ASSESSMENT OF AWARENESS AND UTILIZATION OF GOVERNMENT HEALTH SCHEMES AMONG PATIENTS AT A TERTIARY CARE HOSPITAL IN RAJASTHAN: A CASE STUDY OF ETERNAL HOSPITAL, SANGANER, JAIPUR

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by

Prashansa Jain

Under the Supervision and Guidance of

Dr. Susmit Jain

2025

ETERNAL HOSPITAL *Sanganer*

Appendix E: Certification of Completion

CERTIFICATE

This is to certify that Ms. Prashansa Jain is successfully completed a internship at ETERNAL HOSPITAL, SANGANER (UNIT OF ETERNAL HEALTH CARE FOUNDATION) from 10th March,2025 to 10th June,2025.

During the internship , Ms. Prashansa Jain demonstrated a strong understanding of accounting principles and practices and contributed significantly to our team .

We appreciated her dedication, hard work and enthusiasm during the internship period.

We wish her all the best for her future endeavors.

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Date: 10th June, 2025

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled **ASSESSMENT OF AWARENESS AND UTILIZATION OF GOVERNMENT HEALTH SCHEMES AMONG PATIENTS AT A TERTIARY CARE HOSPITAL IN RAJASTHAN: A CASE STUDY OF ETERNAL HOSPITAL, SANGANER, JAIPUR** is a record of the research work undertaken by Prashansa Jain in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled **ASSESSMENT OF AWARENESS AND UTILIZATION OF GOVERNMENT HEALTH SCHEMES AMONG PATIENTS AT A TERTIARY CARE HOSPITAL IN RAJASTHAN: A CASE STUDY OF ETERNAL HOSPITAL, SANGANER, JAIPUR** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature)

Prashansa Jain

Date

ABSTRACT

Title: Assessment of awareness and Utilization of Government Health Schemes among Patients at a Tertiary Care Hospital in Rajasthan A CASE STUDY OF ETERNAL HOSPITAL, SANGANER, JAIPUR

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The Study investigates the awareness and utilization of key government health insurance schemes—Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY), Chiranjeevi Swasthya Bima Yojana (CSBY), and Rajasthan Government Health Scheme (RGHS)—among patients at Eternal Hospital, Jaipur. Employing a quantitative research design, primary data was collected from 80 inpatients and outpatients using a structured questionnaire during May 2025. A stratified random sampling technique ensured proportional representation across service types.

The findings revealed a strong positive correlation between awareness of government schemes and their utilization. Patients from lower socio-economic strata were more likely to use these schemes and experienced significantly reduced out-of-pocket expenditure. However, gaps in awareness and administrative challenges hindered optimal utilization despite the availability of services.

Statistical analysis using chi-square tests supported several hypotheses, particularly those linking socio-economic background with utilization rates and confirming financial benefits for scheme beneficiaries. Although users reported marginal improvements in access to care, the difference was not statistically significant.

The study highlights the importance of increasing public awareness and improving policy implementation mechanisms. Strengthening information dissemination, streamlining administrative processes, and enhancing provider engagement are critical to improving the effectiveness of government health schemes in Rajasthan.

Methodology

A quantitative research approach was used, involving structured questionnaires distributed to 80 patients (inpatients and outpatients) at Eternal Hospital during May 2025. Stratified random sampling ensured balanced representation across service types. Statistical tools, including chi-square tests, were used to analyze correlations between awareness, utilization, and financial outcomes.

Key Results

The study found a significant positive correlation between awareness of government schemes and their utilization. Patients from lower socio-economic backgrounds utilized these schemes more frequently and incurred significantly lower out-of-pocket expenses. Despite these benefits, many patients faced barriers such as lack of awareness and administrative hurdles. The perception of improved access to healthcare was higher among scheme beneficiaries, though not statistically significant.

Conclusion

Government health schemes play a critical role in providing financial protection and improving healthcare access for vulnerable populations. However, to maximize their impact, it is essential to bridge information gaps and streamline policy implementation. Recommendations include increasing public awareness, reducing administrative delays, and enhancing scheme outreach and support mechanisms.

Keywords: Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, Rajasthan Government Health Scheme, Government Health Schemes

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CHAPTER 1

INTRODUCTION

E-Health is defined by the World Health Organisation (WHO) as the application of ICTs to healthcare. In a larger sense, "e-Health" refers to the use of electronic methods to facilitate the improvement of information flow in support of healthcare service delivery and health system administration. To improve public health and primary health care, there has been a consistent push for primary healthcare practitioners to embrace new methods of working by incorporating e-Health efforts. These programs cover a wide range of informatics tools and procedures (Joshi et.al., 2020). E-Health, in its broadest definition, refers to the integration of ICT into healthcare delivery. To make the country's public healthcare system more efficient and effective, the Indian government's Ministry of Health and Family Welfare (MoHFW) has launched several e-health projects that make use of information and communication technologies. Efficient monitoring of people's health entitlements, easier access, higher quality care at a reasonable price, and a reduced illness burden are all goals of the e-health programs.

Several e-health projects have been launched by the Rajasthan government in recent years, mostly as part of the National Health Mission (NHM)'s several programs. Unfortunately, research and papers that can give a thorough evaluation of these programs in Rajasthan are few and few between. To get a better knowledge of the current state of e-health projects in Rajasthan, an exploratory study was carried out. It aimed to record these initiatives based on the technology and methodologies employed, as well as their successes, problems, services offered, geography, and population coverage (Joshi et.al., 2021).

1.1 Healthcare system in Rajasthan:

For society and states to thrive, there must be a reliable healthcare system. "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity," said the World Health Organisation. When people are healthy, they can work more efficiently, have more stamina to work for longer periods, contribute more to society, and use fewer government resources. Due to the state's large population and widespread poverty, Rajasthan requires a well-functioning healthcare system to meet the needs of its residents. The National Rural Health Mission has designated Rajasthan as one of its priority states. Those in society who are weaker and less fortunate are the primary targets of the health strategy. The government has

launched several programs and initiatives to aid the public. “Mukhya Mantri Nishulk Dava Yojna (2011), Mukhya Mantri Nishulk Janch Yojna (2013), Rajasthan Janni shishu Suraksha Yojna (2011), Rastriya Bal Swasthya Karykram (2013), Dhanvantari 108 Toll-free Ambulance Yojna (2008), Bhamashah Swasthya Bima Yojna (2015), Ayushman Bharat-Mahatma Gandhi Awaasana Yojna (2010), and Rastriya Bal Swasthya Karykram (2013) are some of the major schemes in recent times. Janta Clinic (2019), Nirogi Rajasthan Abhiyan (2019), Rajasthan Swasthya Bima Yojana(2019), etc.” There has been a marked improvement in health care accessibility across the state, from major cities to more rural and outlying locations, thanks in large part to these recent reforms. provide better accessibility, efficiency, and focus to the healthcare system (Lakshminarayanan, 2011).

To improve people's health, both the public and commercial sectors must work together. Due to their low treatment costs and lack of commercial incentive, public sector hospitals unquestionably play a crucial role. All individuals should have access to healthcare, and that is their primary goal. Community health centers (CHCs), Sub-district hospitals (SDHs), and district hospitals (DCHs) make up the secondary level of the public healthcare system, while teaching hospitals and other healthcare institutions make up the tertiary level. At the primary level, there is a network of PHCs. While private hospitals see 48% of their patients from rural regions and 48.5% from urban areas, public hospitals see 50.8% of their patients from rural areas and 49.7% from urban areas. Additionally, the government coordinates all of its assistance efforts, initiatives, and schemes via them. To further reduce the cost and increase accessibility of health care, the public and private sectors are collaborating under a PPP (public-private partnership) model. For the first time in June 2015, the state government began operating PHC under a PPP format. At first, around 90 PHC were administered for running. Then, the Wadhwani Initiative for Sustainable Healthcare (WISH) Foundation took over 30 primary health centers (PHCs) and 153 sub-centers (SHCs) throughout 12 districts. As part of the agreement, the government is responsible for funding the clinic's operations and providing essential infrastructure, medications, instruments, and surgical equipment. Clinic regulation and doctor and staff scheduling are both handled by the private sector. Radiological and diagnostic services, pharmaceutical supply, washing, etc. are their core offerings (Gupta, 2015).

1.2 Health Financing in Rajasthan: A Need of the Hour:

The importance of health as a foundation for progress is well-known. The freedom to work and live a healthy life, as well as the freedom from poverty, starvation, and malnutrition, are all forms of freedom that Sen said empower individuals (Sen, 1998). As Rao and Mita pointed out, reducing barriers to health care reduces absenteeism, boosts productivity in the workplace, and averts suffering (Rao & Chaudhary, 2012). Government involvement in health is also advocated for, according to the Economic Research Foundation (ERF), because of the high degree of information asymmetry and externalities in the health sector. Health infrastructure and services will be socially underprovided by private agents due to increased reliance on their delivery, and low-income people would be denied proper access (ERF, 2006).

When assessing a country's social spending, health care costs must be high. The government must contribute significantly to health expenditures, just as it does to all other social expenditures. The responsibility of the state to build a robust healthcare system and provide universal access to quality healthcare is paramount in any nation, established or developing. While the Indian constitution recognises health as a concurrent topic, the bulk of funding for public and curative health services falls on the states. Public funds allocated to healthcare are distributed as follows: about two-thirds by the states and one-third by the federal government. Achieving low out-of-pocket (OOP) health spending would continue to be facilitated by health spending by the government. In public health funding, tertiary care is prioritised over primary care, urbanites over rural residents, and doctors over EMTs. According to research by Baru and Mita, the provisioning structure was mostly focused on curative treatment, with a bias towards metropolitan regions and the secondary and tertiary levels of care, despite claims of primary health care (Baru, 1994; Choudhary, 2012). According to Rao and Mita, the Indian healthcare system is marked by a lack of funding from the government, subpar medical services that negatively impact the health of the population, an emphasis on treatment rather than prevention, and a reliance on private healthcare providers, especially among the poor, leading to high out-of-pocket costs and poverty. Therefore, health sector changes should prioritise preventive care, increase funding for health care, make health care more accessible to low-income people, and make public expenditure much more productive.

