Assessment of barriers to utilization of government health insurance schemes among rural households

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Abstract:

Background: Government-funded health insurance schemes have become an important component of India's strategy to achieve universal health coverage and protect economically vulnerable households from healthcare-related financial hardship. Programmes such as Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), Rashtriya Swasthya Bima Yojana (RSBY), and various state-sponsored health insurance schemes aim to improve access to affordable hospitalisation and reduce out-of-pocket expenditure. Despite considerable expansion in financial coverage, the actual utilisation of these schemes among rural households remains influenced by multiple social, economic, geographical, and administrative and health-system factors.

Objective: To examine the major barriers affecting awareness, enrolment, accessibility and utilisation of government health insurance schemes among rural households in India and to identify strategies for improving equitable access and financial protection.

Methods: This article adopts a narrative review approach based on published research articles, national health policy documents and available evidence concerning publicly funded health insurance programmes in India. Relevant literature was examined to identify recurring barriers associated with beneficiary awareness, eligibility verification, documentation, geographical accessibility, hospital empanelment, administrative procedures, service availability, socioeconomic inequalities and out-of-pocket expenditure.

Discussion: Evidence indicates that possessing eligibility for a government health insurance scheme does not necessarily translate into effective utilisation. Limited knowledge of scheme benefits, difficulties in identifying eligible family members, inadequate documentation, digital literacy limitations, and transportation expenses, shortages of empanelled facilities, delays in beneficiary verification and incomplete understanding of cashless treatment procedures can prevent rural households from receiving entitled services. Gender inequality, caste-related disadvantage, poverty, low educational attainment and geographical isolation may further intensify these barriers. Moreover, indirect expenses and payments for services outside the approved benefit package can continue even when hospitalisation is covered.

Conclusion: Improving the utilisation of government health insurance schemes requires more than expanding financial coverage. Beneficiary-centred communication, simplified enrolment and verification, strengthened rural healthcare infrastructure, effective hospital monitoring, transparent grievance redressal and community participation are essential. Nurses, community health workers, ASHAs and local health institutions can play an important role in connecting eligible households with available benefits. A coordinated approach is necessary to ensure that government health insurance translates into meaningful healthcare access and financial protection for rural populations.

Keywords:
Government health insurance, rural households, Ayushman Bharat, PM-JAY, health insurance utilisation, healthcare accessibility, financial protection, awareness, enrolment barriers, out-of-pocket expenditure, universal health coverage.

1. Introduction:

Health is an essential component of human development and socioeconomic progress. Access to timely, affordable and quality healthcare enables individuals to maintain their physical, psychological and social well-being. However, the cost of medical treatment remains a major challenge for economically disadvantaged populations, particularly those living in rural areas. Hospitalisation, diagnostic investigations, medicines, transportation and prolonged treatment can create considerable financial pressure on households. For families with limited and irregular income, even a single episode of serious illness may result in borrowing, selling household assets, reducing essential consumption or falling into poverty.

In India, the healthcare financing system has historically involved substantial expenditure directly from household resources. Out-of-pocket expenditure (OOPE) includes payments made by individuals and families at the time of receiving healthcare services, which are not reimbursed through insurance or other financing arrangements. Such payments can create financial hardship, especially among households that depend on agriculture, daily-wage employment, seasonal occupations and informal labour.

The Government of India has introduced several health financing initiatives to improve healthcare accessibility and protect vulnerable populations against excessive medical expenditure. These initiatives have evolved from targeted insurance programmes towards broader approaches to universal health coverage. Rashtriya Swasthya Bima Yojana (RSBY), introduced in 2008, represented an important effort to extend hospitalisation coverage to poor and informal-sector households. Subsequently, Ayushman Bharat was launched in 2018, incorporating two complementary components: Health and Wellness Centres, now developed as Ayushman Arogya Mandirs, and Pradhan Mantri Jan Arogya Yojana (PM-JAY).

PM-JAY provides eligible beneficiaries with hospitalisation coverage of up to ₹5 lakh per family per year for specified secondary and tertiary care services, subject to scheme provisions and applicable state arrangements. It was designed to reduce financial barriers to hospital-based treatment and improve access for economically vulnerable families (National Health Authority, 2018).

