out how successful it was at increasing healthcare consumption and decreasing

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out-of-pocket costs. The 450 respondents from all forms of healthcare who provided information were gathered using the use of questionnaire method. The findings of the study includes (1) Among the 450 respondents, only 57% had some type of insurance. This revealed the district's low level of health insurance coverage. (2) The health insurance programme was familiar to 64% of the respondents, indicating a modest amount of publicity for the programme. The study's results additionally demonstrate that 13.4% of patients' overall health-related spending increased after acquiring insurance, but hospital visits increased for 23.3% of people as a result of having insurance. The author also suggested for addressing the significance of raising awareness of the need for various healthcare insurance, notably among low-income populations in rural parts of the district.

MANAGERIAL IMPLECATION AND CONCLUSION

Most of the population struggles daily for survival and upward mobility due to economic hardships. Any unplanned medical emergency might wipe out a family's earnings and progress, returning them to the savage grip of poverty. Hence, healthcare is urgently needed to build a better and healthier society. The most pertinent extant literature on different health insurance schemes and their effects on society was examined for this study. According to the review of above literature regarding various health care schemes **Azad Bali and M Ramesh (2015)** study propounds that the government did not exert the necessary stewardship over the health system, which is why India's health care reforms failed to meet stated objectives of schemes**.** The findings of **R. Nagabhushana (2017)** reveal that, despite their best efforts, the cooperative societies could not reach the membership target because of financial constraints, which places the beneficiaries of the Yeshasvini plan quite far from its advantages. The findings of **Priyadarshini, M. (2013)**the majority of respondents (84.5%) were aware of the different insurance coverage, and 71.2% had invested in one. Chi square value value (20.305 > table value =20.305) indicate that the respondent's income level also influences their decision to get an insurance policy. According to the findings of the **Gumber A, Kulkarni V (2000)**more than 92% of insured families under various insurance schemes in both rural and urban regions are ignorant of the prevailing health insurance programme. It also found that the effectiveness of the plan decided on the supplementary benefits coverage under schemes which has got the highest ratings in both the rural and urban sample result areas, scoring 20.07%.

Nevertheless, implementation has made significant strides in achieving universal health coverage. The study's study showed that these healthcare initiatives have marginally increased access to high-quality treatment while decreasing out-of-pocket costs for the underprivileged population. However, the study also revealed that the biggest obstacles to achieving universal health care are the low level of awareness about programmes, the lack of health infrastructure, and the limited disease coverage under programmes. In a country India, where the majority of the population is poor and without health insurance and programmes like ayushman bharat and Janani Suraksha Yojana, has great potential to achieve Universal health coverage.

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Corresponding author: **Dr. Suresh Kumar**

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