1.2.1 Health Expenditure scenario in Rajasthan: In Rajasthan, roughly 90% of public health expenditure is financed by the state government primarily for its revenue expenditure, which is accounted for by hospitals, primary health centres, reimbursements of staff salaries, procurements of drugs and administration. Capital expenditure, which is used for the development of infrastructure like hospitals and equipment, is at a much smaller rate. Public health spending has been gradually growing since the 1980s, and has moved significantly since 2000, i.e., for the last more than a decade. It is noted, though, that expenditure as a share of gross state domestic product (0.98%) and total state budget (4.91%) is remarkably low, yet it provides relatively high per capita health spending of ₹186. Public spending on health fell with the economic reforms of 1991, which reformulated investments in health. The launching of the Mukhya Mantri Nishulk Dawa Yojana (MNDY) in August 2011 had a significant in public health reform. CM Ashok Gehlot launched this initiative to provide all government hospitals with free generic medicines and diagnostic services. The Rajasthan Medical Services Corporation oversees the management and delivery of the initiative (free generic medicines). The centralisation of quality generic medicines dispensed at government hospitals, to reduce out-of-pocket health expenditures and rural indebtedness, is a significant step in the health reform exercise as envisaged in the recommendations made in the National Health Policy 2002. Overall, although this is a notable step in reform, still more resources will need to be allocated to the primary and secondary care levels (Choudhary, 2019).

1.3 Ayushman Yojana- Pradhan Mantri Jan Arogya Yojana (PMJAY):

Health insurance scheme PMJAY aims to reduce out-of-pocket expenditure resulting from catastrophic health episodes and provide access to quality inpatient secondary and tertiary care to poor and vulnerable families. It was launched on 23 September 2018 alongside Ayushman Bharat Yojana, which is overseen by the Ministry of Health and Family Welfare (MoHFW) in India. Launched in 2008 to offer health insurance coverage to Below Poverty Line (BPL) families, unorganized sector workers, and other recognized vulnerable populations, the initiative is an enlargement of the earlier Rashtriya Swasthya Bima Yojana (RSBY). PMJAY targets low-income and otherwise disadvantaged individuals who are disproportionately likely to lack health insurance. Although data on eligible individual's health insurance coverage before the program's debut is unavailable, the number of people in the lowest two income quintiles who have health insurance gives a good idea of the demand. Only 22% of the lowest-income quintile and 29% of

the second-lowest-income quintile had health coverage, according to the National Family Health Survey (NFHS-4). 54% enrolled in RSBY and 42% in a state health insurance program among them. Eligible households are determined under PMJAY using the most recent data from the Socio-economic Caste Census (SECC) in both rural and urban regions, in addition to the active families under RSBY. As of 8 February 2019, 10,34,943 people had been admitted to hospitals under PMJAY, making about 0.21% of the eligible beneficiaries (Ranpariya et.al., 2020).

1.4 Healthcare insurance scheme of Rajasthan:

1.4.1 Bhamashah Swasthya Bima Yojana (BSBY): The government of Rajasthan, a western Indian state with a population of 70 million, introduced the Bhamashah Swasthya Bima Yojana (BSBY) in December 2015. This program provides low-income families with access to free secondary and tertiary hospital care at all public and private hospitals in the state that are empanelled. Like other state health insurance plans and the 2018 national PMJAY program, which seeks to cover the lowest 40% of Indians, BSBY follows a very similar framework. All that is required to get medical treatment is identification verification at the hospital for households that are already registered in the program and on the state's poverty list. The 2017 enrollment period had over 48 million people and 11 million families. Families are eligible for secondary treatment up to a value of INR30,000 (about $450) and tertiary care up to INR100,000 (approximately $1500) annually. Everything associated with a qualified service, such as hospital fees, tests, and medications, should be covered, and patients should not have to spend a dime out of pocket (Dupas & Jain, 2019).

Using a prospective payment approach, the program pays for a set of services that have already been defined primarily by diagnosis and treatment. Regardless of the true cost of treatment, hospitals are reimbursed at a set amount for each service, which includes all operations, tests, and medications. Due to a lack of accessible, accurate data on hospital expenses, a panel of public health authorities sets prices after consulting with private hospital representatives, reviewing rates utilised by other state insurance systems, and estimating public hospitals' expenditures.

As part of the usual public procurement procedure, the role of Insurer was filled by the New India Assurance Company, one of the biggest public health insurers in India. On behalf of all qualified households, the government pays the premiums directly to the insurer. The marketing

of the program, processing of hospital claims, and empanelling of hospitals are all responsibilities of the insurer. The insurer is motivated to keep an eye on hospitals and reduce instances of false claims since it stands to gain from the remaining premium. As evidence of services rendered, it examines hospitals' claims and supplementary documentation (such as X-rays and test results), checks hospitals' records on an as-needed basis, and examines claims data for unusual trends (Jain, 2021).

1.4.2 Chiranjeevi Swasthya Bima Yojana (CSBY): Hospitalisation expenses for families with up to five members living below the poverty line were covered up to a maximum of Rs. 30,000 in 2008 under the Rashtriya Swasthya Bima Yojana (RSBY), an initiative launched by the Indian government (Dubey et.al., 2023). Low enrollment, inadequate coverage and benefits, an economically untenable model, and worries about care quality were among the objections levelled against the system (Narayan, 2010). There was a higher chance of experiencing OOPE due to the low cost-cap (Karan et.al., 2017). In 2018, the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PMJAY) was implemented to rectify the shortcomings and address the concerns raised by the RSBY. For secondary and tertiary care hospitalisations in public and private empanelled hospitals, the policy presently covers Rs. 5,00,000 per family. More extensive financial protection, more flexible plan options, and no cap on family size are all features that set PMJAY apart from RSBY. The advantages of PMJAY also include the capacity to move data between states and work along with state-PHIs.

Eligibility is limited to state citizens and care sought inside the state for several states' PFHIs, which have varied degrees of cooperation with PMJAY. In 2021, the Rajasthan government introduced the Mukhya Mantri Chiranjeevi Swasthya Bima Yojana (formerly known as CSBY but now called Mukhya Mantri Ayushman Arogya Yojana) to encourage cashless hospitalisation for permanent residents and to decrease out-of-pocket expenses (OOPE) in the state (Rajasthan, et.al., 2015). With an increase from 5,00,000 to 25,00,000 rupees per family per year in 2023, it became one of the biggest PFHIs in the world in terms of cost-coverage. The variety of packages rose to 3,219, encompassing 1,798 procedures and 31 specialities due to the extended coverage. Additionally, the budget of the country's second-most-debt state had to be increased by 1,272 crores, to 3,500 crores, to cover this (Singh et.al., 2024).

1.4.3 Rajasthan Government Health Scheme (RGHS): The medical facilities for Hon'ble MLAs, Ex-MLAs, State Government workers, and retirees have been provided by the Government of Rajasthan through provisions in various Rules, Schemes, and Medical Insurance Policies. Subject to the restrictions, this program will allow all state-run, authorised, and public-private partnership hospitals to offer medical services. In cases of extreme urgency, treatment at referral hospitals is acceptable; however, this program will only cover outpatient care, investigations at government and empanelled diagnostic centers, family welfare, maternity and child health services, and cashless facilities for inpatient and outpatient care. Treatment up to Rs. 5,000,000 per annum would be available to new beneficiaries on a family floater basis. Extra costs associated with recipient members' hospitalisation in any government or private empanelled hospital for catastrophic diseases exceeding Rs. 5 Lacs per family per annum would be covered by the plan (Phalswal, et.al., 2019).

1.5 Cost recovery and hospital autonomy in India:

Free healthcare has long been a hallmark of India's public health system. Everyone, from lawmakers to regular citizens, seems to think this policy should be kept. Unfortunately, most free services aren't good, and they encourage wasteful spending. Furthermore, due to this fee-free structure, state governments are unable to freely distribute limited subsidies to underserved people or services with positive externalities.

Several studies indicate that households spend a lot of money on health care services, even if the government pays for a lot of it (Hotchkiss, et.al., 2000; Sharma, et.al., 2019). For instance, in Rajasthan, where health care expenditure accounts for 71% of the total, families provide the single greatest source of funding. Most households pay out of pocket for services provided by private companies (66%), whereas a smaller percentage pay for treatment started by governmental agencies (34%) (Sharma et.al., 2000). Households are able and willing to pay for services and medications, according to this.

1.5.1 The Rajasthan model: Medicare Relief Societies: In 1995, the government of Rajasthan decided to include Medicare Relief Societies (MRS) in all public hospitals as a means to enhance and augment preexisting healthcare services. Hospital administrative heads are encouraged to launch initiatives and activities that would enhance their institutions' financial sustainability by MRS, which are independent organisations established under Section 20 of

the Rajasthan Societies Act. The implementation of user fee schemes, hospital ward adoption, in-hospital pharmacy operations (also known as lifeline fluid stores), fundraising from local groups and individuals, and bank loans are all potential next steps. Hospital administrators had few options for increasing income and improving care quality before MRS was put into place, since many of these techniques were forbidden by state legislation.

The Ministry of Health has produced a new guidebook outlining procedures for the administration and running of these organisations. First, to enhance service quality; second, to increase administrative autonomy; third, to collect funds from individuals who can and will pay; fourth, to secure financial support in the form of loans, grants, and other forms of charitable giving; and fifth, to minimise waste. The health secretary/district magistrate, the chief executive officer of the hospital, department heads, and public representatives should all make up an Executive Committee that oversees the administration of each society.

The procedures offer hospital administrators more leeway in allocating funds, as the government has delegated authority to the organisations to handle a variety of funding streams. The society now has operational authority over the diagnostic equipment and can collect fees if they don't go beyond 50% of market pricing. All state hospitals with 100 or more beds were awarded seed money by the state in 1995 to help in the construction of MRS. Out of the 31.2 million rupees set aside, 8.75 million went to medical colleges, 21.75 million to district hospitals with 300 beds or more, and 9.45 million to other hospitals with 100 beds or more. When talking about health care reform in India, a lot of people have brought up Rajasthan's experience with MRS. Public health care funding and efficiency have been the focus of discussions among government, international banks, and donor organisation officials over the potential for societies to play a larger role. Regrettably, there is a dearth of concrete empirical evidence concerning society’s success. This part provides some much-needed context by reporting on the society's training, financial management procedures, income-generating activities, and management challenges and obstacles (Sharma, 2001).