The importance of these programmes is particularly evident in rural India, where healthcare facilities may be geographically distant, specialist services are unevenly distributed and household income is frequently unstable. Rural residents may face several interconnected difficulties before reaching a hospital, including lack of information, limited transport facilities, dependence on family members, lost wages and inadequate availability of appropriate medical services.

Although government health insurance schemes have expanded financial coverage, enrolment and utilisation are not equivalent. An individual may be eligible but unaware of the scheme, aware but unable to complete verification, registered but unable to identify an appropriate hospital, or admitted to a hospital but still required to make additional payments. Therefore, the effectiveness of publicly funded insurance should be assessed not only through the number of beneficiaries identified or cards generated but also through actual access to entitled healthcare services.

Studies examining PM-JAY awareness have identified socioeconomic differences in beneficiaries' knowledge and understanding of their eligibility. Respondents with higher educational attainment and salaried employment were generally more likely to be aware of the scheme than individuals belonging to more disadvantaged socioeconomic groups (Khan et al., 2023). This indicates that the populations with the greatest need for financial protection may also experience greater difficulties in understanding and accessing available benefits.

Similarly, Trivedi et al. (2022) documented challenges experienced by PM-JAY beneficiaries during hospitalisation, including differences in information access, hospital responsiveness and additional expenditure. Their findings highlight the importance of effective implementation at the hospital level rather than relying exclusively on formal insurance entitlement.

The evolution of publicly funded health insurance in India also demonstrates that expanding the financial coverage of a scheme does not automatically eliminate inequities in healthcare delivery. Differences in geographical distribution, hospital availability, administrative capacity and service utilisation continue to influence the benefits received by different population groups (Srivastava et al., 2023).

Rural households therefore represent an important population for examining the barriers associated with

government health insurance utilisation. Understanding these barriers is essential for improving the implementation of existing programmes and developing practical strategies that ensure equitable access to healthcare.

2. Background of Government Health Insurance Schemes in India:

2.1. Concept of Government Health Insurance:

Government health insurance refers to a publicly financed or publicly supported arrangement through which eligible individuals and households receive financial protection against specified healthcare expenses. The government may finance the programme directly, purchase healthcare services from public and private hospitals, or establish partnerships with insurance agencies and healthcare providers.

The primary purpose of these schemes is to reduce the financial burden associated with illness and improve access to essential healthcare services. Depending on the programme, benefits may include hospital admission, surgery, medical treatment, diagnostic procedures, medicines, pre-hospitalisation services and post-hospitalisation care.

Unlike conventional private insurance, many government-funded schemes target economically vulnerable groups and provide benefits without requiring beneficiaries to pay a regular insurance premium. Eligibility is generally determined through predefined socioeconomic criteria, government databases or state-specific beneficiary identification systems.

However, the availability of insurance coverage does not guarantee that every eligible individual will receive treatment. Effective utilisation depends on awareness, identification, administrative procedures, healthcare infrastructure, provider participation and the ability of beneficiaries to reach appropriate facilities.

2.2. Rashtriya Swasthya Bima Yojana (RSBY):

Rashtriya Swasthya Bima Yojana was launched in 2008 by the Government of India to provide health insurance coverage to households below the poverty line and selected informal-sector workers.

The scheme was intended to reduce the financial burden of hospitalisation by providing cashless treatment through participating hospitals. It used biometric smart cards to identify beneficiaries and facilitate access to covered services.

RSBY represented an important development in India's publicly financed health insurance system because it attempted to combine financial protection with a technology-supported identification mechanism.

However, evaluations identified several limitations, including inadequate financial coverage, exclusion of some eligible households, uneven hospital availability and limited effects on household healthcare expenditure.

Karan et al. (2017) found that RSBY did not significantly reduce several important measures of out-of-pocket expenditure among participating households. Their findings demonstrated that insurance coverage alone may be insufficient when healthcare-related expenses extend beyond the services included in the insurance package.

Azam (2018) reported evidence of increased healthcare utilisation among rural RSBY beneficiaries, but did not find corresponding evidence of reduced per-person out-of-pocket expenditure. This suggests that greater access to treatment and improved financial protection are separate outcomes that require independent assessment.

2.3. Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana:

Ayushman Bharat was introduced in 2018 as a major national initiative to advance universal health coverage. Its two principal components are:

1. **Ayushman Arogya Mandirs:** These facilities aim to strengthen comprehensive primary healthcare, including preventive, promotive, curative, rehabilitative and palliative services.
2. **Pradhan Mantri Jan Arogya Yojana:** This component provides eligible families with financial coverage for specified secondary and tertiary hospitalisation services.

PM-JAY was designed to reduce the financial burden of major illnesses and improve access to hospital-based care among vulnerable households.

The scheme provides up to ₹5 lakh per eligible family per year for covered hospitalisation services. It supports cashless treatment at empanelled public and private hospitals, subject to applicable eligibility rules, treatment packages and operational guidelines.

The scheme also provides portability provisions that allow eligible beneficiaries to receive covered treatment outside their home state at participating facilities.

According to the Ministry of Health and Family Welfare, the programme has progressively expanded its beneficiary coverage and hospital network. In 2024, the government also approved the extension of PM-JAY

benefits to all senior citizens aged 70 years and above, irrespective of socioeconomic status, subject to applicable scheme provisions.

Nevertheless, the actual benefit received by a household depends on whether its members can establish eligibility, locate an appropriate empanelled facility and successfully complete the necessary administrative procedures.

2.4. State-Specific Government Health Insurance Schemes:

Several Indian states have introduced their own publicly funded health protection programmes to address regional healthcare needs.

Examples include:

1. Rajasthan's Mukhyamantri Ayushman Arogya Yojana, which evolved from the state's earlier health insurance arrangements.
2. Tamil Nadu Chief Minister's Comprehensive Health Insurance Scheme.
3. Karnataka's state-supported health protection arrangements.
4. Maharashtra's Mahatma Jyotirao Phule Jan Arogya Yojana.
5. Andhra Pradesh's Dr. NTR Vaidya Seva.
6. Telangana's Aarogyasri health protection programme.

The structure, eligibility conditions, benefit packages, hospital networks and administrative arrangements differ across states.

In some states, national and state schemes operate through integrated arrangements, while others maintain additional state-funded benefits. Consequently, rural households may encounter differences in eligibility verification, documentation, available hospitals and covered procedures depending on their state of residence.

These variations make it important to examine government health insurance utilisation within the broader state healthcare system rather than considering a single national programme in isolation.

3. Understanding Utilisation of Government Health Insurance Schemes:

Utilisation refers to the actual use of healthcare services or financial benefits provided through a health insurance programme by eligible beneficiaries.

In the context of rural households, utilisation involves several interconnected stages. A family must first know about the scheme, understand whether it is eligible, complete the required identification or verification process, locate a participating hospital and obtain treatment covered under the programme.

Therefore, utilisation is a process rather than a single event.

3.1. Awareness of the Scheme:

Awareness is the first step towards accessing government health insurance. It includes knowledge of the scheme's name, purpose, eligibility requirements, financial benefits, covered treatments and participating healthcare facilities.

A household may have heard about Ayushman Bharat but may not understand how the scheme operates. For example, family members may know that free treatment is available but remain unaware of the difference between outpatient consultation and covered hospitalisation.

Functional awareness is more important than simple name recognition. Beneficiaries should understand where they can obtain treatment, which documents may be needed, how cashless admission works and whom to approach when difficulties arise.

3.2. Eligibility Identification:

Eligibility identification refers to determining whether a household or individual qualifies for a government-funded health insurance programme.

Different programmes may use different eligibility databases and identification procedures. Under PM-JAY, eligibility is linked to the applicable beneficiary database and subsequent government-approved expansions.

Some households may assume that possessing a ration card, Aadhaar card or other government document automatically establishes eligibility. However, possession of an individual identity document does not necessarily establish entitlement under every insurance programme.

Clear communication regarding eligibility is therefore essential.

3.3. Registration and Beneficiary Verification:

Registration and verification involve confirming the identity and eligibility of beneficiaries according to programme requirements.

The process may involve:

1. Checking the beneficiary database.
2. Verifying identity documents.
3. Confirming family details.
4. Correcting spelling or demographic errors.
5. Completing electronic authentication.
6. Generating or downloading the beneficiary card where applicable.

Although digital identification can improve administrative efficiency, technical difficulties and limited digital literacy may create obstacles for rural families.

3.4. Access to Empanel Hospitals:

Empanelled hospitals are healthcare facilities approved to provide services under a particular government insurance programme.

Beneficiaries must identify an appropriate hospital that provides the required treatment and participates in the scheme.