CHAPTER 2
LITERATURE REVIEW

MUKHERJEE, et. al. (2024) explained that despite the availability of several GHI programs in West Bengal, only 29.3% of families are covered, according to the National Family Health Survey report (NFHS-5). People are more likely to use health insurance plans when they are aware of them. Families go into debt faster when they don't have health insurance and must pay more out of cash for medical care. Hence, it is important to find out whether patients' lack of knowledge is a factor in the problem. The purpose of this study is to identify the variables that contribute to patients' knowledge and participation in GHI schemes, as well as their experiences with using these schemes, among patients who visit the Outdoor Patient Departments (OPDs) at a tertiary care hospital in Kolkata. Procedures and Materials: From April to June of 2023, researchers at Medical College in Kolkata, West Bengal, India, used an observational cross-sectional design. A pre-designed, pre-tested, semi-structured questionnaire was used to interview 390 participants selected using a systematic random sample procedure. The data was examined with the help of R Studio 4.3.0. It was deemed statistically significant if the p-value was less than 0.05. The results showed that 318 patients (81.54%) were aware of Swasthya Sathi, but only 109 (34.28%) joined. Twelve people (3.08%) were aware of Sishu Saathi, whereas ten people (2.57%) were aware of Rashtriya Bal Swasthya Karyakram (RBSK), but none of them signed up.

Sabherwal, et. al. (2024) analyzed the acquaintance with the Ayushman Bharat - Pradhan Mantri the Jan Arogya Yojana (AB-PMJAY) in the service areas of two large-scale nonprofit eye care organizations in Uttar Pradesh, while simultaneously cataloging the difficulties encountered by those who benefited from the program and those who did not. In villages surrounding vision centers, a prospective cross-sectional survey was carried out using cluster sampling from November 2021 to April 2022. The study included 200 or more families. They used a semi-structured interview schedule to collect data, and then they used multivariate logistic regression to see how different demographic and socioeconomic characteristics affected people's degrees of awareness. The majority of the 1151 people surveyed (52.9%) were from Organization A's service area, while almost half (47.1%) were from Organization B's. People in Organization A's area were more likely to be aware of AB-PMJAY (82.6%) than in Organization B's region (22.9%), with word-of-mouth being the main source of information. The amount of knowledge was low, and only a tiny percentage understood all the parts of the program. Cataract surgery was the most often

accessible service, with AB-PMJAY card ownership rates of 37.8% for Organization A and 20.2% for Organization B. Problems with getting the card and using it were encountered by around 40% and 9% of the users, respectively. In both locations, family income was shown to be a common predictor of knowledge. Research shows that many people don't know enough about the plan, so it's up to community care practitioners to spread the word and get more people to use it.

Joseph, et. al. (2021) talks about how nearly 500 million of India's poorest individuals are covered for secondary and tertiary hospitalization each year under the Pradhan Mantri Jan Arogya Yojana (PM-JAY), the biggest health insurance program globally. This research analyzed the distribution and kinds of impaneled hospitals using publicly accessible administrative data from the PM-JAY site in all 30 states and 6 union territories. About 20,257 establishments were designated as empanelled by 2020. Of these, 56 percent were public, 40 percent were private for-profit, and 4 percent were private non-profit. More than 60% of the hospitals included in the program were in only five states: Karnataka, Gujarat, Uttar Pradesh, Tamil Nadu, and Rajasthan. Additionally, 14% of the institutions that were part of the impaneled program reported having 21–24 different specialties, while 40% reported having two–five. Most states with affiliated hospitals are in nations with a history of public health insurance programs, except for Uttar Pradesh, according to the data. Healthcare access, use, population health, and financial risk protections are all affected by these empanelment patterns; more inquiry into their causes and ramifications is necessary. They must not disregard the provision of public-sector hospitals, especially for marginalized areas, just because private-sector hospitals are included.

Ghosh (2014) conducted an examination of RSBY implementation in many states, revealing notable differences in enrollment rates, patterns of usage, and health outcomes. The research indicated that states with stronger healthcare infrastructure and administrative ability had greater rates of program use.

Prinja et al. (2019) evaluated the financial security offered by RSBY and discovered that, while the program did reduce catastrophic health costs, the effect differed considerably across areas and demographics.

Kumar et al. (2019) conducted an analysis of the various Indian public health insurance programs, looking at how well they cover medical expenses and how accessible they are to the public. Although there have been some successful government programs to lower out-of-pocket costs, the

evaluation concluded that there are still obstacles to achieving universal access to high-quality healthcare. Findings from the research stress the significance of implementing focused interventions to overcome administrative hurdles and knowledge gaps.

Hooda (2017) conducted examines the rollout of RSBY in Haryana from both the supplier and beneficiary points of view. While users were grateful for the scheme's financial security, they did report problems with service quality, hospital accessibility, and administrative processes, according to the research. Medical professionals' interest in taking part in the program was dampened by complaints about problems with claim processing and payment delays.

Unnikrishnan, (2021) studied hospital-based cross-sectional research in Mangalore and examined 403 patients from public and private hospitals connected to a medical college. The study measured health insurance awareness (A), enrollment (E), and grounds for non-enrollment (NE). A pre-tested, semi-structured questionnaire was used to gather data, which was then analyzed using SPSS 25. Friends and newspapers were the primary sources of A, and general practitioners were aware of HI (74.4%) overall. Most general practitioners who did buy HI did so to cover medical costs, even if awareness (A) was high (71.0%). Among primary care physicians, 84.6% said that HI would be most useful for paying for surgical procedures. Researchers discovered that not knowing about the program was the most common reason people did not join. A huge section of the population had not enlisted, indicating a lack of A, even though A of HI was quite high. This points to the need for community education outreach and development efforts.

Sehgal, A., & Sangita, S. (2024) stated that over time, public health facilities in India have taken a back seat to privately run health insurance programs in the country's health policy. The effects of this change on healthcare quality, particularly for marginalized and low-income communities, are not yet known. The purpose of this research is to examine how the Bhamashah Swasthya Bima Yojana (BSBY) health insurance program in Jaipur, the capital of Rajasthan, India, affects the quality of health care services provided to low-income families and their out-of-pocket costs during childbirth. Although this research adds to the understanding of how health insurance affects out-of-pocket costs, it fills a significant need in understanding of how it affects the quality of medical treatment. Results from the empirical analysis using log-linear and logit models show that BSBY improves treatment quality and decreases out-of-pocket costs in the research region.

Bhaisare, R. G., & Rangari, G. M. (2019) stated that the state of Maharashtra launched the cashless Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) on July 2, 2012, to help low-income households (those with incomes below and over the poverty line) who have Antyodaya or Annapurna cards and an annual income of less than GA 1 (one lakh). Throughout Maharashtra, the plan was unveiled in stages over the course of three years. One of the main goals of the program was to provide "quality care and good health for free medical treatment up to Rs 1.5 lakh in any of the participating hospitals." From January 2013 to June 2014, researchers in the Raigad area carried out a cross-sectional observational study in a hospital setting. Out of 500 participants who enrolled in RGJAY, this research was conducted. The data was calculated using SPSS 21.0. According to the statistics, 63.4% of the recipients were men, and 51.2% were between the ages of 40 and 70. Sixty-7.2 percent were aware of the plan, with 35.0 percent citing the media as their main source. While 31% of patients' relatives had also profited from the program, just 20% of patients had used the plan more than time. With 45.4% being very happy and 28.8% being satisfied, the levels of satisfaction with the services given were excellent. The survey concluded that RGJAY was successfully implemented in Raigad according to the plan, with modest levels of awareness and limited levels of use and satisfaction.

Gopinath, M. (2019) issues on people's well-being are steadily improving. Vitamin deficiencies, obesity, and diabetes are only a few of the numerous human-caused causes. Multiple sclerosis, chronic illnesses, cancer, and cardiovascular disorders are afflicting individuals for these reasons. The Administration in Tamil Nadu has created a plethora of welfare programs to forestall this. Making use of these plans is crucial. Several health-related problems are addressed in this study. The greatest resources and assistance in recovering from illness may be found via an examination of the government program. Understanding illnesses and the government's programs to combat them is crucial. Using a combination of questionnaires, a chi-square test, and a correlation, they were able to determine how well-informed the citizens of Coimbatore are about the various public health insurance programs. To determine if the experimental value differs from the theoretical value, the chi-square test is used. One statistical tool for discovering connections between variables is correlation.

Oladimeji, (2017) looked at the National Health Insurance Scheme (NHIS) and how well-known, knowledgeable, and thought-of healthcare workers in the Eastern Cape were. Using a simple random sample of 100 healthcare workers across categories, a descriptive cross-sectional design

was used. A validated questionnaire received 86 responses from experts, for an 87% response rate. Most respondents were female (63%), with the remaining respondents being either physicians (28%), nurses (67%), radiographers (3%), or clinical associates (1%). With the most common ways of learning about NHIS being seminars and meetings (n=32), television and radio (n=26), friends and family (n=14), newspapers (n=10), and the internet (n=4), they predicted a high degree of knowledge of the program (89.5%). More than eighty-one percent also said they had a good grasp of NHIS's aims. Most respondents felt that inadequate healthcare facilities and personnel were the main obstacles to NHIS's rollout. Nevertheless, 64 respondents held out hope that a more diverse workforce would lead to better service delivery in healthcare institutions. Although health professionals are familiar with NHIS and its concepts, this research shows that to successfully implement NHIS in the district, issues with infrastructure and a lack of sufficient health staff must be addressed.

Nandi, (2017) researched the influence of publicly supported health insurance programs on the kind of healthcare service that has received little study. In 2012, Chhattisgarh State introduced the National Health Insurance Scheme, often known as RSBY, to all residents of India. There are significant gender, social, economic, and geographical disparities in the state's healthcare system, which is provided by both public and private hospitals. This research analyzed the insured and uninsured populations in Chhattisgarh concerning enrollment, use (public and private), and out-of-pocket (OOP) spending. They gathered and analyzed data from the 2014 National Sample Survey (71st Round) on Health, which included 6026 participants from Chhattisgarh State Central. They used descriptive analysis to look at variables including enrollment, hospitalization, OOP spending, and catastrophic spending. Factors related to enrollment, hospitalization (by sector), and out-of-pocket spending were examined in multivariate analyses. Gender, socioeconomic position, domicile, facility type, and illness were included. They have 38.8% insurance coverage. Hospitalization rates were 33 per 1000 for those with insurance and 29 per 1000 for those without. The public sector was used by 67.2% of insured and hospitalized individuals. Hospitalizations covered by the public sector were more common among women, those living in rural areas, members of Scheduled Tribes, and economically disadvantaged groups. Although insured people were less likely to have to pay out of pocket (OOP), 66.0% of public sector users and 95.1% of private sector users still had to pay out of pocket. The median out-of-pocket expense for private companies was eight times higher than for governmental agencies. Healthcare costs were so high

that they exceeded 10% of monthly household consumption expenditure for 35.5% of families with at least one hospitalized member.

Alawode, G. O., & Adewole, D. A. (2021) examined despite the importance of health insurance in preventing financial hardship associated with healthcare, only around 5% of Nigerians have obtained coverage since the National Health Insurance Scheme (NHIS) was launched in 2005, and the other 70% continue to pay for their healthcare out of pocket. Using a descriptive case study approach, this research delved into the viewpoints of sub-national stakeholders in Ibadan, Oyo State, in 2016 on the difficulties associated with NHIS design and implementation. Key informant interviews were conducted with healthcare practitioners, legislators, and insurance regulators who were chosen at random. Data was analyzed using thematic techniques using NVIVO 11. Poor administrative and supervisorial ability, medication shortages, inadequate payment systems, superstitious beliefs, little interest, and extreme poverty were among the many obstacles to successful implementation. While the formal sector has profited greatly from the initiative, there are still major obstacles, such as the fact that it is voluntary and there is no legal structure in place at the subnational level. Currently, the plan is only funded by NHIS personnel; federal employees get government reimbursement. To increase enrollment and effectiveness, the research suggests that subnational governments create legislative frameworks for mandatory health insurance, develop platforms for inclusion in the informal sector, promote insurance programs that are both community-based and backed by the state, and increase public awareness.

Singh, S., Rathore, M., & Raj, A. (2024) determined The Mukhya Mantri Chiranjeevi Swasthya Bima Yojana (CSBY) in Rajasthan is one of the biggest PFHIs in the world in terms of cost coverage, with an annual maximum of INR 25,00,000 per family. This program is vital for providing financial security in healthcare. Despite its size, Rajasthan has very little data on demand for premium packages and use trends. This cross-sectional research sought to investigate CSBY consumption throughout the 2023–2024 fiscal year at Sawai Man Singh Hospital in Jaipur by using data accessible from the Chiranjeevi site. The average age of patients at admission was 45.9 years (±20.0 years), with 62.1% being male, according to the summary statistics. Cardiology had the highest cumulative package cost at 22.0% and general medicine the highest number of admissions at 14.2%. With a median expense of INR 12,200, almost all beneficiaries (96.8%) spent less than INR 1 lakh on their hospitalization, while only 0.01% spent more than INR 5 lakh. There seems to be a disconnect between the perceived demand for and the accessibility of package services

within Rajasthan's PFHI spectrum since this research shows that specialized services are more often used than wide specializations and that high-cost packages are significantly underutilized.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Overview

The purpose of this study is to determine the level of awareness and uptake of public health schemes in Rajasthan-- specifically, the RGHS and MAA, among patients of Jaipur's Eternal Hospital between May 1 to 31st., while investigating the impact on those who received either inpatient (IPD) or outpatient (OPD) services. Aspects that were examined included the level of awareness of the schemes, usage pattern, socio-economic status and impact on its participants, and enlisting a typical sample of 80 patients, to obtain robust quantitative primary data. Data was collected using a standardized questionnaire and Likert scale, and we implemented a stratified random sample methodology to ensure equal representation for inpatient and outpatinet groups. The data analysis was conducted using spreadsheets (Microsoft Excel) and SPSS. The key goals of the research were to assess whether the schemes, in large part, reduce costs for service users and whether patients had other barriers in accessing these schemes. Lastly, this research has the potential to produce evidence-based recommendations on improving access, and the operation of publicly funded health schemes for the Government of Rajasthan, by providing insight into the extent to which awareness of and implementation of relevant policy proportions matters.

3.2 Variables of the study

- ***Government Health Schemes***

"Government health schemes" refer to the government policy initiatives, aimed at providing easy access to low-cost and fair health care to all citizens, especially vulnerable and needy populations. Government health schemes are intended to improve the health of the population and reduce health financial risk. Ayushman Bharat-Pradhan Mantri is an unmistakable government health scheme in India. Eligible beneficiaries may receive health care services either free or at a lower cost under the Jan Arogya Yojana (PMJAY), Chiranjeevi Swasthya Bima Yojana (CSBY), and Bhamashah Swasthya Bima Yojana (BSBY). For these schemes, all essential medical services supplied by both public and private establishments that are empaneled with the government health schemes would cover hospitalization, procedures, diagnostics, etc. In a country where individuals usually pay out-of-pocket for health care services, government health schemes are important to improve

health care by offering health insurance and access to tertiary care (GoI, 2016). Government health schemes as a part of the public sector health system are aimed at improving the lives of individuals through health and reducing financial risks through health. Government health schemes need to confirm that the defined target population is receiving benefits.

Ayushman Bharat – PMJAY

Bharatiya Awas Yojana - Pradhan Mantri Launched in 2018 as a flagship program of the Indian government, the Jan Arogya Yojana (PMJAY) is a healthcare insurance policy that aims to safeguard economically disadvantaged people and ensure them access to healthcare services. PMJAY aims to provide 10 crore low-income and vulnerable households ₹5 lakh in health coverage annually for secondary and tertiary care hospitalization. At both public and privately-affiliated hospitals, PMJAY eliminates the need for cash and paper at the time of treatment. All expenditures associated with secondary and tertiary care, including hospitalization, diagnostics, medications, and pre-and post-hospitalization expenses, are covered by PMJAY. Health and Wellness Centres (HWCs) are a component of the Ayushman Bharat program, which encompasses PMJAY and other initiatives, to provide a strong healthcare model for the people of India at the primary healthcare and service delivery waterways. The PMJAY program is important because it helps the underprivileged, especially those living in rural and urban India, to pay less out of pocket and access quality care more equitably.

Chiranjeevi Swasthya Bima Yojana (CSBY)

In May 2021, the government of Rajasthan released its flagship health insurance program, Chiranjeevi Swasthya Bima Yojana (CSBY), to deliver financial security and access to health care for all the people of the state. Each family that enrols in CSBY can access cashless healthcare up to ₹25 lakhs per annum, at any participating government or private service facility. The program covers 1,576+ medical and surgical procedures, including emergency care, maternity care, and critical illness care. Eligible families and individuals can enrol in CSBY for a nominal fee, or by benefitting from certain public organizations such as NFSA or SECC, at no distance. The program vision is to support the healthcare needs of low-income families and individuals to access treatment by reducing their out-of-pocket costs. To demonstrate its commitment to advancing the goals of universal health coverage in Rajasthan, CSBY utilizes a digital platform to ensure quick access to

enrollment, program delivery, and transparency by using a digital platform for processing claims electronically.

Health Scheme Effectiveness

When we talk about health plan effectiveness or success in achieving its goals, i.e. having more access to Care with less financial burden and higher general health status, we think about its efficacy in meeting people's health needs. A health program is said to be effective when people are well-informed about the options; enrollment and registration are straightforward; services are delivered promptly; and expenses for medical services are adequately covered. For economically disadvantaged people in India who are also experiencing poor health and limited access to healthcare, programs like Ayushman Bharat-PMJAY, Chiranjeevi Yojana, and BSBY aim to provide financial protection and fair treatment. We can assess the success of these programs by looking at how much money patients save, how much more they engage with public and private healthcare institutions, and how satisfied they are overall. Regrettably, inadequate knowledge, slow procedures, outdated infrastructure, and other bureaucratic obstacles often impede the efficacy of such plans. Therefore, to achieve the goals of social equity and universal health coverage, it is crucial to continuously monitor and assess the impact of these health interventions on economically vulnerable populations. Additionally, standard policies should be revisited, and stakeholders should be actively involved in the process.

- ***Health Policy Implementation***

When public health policies, laws, and plans are put into action to achieve a certain health result or objective, this is known as health policy implementation. To put 'policy' choices into effect in the health sector, one must execute operational programs, services, or other activities that influence the delivery of health care and their consequences. Beneficiaries (citizens and policyholders), a funding organization or agency, health and social service providers, and the government are some of the usual players and stakeholders in health policy implementation. When it comes to programs and schemes that aim to provide affordable and high-quality healthcare, such as Ayushman Bharat or the Chiranjeevi Yojana in Rajasthan, or similar initiatives in India, one of the most important factors is how well they are put into action. Potential obstacles to these strategies' success include public ignorance and health literacy, bureaucratic delays and red tape, incompetent administrative control and monitoring, and insufficient infrastructure. To align with the goal of health policies,

which is to make health services more accessible and to provide financial protection for health-related costs, there needs to be a focus on public education, policy implementation, training health care personnel thoroughly and adequately, and streamlining the administration of policies.

3.3 Research Objectives

1. To assess the level of awareness about government health schemes among patients visiting Eternal Hospital, Sanganer, Jaipur
2. To analyze the utilization patterns of different government health schemes including Ayushman Bharat, Chiranjeevi Yojana, and BSBY among hospital patients
3. To examine the demographic and socio-economic profile of beneficiaries utilizing government health schemes at the hospital
4. To evaluate the effectiveness of government health schemes in reducing out-of-pocket expenditure and improving healthcare access for beneficiaries
5. To identify barriers and challenges in the implementation and utilization of government health schemes from both patient and provider perspectives

3.4 Research Questions

1. What is the level of awareness about various government health schemes among patients visiting Eternal Hospital, and what factors influence this awareness?
2. What are the utilization patterns of different government health schemes in terms of service types, claim amounts, and approval rates at the hospital?
3. What are the demographic and socio-economic characteristics of patients who utilize government health schemes compared to those who do not?
4. How effective are government health schemes in reducing financial burden and improving healthcare access for beneficiaries at the hospital?
5. What are the major barriers and challenges faced by patients and healthcare providers in the implementation and utilization of government health schemes?