The presence of an empanelled hospital within a district does not necessarily mean that it is geographically accessible to every village. Distance, road connectivity, public transportation, specialist availability and referral arrangements influence actual accessibility.

3.5. Receiving Covered Treatment:

The final stage involves obtaining the required medical treatment under the scheme.

The hospital must verify eligibility, identify the appropriate treatment package and follow the required authorisation and documentation procedures.

Beneficiaries may experience difficulties when they do not understand which services are included in the package, whether additional investigations are covered or what steps to take when a hospital requests payment. Consequently, successful utilisation should be evaluated through the entire pathway from awareness to treatment completion.

4. Major Barriers to Utilisation of Government Health Insurance Schemes among Rural Households:

The barriers affecting utilisation are multidimensional. They are interconnected and frequently reinforce one another.

4.1. Lack of Awareness and Inadequate Health Insurance Literacy:

Limited awareness is one of the most frequently identified barriers to the utilisation of publicly funded health insurance schemes.

Many rural households receive information about government programmes through television, newspapers, community announcements, health workers, village meetings and local administrative offices. However, the availability of information does not guarantee that the intended population understands it.

In rural communities, information may be communicated through technical terminology or administrative language that is difficult for individuals with limited formal education to understand.

Some beneficiaries may know about PM-JAY but remain unaware of:

1. The financial coverage available under the scheme.
2. The eligibility requirements.
3. The hospitals where treatment can be obtained.
4. The procedures covered under the programme.
5. The process for obtaining a beneficiary card.
6. The availability of interstate portability.
7. The grievance redressal mechanism.
8. The procedures for reporting denial of entitled services.

Khan et al. (2023) examined awareness of PM-JAY across six Indian states and identified important differences according to educational attainment, employment and socioeconomic characteristics. The findings suggest that information dissemination must specifically reach socially and economically disadvantaged populations.

A lack of awareness may also result from the assumption that government schemes are automatically implemented for every household. Families may believe that they are already registered or that no additional verification is necessary.

Another problem is the absence of continuous communication. One-time awareness campaigns may introduce a programme but may not provide sufficient information when a family actually needs hospital treatment.
Health insurance literacy therefore requires more than the distribution of leaflets or the display of posters. Beneficiaries need repeated, understandable and practical information.

4.2. Difficulties in Identifying Eligibility:

Eligibility-related confusion can prevent rural households from accessing available benefits.
Government insurance schemes may use databases developed from earlier socioeconomic surveys, beneficiary lists or other administrative records. Changes in household composition, migration, marriage, birth, death and changes in personal information may create differences between existing records and current household circumstances.
For example, a family may have shifted to another village, a woman's name may have changed after marriage, or a newly added family member may not appear in the available beneficiary record.
Such discrepancies can create difficulties during verification.
Some households may incorrectly assume that every economically poor family is automatically eligible. Others may believe that they are excluded because they do not possess a particular document, even when alternative verification arrangements may exist under the applicable scheme.
Eligibility confusion is particularly important because the initial identification process determines whether an individual can proceed towards receiving benefits.
Srivastava et al. (2026) examined the gap between eligibility and verification under PM-JAY and highlighted the influence of education, gender, administrative requirements and district-level implementation capacity on beneficiary verification. Their findings reinforce the importance of simplifying identification and ensuring that eligible household members are not unintentionally excluded.

4.3. Documentation-Related Barriers:

Documentation requirements can create considerable difficulties for rural households.
Beneficiaries may be asked to provide identity information, family details or supporting documents depending on the scheme and verification procedure.
Common difficulties include:

1. Missing identity documents.
2. Incorrect spelling of names.
3. Differences in age or date of birth.
4. Incomplete household information.
5. Errors in electronic records.
6. Missing mobile numbers.
7. Inconsistent residential information.
8. Difficulties updating family details.
9. Lack of access to photocopying or printing facilities.

These problems may appear minor from an administrative perspective but can become significant obstacles for households living far from service centres.
Women, older adults, persons with disabilities and individuals who are dependent on family members may experience additional difficulties in arranging documents and travelling to complete verification.
Documentation should therefore be viewed as an important access-related factor rather than simply an administrative requirement.
The process should be transparent, accessible and consistent with the identification provisions of the relevant scheme.