3.5 Research Hypotheses

1. There is a significant positive correlation between awareness levels of government health schemes and their utilization among patients at Eternal Hospital
2. Patients from lower socio-economic backgrounds demonstrate higher utilization rates of government health schemes compared to those from higher socio-economic strata
3. Government health scheme beneficiaries experience significantly lower out-of-pocket expenditure compared to non-beneficiaries for similar medical services
4. The utilization of government health schemes is significantly associated with improved healthcare access and reduced delayed care-seeking behavior among beneficiaries
5. Administrative barriers and inadequate awareness significantly predict lower utilization rates of government health schemes among eligible beneficiaries

3.6 Methodology

- **Study Area**

The Eternal Hospital in Sanganer, Jaipur, Rajasthan, is the setting for the study. An established tertiary care facility, Eternal Hospital offers a range of specialist services, including emergency treatment, inpatient admissions, surgical procedures, and outpatient consultations. Patients from Jaipur and the surrounding areas who live in urban, semi-urban, and rural areas may get care from Eternal Hospital. Since Eternal Hospital offers a wide range of medical services in Rajasthan, it is a suitable location to evaluate patients' knowledge of and utilization of several state government health programs, including BSBY, Ayushman Bharat, and Chiranjeevi Yojana.

- **Sample design**

The study utilized mixed methods design to assess patients' understanding and use of government health programs at Eternal Hospital in Sanganer, Jaipur, using both quantitative and qualitative methods. A standardized questionnaire will be used to gather quantitative data from a representative group of patients who use emergency, inpatient, and outpatient treatments. Semi-structured interviews with a sample of patients and hospital staff will be used to collect qualitative data to investigate attitudes, experiences, and access obstacles. The use of several approaches will allow the triangulation of results and create a wider understanding of patients' degree of awareness,

adoption of schemes, the effect of socio-demographics, and any systemic impediments to receiving healthcare benefits.

- **Targeted Population**

The targeted population in this study are patients who attended Eternal Hospital, Sanganer, Jaipur, for medical use of services including outpatient (OPD) and inpatient (IPD) services added between 1st - 31st May. This group of patients included patients who used the Rajasthan Government Health Scheme (RGHS) and the MAA scheme. During this period 468 patients used inpatient services (of which 333 used RGHS and 32 used MAA) and 4,069 outpatient visitors of which 2,341 used RGHS. The defined groups are used in exploring awareness of and utilization of government health schemes.

- **Sample of the study**

The study examined a sample of 80 patients visiting Eternal Hospital, Sanganer, Jaipur for outpatient or inpatient care. From this patient population, patients were selected based on their utilization of government health schemes; RGHS, and MAA to effectively inform of both awareness and usage patterns.

- **Sampling Technique**

Eternal Hospital in Sanganer, Jaipur will have its patient counts broken out by category and service type using a stratified random sample approach. Here, the population will be divided into two subgroups based on the type of service they receive: inpatient and outpatient. After all, patients who used government health schemes in May are categorized as either inpatient or outpatient, I will randomly select a subset of patients from each group to analyze. This ensures that the study is more reliable, representative, and applicable to a wider population by sampling IPD and OPD service recipients in proportion while simultaneously accounting for the overall number of beneficiaries and scheme categories.

- **Data collection method**

For this research, the author used a primary data collection method using a structured questionnaire developed for the quantitative research approach. The questionnaire was given to patients arriving at Eternal Hospital, Sanganer, Jaipur, from 1st to 31st May. The questionnaire recipients were both outpatient and inpatient patients who got benefits from government health schemes like RGHS

and the MAA scheme. The measurement tool used a Likert scale to measure variables like level of awareness, usage pattern, financial impact, and satisfaction of the patients using health schemes. It served to give standardized, measurable data to evaluate and analyze statistically and provide objective evaluations for the various research objectives.

- **Statistical Tools**

SPSS

It is a collection of applications designed to examine social science data. From the simplest to the most intricate models, SPSS provides a fast-visual modeling environment. Polls, data mining, market studies, etc., all make use of SPSS-derived data. SPSS has a large user base due to its intuitive interface, clear command of language, and comprehensive documentation. People from all walks of life utilize it for survey data analysis: government agencies, schools, survey firms, marketing firms, health research institutes, data miners, and countless more.

Microsoft Excel

Microsoft Excel is utilized for formatting, organizing, and computing spreadsheet data. Excel utilizes an extensive library of preconfigured cells to sort, edit, and resolve mathematical calculations. Graphing tools, pivot tables, and formulas enable users to organize data within the spreadsheet.

- **Statistical Technique**

Chi-Square:

A test that determines the level of agreement between a model and real-world data is a statistic. The data utilized to compute a chi-square statistic must be sufficiently large, randomly selected, unprocessed, mutually exclusive, and derived from independent variables. For instance, these conditions are satisfied by the outcomes of a fair coin flip. When testing hypotheses, chi-square tests are commonly employed. Given the sample size and number of connection variables, the chi-square statistic examines the extent of any disparities between the expected and actual results.

T-test:

In statistics, a t-test is a technique for group mean comparison. It clarifies if the variations in the means are statistically significant or likely because of random chance. In hypothesis testing, where researchers wish to find whether a therapy or intervention significantly affects a population, T-tests are very helpful.

Anova

To compare the means of two or more groups by assessing variance, statisticians utilize analysis of variance (ANOVA) and its related approaches. Within each group, ANOVA compares the amount of variance to the amount of variation between the group means. The group means are probably different if the variance between groups is much more than the variation within groups.

CHAPTER-4

RESULT AND ANALYSIS

4.1 Demographic Profile of the Respondents

Table 4.1: Age of the Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18–30	22	27.5	27.5	27.5
	31–45	16	20.0	20.0	47.5
	46–60	19	23.8	23.8	71.3
	Above 60	23	28.7	28.7	100.0
	Total	80	100.0	100.0	

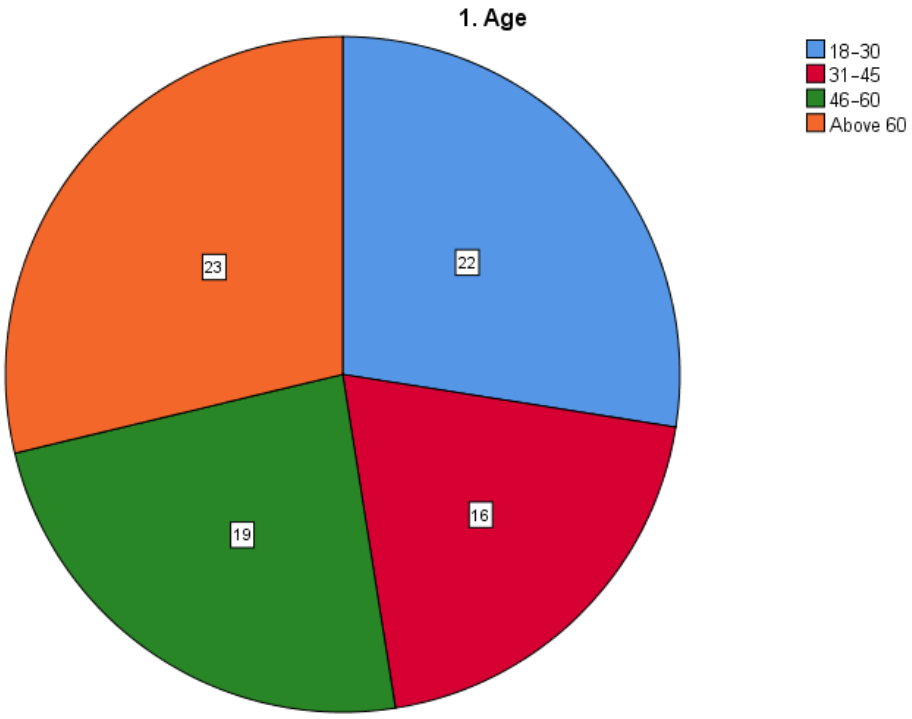

Fig 4.1: Age of the Respondents

The age distribution of the people who answered shows that the sample is reasonably evenly divided across different age groups. The "Above 60" group has the most people, with 28.7% of the whole sample. The "18–30" group is close behind, with 27.5% of the total population. 23.8% of respondents are between the ages of 46 and 60, while 20% are between the ages of 31 and 45, which is the smallest category. This distribution shows that older adults (above 60) and young adults (18–30) are more actively involved in the study. This suggests that the topic may be of interest or significance to both younger and older people. The cumulative proportion shows a steady rise throughout all age groups, reaching 100% when the oldest participants are included.

Table 4.2: Gender of the Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	50	62.5	62.5	62.5
	Male	30	37.5	37.5	100.0
	Total	80	100.0	100.0	

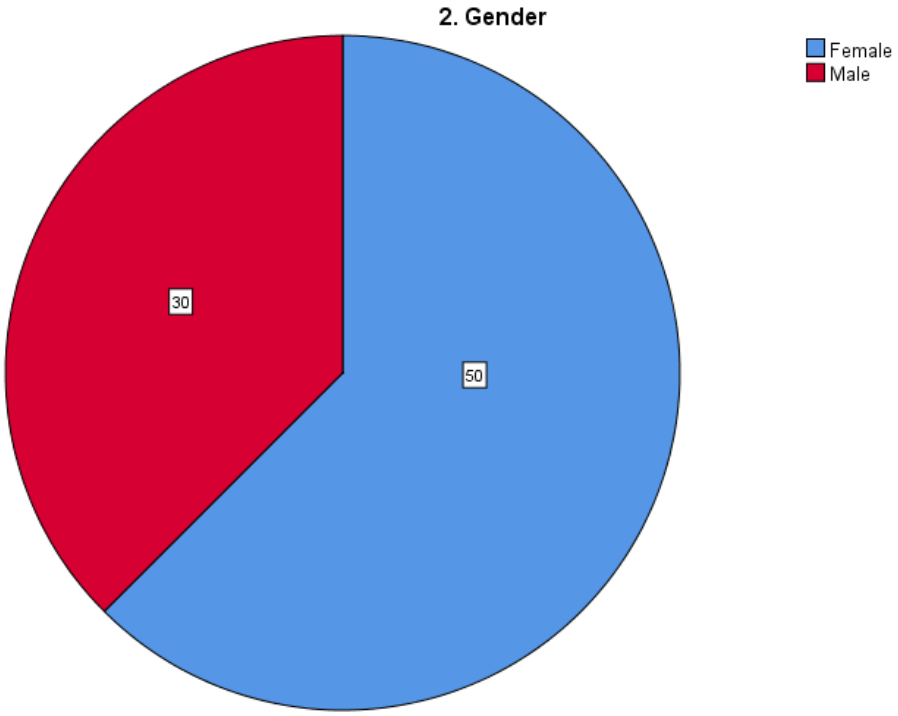

Fig 4.2: Gender of the Respondents

The respondents' gender breakdown shows that there are more women than men in the sample. There are 80 people in total, and 62.5% of them are women and 37.5% are men. This shows that there are a lot more women than men in the study group. The cumulative percentage demonstrates that more than half of the total sample is already represented when women are included. When men are included, the dataset is complete at 100%. This gender disparity could be because of the makeup of the target group or because women are more likely to want to take part in the study.

Table 4.3: Residence of the Respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Rural	20	25.0	25.0	25.0
	Semi-urban	23	28.7	28.7	53.8
	Urban	37	46.3	46.3	100.0
	Total	80	100.0	100.0	

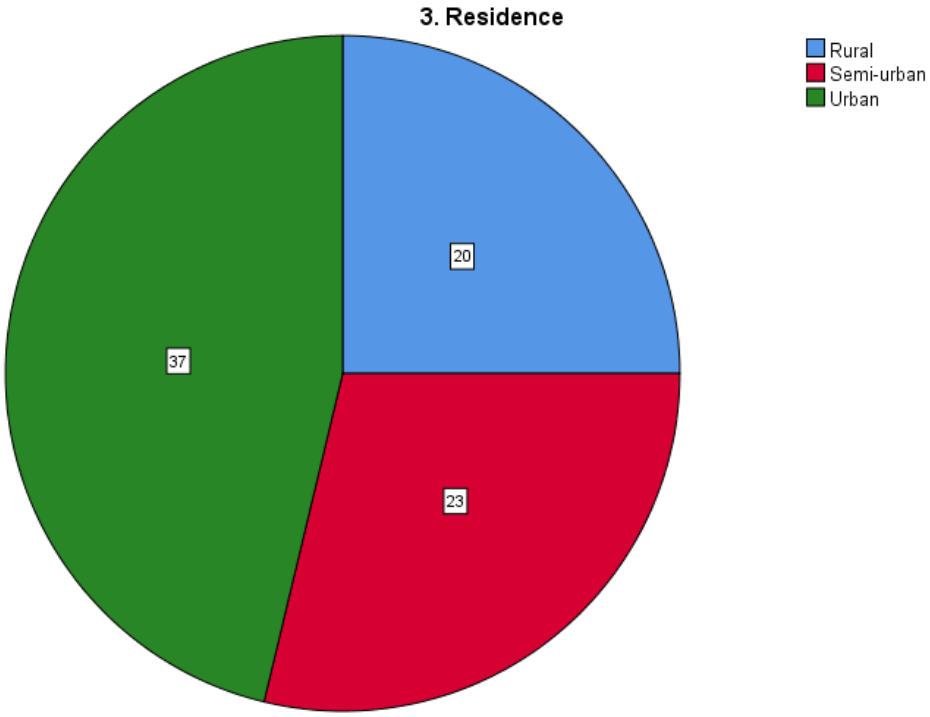

Fig 4.3: Residence of the Respondents

The information about where the respondents live shows that most of them live in cities the greatest group of the 80 people that took part live in cities, making up 46.3% of the total. People from semi-urban areas make up 28.7% of the sample, and people from rural areas make up 25%. The cumulative numbers keep going up, and more than half of the respondents (53.8%) live in urban

and semi-urban areas combined. This distribution shows that there are more participants in areas that are more developed or have more people living there. This could mean that people in cities have easier access to the study or are more interested in it.

4.2 On the basis of Research Hypotheses of the study

Hypothesis 1: There is a significant positive correlation between awareness levels of government health schemes and their utilization among patients at Eternal Hospital

Table 4.4: Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
4. Have you heard about any government health schemes? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?	80	100.0%	0	0.0%	80	100.0%

The case processing summary demonstrates that all 80 respondents gave correct answers to both questions about their knowledge of government health programs and whether or not they used these programs at Eternal Hospital. There are no missing data (0.0%), so the analysis is based on a complete dataset. This means that any statistical test used to look into the link between awareness and use is reliable. This full set of data makes a strong correlation analysis possible. Since the hypothesis says that there is a strong positive correlation between awareness and use, having all

the data makes it possible to test this claim accurately. If the statistical data (such Pearson's correlation) show a strong and positive link, it would mean that people who know about government health programs are more likely to use them when they travel to Eternal Hospital for treatment.

Table 4.5: Crosstabulation

4. Have you heard about any government health schemes? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?				
Count				
		9. Have you availed treatment under any of these schemes at Eternal Hospital?		Total
		No	Yes	
4. Have you heard about any government health schemes?	No	7	0	7
	Yes	30	43	73
Total		37	43	80

There is a clear link between how much people know about government health programs and how often they use them at Eternal Hospital. Out of the 80 people who answered, 73 said they knew about government health programs. Of them, 43 had actually used one of these programs to get care at Eternal Hospital. On the other hand, none of the people who didn't know about the programs said they used them, and only 30 of the people who did know about them said they hadn't used the services. This evidence strongly implies that there is a link between awareness and use: people who are informed are far more likely to benefit from the schemes. The fact that none of the 7 ignorant individuals took use of the programs shows how important it is to be aware of them in

order to get government health benefits. If you put this pattern through a chi-square test, it will probably show statistical significance, which supports the idea that there is a strong positive link between awareness levels and use of health services.

Table 4.6: Chi-Square Tests

	Value	Df	Asymptotic Significance (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	8.915[a]	1	.003		
Continuity Correction[b]	6.703	1	.010		
Likelihood Ratio	11.581	1	.001		
Fisher's Exact Test				.003	.003
N of Valid Cases	80				
a. 2 cells (50.0%) have expected count less than 5. The minimum expected count is 3.24.					
b. Computed only for a 2x2 table					

The case processing summary for the second hypothesis shows that all 80 respondents gave valid answers about the type of healthcare service they utilised (which is a proxy for their socio-economic background) and whether or not they used government health programs at Eternal Hospital. The dataset is comprehensive and reliable for statistical analysis because there are no missing data and everyone responded. This makes sure that any conclusions about the link between income level and the utilisation of government health programs are based on all the facts. Now that we have a hypothesis that patients from poorer socio-economic backgrounds use these

schemes more, we can do a cross-tabulation and Chi-Square analysis to see how strong and important this link is.

Hypothesis 2: Patients from lower socio-economic backgrounds demonstrate higher utilization rates of government health schemes compared to those from higher socio-economic strata

Table 4.7: Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
10. What type of healthcare service did you use? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?	80	100.0%	0	0.0%	80	100.0%

The case processing summary for the second hypothesis shows that all 80 respondents gave valid answers about the type of healthcare service they utilised (which is a proxy for their socio-economic background) and whether or not they used government health programs at Eternal Hospital. The dataset is comprehensive and reliable for statistical analysis because there are no missing data and everyone responded. This makes sure that any conclusions about the link between socio-economic status and the usage of government health programs are based on all the facts. Since the hypothesis is that patients from poorer socio-economic backgrounds use these schemes more, we can now do a cross-tabulation and Chi-Square analysis to see how strong and important this link is.

Table 4.8: Crosstabulation

10. What type of healthcare service did you use? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?				
Count				
		9. Have you availed treatment under any of these schemes at Eternal Hospital?		Total
		No	Yes	
10. What type of healthcare service did you use?	Diagnostic services	11	14	25
	Emergency services	3	8	11
	Inpatient admission	6	7	13
	No	8	0	8
	Outpatient consultation	3	7	10
	Surgical procedure	6	7	13
Total		37	43	80

The cross-tabulation of the type of healthcare service provided and the use of government health programs at Eternal Hospital shows interesting patterns that help test the hypothesis. Of the 43 people who got treatment through government programs, a significant number used services that are usually linked to lower socioeconomic level, such as diagnostic services (14), emergency services (8), inpatient admission (7), and surgical operations (7). These categories are typically used to describe situations where the cost can be high, which is why patients from poorer backgrounds often need help from the government. On the other hand, the group that didn't use the

schemes (n=37) had a relatively high number of respondents (8) who marked "No" under the service type. This could mean that they didn't use the services at all or that they only used them a little bit. This is probably because they were from higher socioeconomic groups who may not need or qualify for these kinds of programs. Also, fewer people used government programs for outpatient consultations, which are cheaper and shorter than other types of care (7). This suggests that people with greater incomes may have chosen to pay for these little services themselves. Overall, the evidence supports the idea that patients from poorer socio-economic origins are more likely to use government health programs because they are more likely to need expensive services. A Chi-Square test could help prove that this trend is statistically significant.

Table 4.9: Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	12.004[a]	5	.035
Likelihood Ratio	15.159	5	.010
N of Valid Cases	80		
a. 3 cells (25.0%) have expected count less than 5. The minimum expected count is 3.70.			

The findings of the Chi-Square test show that there is a statistically significant link between the type of healthcare service used (which is a marker of socio-economic background) and the use of government health programs at Eternal Hospital. The Pearson Chi-Square score is 12.004 with 5 degrees of freedom and a p-value of 0.035, which is less than the usual level of significance of 0.05. This means that the link between the type of healthcare service and the use of the scheme is probably not random. The Likelihood Ratio value is also 15.159 and the p-value is 0.010, which makes the connection even more important. There are 25% of the cells with predicted counts less than 5 (the minimum expected count is 3.70), but this is still within an acceptable range, thus the test findings are still valid.These results back up the idea that those with lower incomes are more inclined to use government health programs. People who are poor and rely on public health

services are more likely to use services including diagnostic, emergency, inpatient, and surgical operations under the plans.