4.4. Low Educational Attainment and Digital Literacy:

Digital systems are increasingly used for beneficiary identification, authentication, hospital registration and administrative monitoring.
Although these systems may improve transparency and efficiency, they can create difficulties for beneficiaries who have limited familiarity with digital technology.
Some rural households may not have smartphones, reliable internet connections or regular access to electronic communication. Others may depend on family members, cybercafés, Common Service Centres or local intermediaries to access online services.
Digital literacy involves the ability to use digital devices, understand online information, complete electronic forms and identify reliable sources of information.

A person who cannot independently access a beneficiary portal may be unable to verify eligibility without assistance.

Older adults may face difficulties using biometric authentication or understanding electronic messages. Individuals with visual, hearing or cognitive impairments may require additional support.

Srivastava et al. (2023) identified technological and administrative challenges during the early implementation of PM-JAY, including inadequate data integration, internet connectivity problems and difficulties associated with information systems.

Digitalisation should therefore complement community-based assistance rather than replace accessible offline support.

4.5. Geographical Distance and Transportation Difficulties:

Geographical accessibility is a major concern for rural households.

Many villages are located far from district hospitals, specialist centres and private facilities participating in government insurance schemes.

Even when a beneficiary is eligible, reaching the appropriate hospital may require considerable time, money and physical effort.

Common transportation-related difficulties include:

1. Long distances between villages and hospitals.
2. Poor road connectivity.
3. Limited availability of public transportation.
4. High private vehicle charges.
5. Inadequate ambulance availability.
6. Difficulties travelling during the rainy season.
7. Additional expenses for accompanying family members.

For patients requiring emergency surgery, cancer treatment, cardiac procedures or other specialised services, transportation delays may influence the timeliness of care.

Rural households may also lose income when the patient and accompanying relatives travel to a distant facility.

Transportation expenditure is generally not equivalent to the cost of the covered hospital package. Therefore, a family may receive cashless hospital treatment while still experiencing substantial travel-related financial pressure.

Geographical distance can also discourage early treatment-seeking. Some individuals may postpone hospital visits until symptoms become severe because they anticipate the difficulties associated with travel.

This indicates that healthcare accessibility must include physical access to participating facilities, not simply the existence of an insurance entitlement.

4.6. Limited Availability of Empanelled Hospitals:

The number and distribution of empanelled hospitals influence the practical utilisation of government health insurance schemes.

A rural district may have several hospitals, but only a limited number may participate in a particular insurance programme. Furthermore, not every empanelled hospital provides every treatment package.

Some facilities may offer general medical and surgical services but lack specialists, intensive care facilities, diagnostic equipment or advanced treatment capabilities.

The problem becomes more serious in remote and economically disadvantaged regions.

The evolution of publicly funded health insurance in India has demonstrated considerable geographical differences in the availability and utilisation of services (Srivastava et al., 2023).

Limited hospital participation may also result in higher patient loads at a small number of participating facilities.

When beneficiaries are referred to distant hospitals, they may encounter additional travel expenses, accommodation difficulties and delays in receiving treatment.

Improving the number of empanelled hospitals is therefore important, but hospital quality, service availability and geographical distribution must also be considered.

4.7. Shortage of Healthcare Professionals and Specialist Services:

The availability of trained healthcare professionals is essential for effective implementation of health insurance programmes.

Rural healthcare facilities may experience shortages of medical officers, specialist doctors, nurses, technicians, pharmacists and administrative personnel.

Even when a hospital is empanelled, the absence of a particular specialist or diagnostic service may prevent beneficiaries from obtaining the required treatment.

For example, a patient requiring specialised cardiac treatment may need to travel to a larger urban facility because the nearby hospital does not have the necessary infrastructure.

Healthcare personnel also play an important role in explaining scheme procedures and guiding beneficiaries through the admission process.

Insufficient staffing at hospital helpdesks may lead to delays in verification, incomplete documentation and inadequate communication.

Srivastava et al. (2023) identified human resource limitations, recruitment difficulties and administrative capacity gaps during the early implementation of PM-JAY in different Indian states.

The availability of insurance must therefore be supported by adequate healthcare workforce planning and infrastructure development.

4.8. Administrative Complexity and Delays:

Administrative procedures can influence whether an eligible beneficiary successfully receives treatment.

Although PM-JAY aims to facilitate cashless hospitalisation, beneficiaries and hospitals must follow prescribed identification, authorisation and documentation procedures.