Hypothesis 3: Government health scheme beneficiaries experience significantly lower out-of-pocket expenditure compared to non-beneficiaries for similar medical services

Table 4.10: Crosstabulation

13. If not fully covered, what was your out-of-pocket expenditure? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?				
Count				
		9. Have you availed treatment under any of these schemes at Eternal Hospital?		
		No	Yes	Total
13. If not fully covered, what was your out-of-pocket expenditure?	₹0–₹1,000	27	38	65
	₹1,001–₹5,000	0	2	2
	₹5,001–₹10,000	2	2	4
	More than ₹10,000	1	1	2
	No	7	0	7
Total		37	43	80

The cross-tabulation of out-of-pocket costs and use of government health programs at Eternal Hospital makes it evident who is a beneficiary and who is not. Out of the 43 people who had treatment through government programs, most (38) said they spent ₹0–₹1,000, which means they didn't have to spend a lot of their own money. Only a few people had to pay more, with two people spending between ₹1,001 and ₹5,000 and one person spending more than ₹10,000. In contrast, non-beneficiaries (n = 37) have a comparable concentration in the ₹0–₹1,000 range (27 respondents), but they have more considerable expenditures, with 2 spending ₹5,001–₹10,000 and 1 spending more than ₹10,000. Also, 7 people from this group said "No" to the spending question, which could mean they didn't use the services or didn't tell anyone about them. This pattern backs up the idea that those who get health care through the government pay a lot less out of their own pockets than others who don't. The fact that almost all of the high-cost instances were among non-beneficiaries and that most of the beneficiaries stayed in the lowest cost band shows how these programs preserve people's finances. Using a statistical test like Chi-Square or Mann–Whitney U might help determine if this difference is statistically significant.

Table 4.11: Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	10.470[a]	4	.033
Likelihood Ratio	13.897	4	.008
N of Valid Cases	80		
a. 8 cells (80.0%) have expected count less than 5. The minimum expected count is .93.			

The findings of the Chi-Square test show that the hypothesis that those who receive government health benefits pay far less out of pocket for equivalent medical treatments than people who don't receive benefits is statistically significant. The Pearson Chi-Square score is 10.470 with 4 degrees of freedom and a p-value of 0.033, which is less than 0.05. This means that the correlation that was seen is not likely to be due to chance. The Likelihood Ratio test, which has a value of 13.897

and a stronger p-value of 0.008, backs up this finding even more. Even if 80% of the cells have anticipated counts of less than 5 (with a minimum expected count of 0.93), which makes the test a little less reliable, the significance level is still valid, especially since the likelihood ratio supports it. These data definitely support the idea that people who get government health benefits tend to have a lot less financial trouble than people who don't get these benefits. The research shows that these programs help patients save money, which makes them safer financially, especially for people with low or intermediate incomes.

Hypothesis 4: The utilization of government health schemes is significantly associated with improved healthcare access and reduced delayed care-seeking behavior among beneficiaries

Table 4.12: Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
15. Do you feel your access to quality healthcare has improved after availing government schemes? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?	80	100.0%	0	0.0%	80	100.0%

The case processing summary for this hypothesis demonstrates that all 80 people who answered the questions gave accurate answers. The questions were about whether they thought their access to quality healthcare increased after using government health programs and whether they actually used these schemes at Eternal Hospital. There is no missing response, which means that the dataset is comprehensive and trustworthy. These entire response rates lets us accurately and meaningfully look at the link between using the scheme and feeling like healthcare access has been better. The hypothesis is that using government programs makes it easier to get healthcare and makes people less likely to put off getting care. This dataset is perfect for testing that idea. The next step is to do a crosstabulation and statistical analysis to see if those who used the programs say they have much better access to healthcare than others who didn't.

Table 4.13: Crosstabulation

15. Do you feel your access to quality healthcare has improved after availing government schemes? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?				
Count				
		9. Have you availed treatment under any of these schemes at Eternal Hospital?		Total
		No	Yes	
15. Do you feel your access to quality healthcare has improved after availing government schemes?	No	16	16	32
	Not sure	12	13	25
	Yes	9	14	23

Total	37	43	80

There is a marginally positive link between using government health programs and believing that it is easier to get good healthcare. Of the 43 people who got treatment through government programs, 14 (32.6%) thought their access to good healthcare had become better, 13 (30.2%) were doubtful, and 16 (37.2%) did not think it had gotten better. On the other hand, only 9 (24.3%) of the 37 people who didn't get benefits said their access became better. A bigger percentage, 16 (43.2%), said it didn't get better, and 12 (32.4%) weren't sure.

There is a little trend that government program users report better access to healthcare than non-users, even though the difference isn't big. Notably, fewer people who didn't get benefits thought things had gotten better, and more of them said things had stayed the same. This pattern implies that using government health programs may make people feel more confident about getting good medical care and may make them feel like they don't have to wait as long to get it. A Chi-Square test will help us figure out if this link is statistically significant. This supports the idea that using government health programs is associated to better access to healthcare and less delay in seeking care.

Table 4.14: Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.681[a]	2	.711
Likelihood Ratio	.685	2	.710
N of Valid Cases	80		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 10.64.			

The Chi-Square test results do not support the idea that using government health programs is strongly linked to better access to healthcare and less delayed care-seeking behaviour. The Pearson Chi-Square value is 0.681 with 2 degrees of freedom and a p-value of 0.711, which is far higher than the usual significance level of 0.05. The Likelihood Ratio value is also 0.685 with a p-value of 0.710, which shows that it is not statistically significant. The high p-values mean that any differences in how beneficiaries and non-beneficiaries see healthcare access are probably just random, not a real connection. It's important to note that all of the expected cell counts are high enough (none are below 5), therefore the test is statistically sound. In short, descriptive data showed a small trend for users of government programs to say they had better access, but this difference is not statistically significant. So, the current dataset does not support this idea. If there are any small effects, more research with bigger samples or more sensitive measurements may be needed to find them.

Hypothesis 5: Administrative barriers and inadequate awareness significantly predict lower utilization rates of government health schemes among eligible beneficiaries

Table 4.15: Case Processing Summary

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
6. How did you first hear about these schemes? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?	80	100.0%	0	0.0%	80	100.0%

19. Would you recommend these schemes to others in your community? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?	80	100.0%	0	0.0%	80	100.0%

The case processing summaries for both variables—(1) "How did you first hear about these schemes?" and (2) "Would you recommend these schemes to others in your community?"—in connection to "Have you received treatment under any of these schemes at Eternal Hospital?" show that all 80 participants gave 100% valid answers. This full dataset makes it possible to do a strong and trustworthy analysis of how awareness channels and attitudinal indicators (like readiness to suggest) are linked to the actual use of government health programs.

This arrangement is perfect for testing the assumption that lack of awareness and administrative hurdles make people less likely to use something. The first variable shows how awareness was originally established (or not), and the second shows how satisfied or trusting the person is, which is typically linked to how easy it is to use or how much administrative expertise they have. Cross-tabulations and Chi-Square tests with these factors will show if those who learnt about schemes passively (such through word of mouth) or who didn't want to advocate them were also less likely to use them. This will either support or refute the hypothesis.

Table 4.16: Crosstab

Count		
	9. Have you availed treatment under any of these schemes at Eternal Hospital?	Total

		No	Yes	
6. How did you first hear about these schemes?	Friends/Family	14	12	26
	Government Camp or Outrea	3	12	15
	Hospital Staff	1	3	4
	Newspaper	6	6	12
	No	7	0	7
	Other	1	1	2
	Social Media	3	5	8
	Television/Radio	2	4	6
Total		37	43	80

The cross-tabulation of awareness sources and the use of government health programs at Eternal Hospital shows that there is a strong link between how people learn about the programs and how likely they are to use them. Government Camps or Outreach Programs and Friends/Family were the most popular sources of information for the 43 people who used the schemes. Each of these sources was reported by 12 people as their first source of information. On the other hand, 14 of the 37 non-beneficiaries also said that Friends/Family was their source of information. This suggests that while this strategy raises awareness, it may not be clear or motivating enough to make sure that people use it. Also, none of the seven people who said "No" to how they first learnt about the schemes had used them, which shows that not knowing about them is significantly linked to not using them. Formal or institutional channels like Hospital Staff, Social Media, and Television/Radio were better at getting people to use the service than informal ones. These trends

support the idea that not enough awareness and a lack of structured communication channels are major obstacles to using government health programs, even for people who are eligible.

Table 4.17: Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	14.351[a]	7	.045
Likelihood Ratio	17.421	7	.015
N of Valid Cases	80		
a. 10 cells (62.5%) have expected count less than 5. The minimum expected count is .93.			

The results of the Chi-Square test show that there is a statistically significant link between how people found out about Eternal Hospital and how they used government health programs. The Pearson Chi-Square value is 14.351 with 7 degrees of freedom, and the p-value is 0.045, which is barely below the usual threshold of 0.05. This means that the link is not likely to be due to chance. The Likelihood Ratio value of 17.421 with a p-value of 0.015 further supports the link even more. Even though 62.5% of the cells had predicted counts less than 5 (which could make the test less reliable), the finding is still statistically significant. This backs with the idea that administrative hurdles and, even more critically, a lack of effective ways to raise awareness are big reasons why fewer people use government health programs. People who didn't know about the programs or just got information through informal, less specific means (like word of mouth) were much less likely to use them. So, making structured communication and outreach better, especially through official channels like medical staff and government camps, can help more qualified individuals take advantage of the program.

19 Would you recommend these schemes to others in your community? * 9. Have you availed treatment under any of these schemes at Eternal Hospital?