Difficulties may arise when:

1. Beneficiary records are incomplete.
2. Verification systems are unavailable.
3. Hospital staff are unfamiliar with procedures.
4. Required documents are not immediately available.
5. Electronic systems experience technical problems.
6. Pre-authorisation procedures take longer than expected.
7. Claims documentation is incomplete.
8. Hospital administrative personnel are unavailable.

For a patient requiring urgent treatment, administrative delays may cause considerable anxiety.

Some beneficiaries may also be unfamiliar with the difference between scheme eligibility, hospital empanelment and approval of a particular treatment package.

Trivedi et al. (2022) identified variations in beneficiary experiences related to hospital responsiveness, helpdesk support, communication and administrative performance. Their findings indicate that implementation quality can differ between hospitals and states.

Administrative simplification should therefore be considered an essential component of improving utilisation.

4.9. Lack of Information about Covered Procedures

Another important barrier is the limited understanding of which treatments and services are covered under a particular scheme.

Beneficiaries may assume that all medical expenses are included because they possess an insurance card.

However, government-funded insurance programmes generally operate through defined benefit packages and specific service conditions.

Differences may exist between:

1. Outpatient and inpatient services.
2. Covered and non-covered procedures.
3. Routine consultations and hospitalisation.
4. Diagnostic investigations and package-linked investigations.
5. Medicines included in treatment packages and medicines purchased separately.
6. Pre-hospitalisation and post-hospitalisation benefits.

Misunderstanding these provisions may result in disagreement between patients and hospital personnel.

A beneficiary may be informed that a particular service is outside the applicable package or that an alternative treatment pathway is required.

Clear and accessible communication about the benefit package is necessary to prevent confusion and unnecessary financial pressure.

4.10. Out-of-Pocket Expenditure despite Insurance Coverage:

Financial protection is one of the major objectives of government health insurance schemes. However, possession of insurance coverage does not always eliminate household expenditure.

Out-of-pocket payments may arise from transportation, food, accommodation, medicines, diagnostic services, outpatient consultations or other expenses not included in the relevant benefit package.
Some patients may also make additional payments because they are unaware of their entitlements or do not know how to report inappropriate charges.
The National Health Accounts Estimates for India 2021–22 reported that household out-of-pocket expenditure accounted for 39.4% of total health expenditure. Although this represented a decline from earlier years, direct household spending remained a substantial component of healthcare financing (Ministry of Health and Family Welfare, 2024).
Karan et al. (2017) found that RSBY did not significantly reduce several measures of inpatient and outpatient out-of-pocket expenditure among poor households.
Trivedi et al. (2022) also reported additional payments among PM-JAY beneficiaries, with variations according to state and type of hospital.
These findings demonstrate that financial protection should be evaluated by examining the complete expenditure experienced by the household rather than only the amount paid through the insurance programme.

4.11. Poverty and Irregular Household Income:
Poverty affects both healthcare-seeking behaviour and the ability to utilise available insurance benefits.
Rural households may depend on agricultural labour, small-scale farming, livestock, construction work, seasonal employment and other informal occupations.
Income may fluctuate according to agricultural seasons, employment opportunities and environmental conditions.
Even when hospital treatment is covered, families may need money for transportation, food, temporary accommodation and other essential expenses.
A household may postpone treatment because the patient or accompanying relative cannot afford to stop working.
For families living close to the poverty line, the indirect cost of hospitalisation may be sufficient to discourage utilisation.
Health insurance can reduce some medical expenses, but it cannot independently eliminate all economic barriers associated with illness.

4.12. Gender-Related Barriers:
Gender inequality may influence awareness, enrolment, decision-making and healthcare utilisation.
In some rural households, women have limited control over financial resources and healthcare-related decisions. They may depend on male family members for permission, transportation and expenditure.
Women engaged in domestic work, agricultural labour and caregiving may delay their own treatment because of family responsibilities.
Pregnant women, older women and women with chronic illnesses may experience additional difficulties when travelling to distant hospitals.
Lack of independent access to mobile phones and identity documents can also influence awareness and verification.
Women may be eligible for government health insurance but remain unaware of the benefits available to them.
Therefore, gender-sensitive implementation should ensure that women can independently obtain information, verify their eligibility and access treatment without unnecessary dependence on other household members.