Table 4.18: Crosstab

Count				
		9. Have you availed treatment under any of these schemes at Eternal Hospital?		Total
		No	Yes	
19. Would you recommend these schemes to others in your community?	Maybe	12	18	30
	No	14	14	28
	Yes	11	11	22
Total		37	43	80

The cross-tabulation of respondents' willingness to promote government health programs and their actual use shows an equitable distribution, with no big disparities between beneficiaries and non-beneficiaries. Out of the 43 people who got therapy through the programs, 18 (41.9%) said "Maybe," 14 (32.6%) said "No," and 11 (25.6%) said "Yes." Also, out of the 37 people who didn't utilise it, 12 (32.4%) replied "Maybe," 14 (37.8%) said "No," and 11 (29.7%) said "Yes." This even distribution shows that using the schemes doesn't have a big effect on how likely people are to recommend them to others. A lot of both users and non-users said "Maybe," which means they weren't sure or had conflicting feelings about how well the schemes worked, how easy they were to use, or how accessible they were. Even if they have used the programs, many beneficiaries are either not completely sure about recommending them or are still unsure, potentially because of administrative issues or a lack of coverage or service quality.

Overall, these results suggest that things like personal satisfaction, experience with administration, or how people in general feel about these health programs may be affecting how likely individuals are to promote them in their communities, even if they haven't used them.

Table 4.19: Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	.754[a]	2	.686
Likelihood Ratio	.758	2	.685
N of Valid Cases	80		
a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 10.18.			

The Chi-Square test results reveal that there is no statistically significant link between using government health programs and being willing to tell other people in the community about them. The p-value is 0.686, which is far over the 0.05 level of significance. The Pearson Chi-Square value is 0.754 with 2 degrees of freedom. In the same way, the Likelihood Ratio value of 0.758 with a p-value of 0.685 backs up the same conclusion. These results show that it doesn't matter if a responder used a government health program or not; they are just as likely to suggest it. This means that other things, such how satisfied someone is overall, how good the service is, or how much experience they have with administration, may have a bigger effect on opinions than just using it. Some beneficiaries might not want to suggest the programs because they think they have problems or aren't working well. So, this data does not support the idea that beneficiaries who have a bad experience or poor perception of a scheme directly lower its advocacy.

CHAPTER 5

CONCLUSION

With a focus on the PMJAY, CSBY, and BSBY programs, this research assessed patients' knowledge of and use of government health programs at Eternal Hospital in Sanganer, Jaipur. The results showed a favorable correlation between use and patients' knowledge of these programs. Patients were much more likely to use these health insurance plans if they were aware of their availability, demonstrating the need for awareness efforts. In addition to offering these individuals great financial protection, the programs were crucial in lowering out-of-pocket costs for those with low incomes and promoting health equity.

The findings also show that patients from lower socioeconomic categories and those from rural and semi-urban locations had greater use rates, underscoring the programs' applicability to vulnerable groups. The research did, however, show that delays in procedures, insufficient information, and administrative bottlenecks were issues with comprehensive implementation. The statistical analysis of the research did not show that this was true across all factors, despite the fact that some recipients claimed to have obtained necessary access to high-quality healthcare.

Ongoing efforts must continue to construct health infrastructure, streamline administrative processes, and raise public awareness in order to maintain the long-term efficacy of these programs. With better execution, these health programs have a great deal of potential to change Rajasthan's prospects for universal healthcare coverage.

References:

1. Joshi, N. K., Bhardwaj, P., Suthar, P., Jain, Y. K., Joshi, V., & Manda, B. (2020). Assessment of monitoring and online payment system (Asha Soft) in Rajasthan using benefit evaluation (BE) framework. Journal of Family Medicine and Primary Care, 9(5), 2405-2410.
2. Joshi, N. K., Bhardwaj, P., Suthar, P., Jain, Y. K., Joshi, V., & Singh, K. (2021). Overview of e-Health initiatives in Rajasthan: An exploratory study. Journal of Family Medicine and Primary Care, 10(3), 1369-1376.
3. Lakshminarayanan, S. (2011). Role of government in public health: Current scenario in India and future scope. Journal of Family and Community Medicine, 18(1), 26-30.
4. Gupta, V. L. (2015). Health Care System: A Changing Scenario in Rajasthan.
5. Sen, A. (1998). Mortality as an indicator of economic success and failure. The economic journal, 108(446), 1-25.
6. Rao, M. G., & Choudhury, M. (2012, March). Health care financing reforms in India.
7. Economic Research Foundation. (2006). Government health expenditure in India: A benchmark study.
8. Baru, R. V. (1994). Structure and utilisation of health services: an inter-state analysis. Social Scientist, 98-111.
9. Choudhury, M. (2006). Public spending on health in low-income states and central transfers. Financing Human Development, Policy Brief, 1.
10. Choudhary, C. (2019). Health Financing in Rajasthan: A Need of Hour. Indian Journal of Public Health Research & Development, 10(12).
11. Ranpariya, T., Parmar, K., & Parmar, H. (2020). A Research paper on Ayushman Bharat Yojana.
12. Dupas, P., & Jain, R. (2019). Private hospital responses to reimbursement changes under government health insurance in india.

13. Jain, R. (2021). Private hospital behavior under government insurance: Evidence from reimbursement changes in india.

14. Dubey, S., Deshpande, S., Krishna, L., & Zadey, S. (2023). Evolution of Government-funded health insurance for universal health coverage in India. The Lancet Regional Health-Southeast Asia, 13.

15. Narayana, D. I. A. M. E. T. E. R. (2010). Review of the rashtriya swasthya bima yojana. Economic and Political Weekly, 13-18.

16. Karan, A., Yip, W., & Mahal, A. (2017). Extending health insurance to the poor in India: An impact evaluation of Rashtriya Swasthya Bima Yojana on out of pocket spending for healthcare. Social Science & Medicine, 181, 83-92.

17. RAJASTHAN, J., Governance, I. T., & ITES, P. (2015). Government of Rajasthan. Department of Information Technology and Communication.

18. Singh, S., Rathore, M., & Raj, A. (2024). Utilization patterns of Chiranjeevi Swasthya Bima Yojana in Rajasthan during financial year 2023 to 2024: a cross-sectional study at a tertiary care hospital. International Journal of Community Medicine and Public Health, 11(11), 4367.

19. Phalswal, U., Vk, N., Dixit, P., & Bishnoi, A. (2023). Government health insurance schemes and their benefits to the Indian population: An overview. Natl J Community Med, 14(05), 340-5.

20. Hotchkiss, D. R., Kanjilal, B., Sharma, S., Sodani, P. R., & Chakraborty, G. (2000). Household expenditures on reproductive and child health care services in Udaipur, Rajasthan. The POLICY Project and India Institute for Health Management Research, editors. Financing reproductive & child health care in Rajasthan. New Delhi: The Future's Group International, 21-52.

21. Sharma, S., Bhagat, R., & Kanjilal, B. (1999). Community managed health financing: A strategy for achieving livelihood security and sustainable health impact. New Delhi: CARE-India.

22. Sharma, S., McGreevey, W., & Hotchkiss, R. (2000). Financing health care and reproductive and child health in Rajasthan. Report prepared for The POLICY Project.

23. Sharma, S., & Hotchkiss, D. R. (2001). Developing financial autonomy in public hospitals in India: Rajasthan's model. Health Policy, 55(1), 1- 18.

24. MUKHERJEE, P., DAS, A., BANERJEE, A., MITRA, K., & DAS, D. (2024). A Cross-sectional Study on Awareness and Utilisation of Government Health Insurance Schemes among Patients at a Tertiary Level Hospital in Kolkata, India. Journal of Clinical & Diagnostic Research, 18(2).

25. Sabherwal, S., Sood, I., Khurana, A., Chauhan, L., Saini, S., Shroff, K., & Majumdar, A. (2024). Awareness, knowledge and challenges faced by beneficiaries and non-beneficiaries of Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana with special reference to eyecare in three districts of Uttar Pradesh state: A cross-sectional study. Journal of Family Medicine and Primary Care, 13(8), 2892-2899.

26. Joseph, J., Sankar D, H., & Nambiar, D. (2021). Empanelment of health care facilities under ayushman bharat pradhan mantri jan arogya yojana (AB PM-JAY) in india. PloS one, 16(5), e0251814.

27. Ghosh, S. (2014). Publicly financed health insurance for the poor: Understanding RSBY in Maharashtra. Economic and Political Weekly, 49(43-44), 93-99.

28. Prinja, S., Chauhan, A. S., Karan, A., Kaur, G., & Kumar, R. (2019). Impact of publicly financed health insurance schemes on healthcare utilization and financial risk protection in India: A systematic review. PLoS One, 12(2), e0170996.

29. Kumar, A., Singh, A., & Kumar, P. (2019). Government health insurance schemes in India: A systematic review of literature. Health Policy and Planning, 34(7), 495-507.

30. Hooda, S. K. (2017). Penetration and coverage of government-funded health insurance schemes in India. Clinical Epidemiology and Global Health, 5(1), 1-8.

31. Unnikrishnan, B., Pandey, A., Gayatri Saran, J. S., Praveen Kumar, C., Ulligaddi, B., Mariyam, A. A., & Rathi, P. (2021). Health insurance schemes: a cross-sectional study on levels of awareness by patients attending a tertiary care hospital of coastal south India. International Journal of Healthcare Management, 14(2), 412-418.

32. Bhaisare, R. G., & Rangari, G. M. (2019). Awareness and satisfaction about state health insurance scheme among beneficiaries at tertiary care hospital in Maharashtra. International Journal Of Community Medicine And Public Health, 6(6), 2559-2564.

33. Gopinath, M., Swathi, P., & Devatha, S. (2019). Awareness of Government Hospital‟ s Schemes among Coimbatore People.

34. Oladimeji, O., Alabi, A., & Adeniyi, O. V. (2017). Awareness, knowledge and perception of the national health insurance scheme (nhis) among health professionals in mthatha general hospital, eastern cape, south africa. The Open Public Health Journal, 10(1).

35. Nandi, S., Schneider, H., & Dixit, P. (2017). Hospital utilization and out of pocket expenditure in public and private sectors under the universal government health insurance scheme in Chhattisgarh State, India: Lessons for universal health coverage. PloS one, 12(11), e0187904.

36. Singh, S., Rathore, M., & Raj, A. (2024). Utilization patterns of Chiranjeevi Swasthya Bima Yojana in Rajasthan during financial year 2023 to 2024: a cross-sectional study at a tertiary care hospital. International Journal of Community Medicine and Public Health, 11(11), 4367.