4.13. Social and Cultural Barriers:
Social structures and cultural beliefs may influence healthcare-seeking behaviour.
In some communities, people may prefer familiar local practitioners or traditional treatment systems before approaching formal healthcare facilities.
Fear of hospitals, misconceptions about treatment, concerns about privacy and lack of trust in healthcare providers may discourage utilisation.
Caste-related inequalities and social exclusion may also influence access to information and healthcare institutions.
Individuals belonging to marginalised communities may experience difficulties in communicating with administrative personnel or may be unaware of their right to receive covered services.
Such barriers should be understood within the broader context of social determinants of health.
Community participation, respectful communication and culturally appropriate awareness programmes are essential for improving trust and utilisation.

4.14. Language and Communication Barriers:

India's linguistic diversity creates additional challenges in communicating information about health insurance.
Government documents and online portals may use administrative terminology that is difficult for some beneficiaries to understand.
Rural households may speak regional languages or local dialects that differ from the language used in official communications.
Important information about eligibility, treatment packages, exclusions and grievance procedures may therefore remain inaccessible.
Health workers should communicate in locally understood languages and use simple explanations, illustrations and practical examples.

4.15. Inadequate Support at Hospital Helpdesks:

Hospital helpdesks are important points of contact between beneficiaries and the insurance administration system.
A properly functioning helpdesk should guide patients regarding eligibility, registration, admission, documentation, treatment authorisation and discharge procedures.
However, insufficient staffing, inadequate training and limited availability of personnel may affect the quality of support.
Patients may also experience difficulty when hospital staff do not clearly explain why a treatment is not approved or what alternative options are available.
Trivedi et al. (2022) highlighted the importance of responsive hospital support and effective communication in improving beneficiary experiences.
Helpdesks should be accessible, adequately staffed and capable of providing information in the local language.

4.16. Lack of Awareness about Grievance Redressal:

A grievance redressal mechanism allows beneficiaries to report problems related to eligibility, denial of services, additional payments, hospital behaviour and other implementation concerns.
However, many beneficiaries may not know that such mechanisms exist.
Some may believe that refusing a hospital's decision could affect their future access to treatment.
Others may not know whom to contact or what information should be provided when submitting a complaint.
An effective grievance system should include clear instructions, accessible communication channels, timely investigation and feedback to the complainant.
Awareness of rights and complaint procedures is necessary for ensuring accountability.

4.17. Weak Coordination between Healthcare Institutions:

Effective utilisation requires coordination between village-level health workers, primary healthcare facilities, district hospitals, specialist centres and insurance administrators.
When referral procedures are unclear, beneficiaries may travel unnecessarily or reach facilities that cannot provide the required treatment.
Poor communication between hospitals and insurance authorities may also delay verification and treatment authorisation.
Srivastava et al. (2023) identified coordination, organisational capacity and administrative support as important factors influencing PM-JAY implementation.
Improved referral systems and clear institutional responsibilities can reduce unnecessary delays.

4.18. Migration and Changes in Household Composition:

Migration is common among rural populations due to employment, education, marriage and other socioeconomic reasons.
Seasonal migration may create difficulties when beneficiary information remains associated with the household's original location.
Some migrants may not know how to access treatment outside their home district or state.
Although PM-JAY includes portability provisions, beneficiaries must still identify participating facilities and complete the necessary verification procedures.
Changes in household composition may also create discrepancies in beneficiary records.
Awareness of portability and accessible record-updating procedures can improve continuity of healthcare access.

4.19. Lack of Trust and Negative Experiences:

Previous experiences with healthcare institutions can influence willingness to use government insurance schemes.

If beneficiaries experience unexplained charges, poor communication, delays, disrespectful behaviour or denial of services, they may lose confidence in the programme.

Negative experiences may spread through families and communities, influencing the decisions of other eligible households.

Trust requires transparency, respectful treatment, reliable information and effective action when problems arise.

Government authorities should regularly collect beneficiary feedback and investigate complaints.

4.20. Weak Monitoring and Accountability:

The performance of government health insurance programmes depends on continuous monitoring.

Monitoring should examine not only beneficiary identification and hospital admissions but also the quality of services, geographical equity, treatment outcomes, additional payments and beneficiary satisfaction.

Inadequate monitoring may allow inappropriate charging, unnecessary administrative delays and inconsistent implementation to continue.

A strong monitoring system should use transparent indicators and involve district authorities, hospital administrators, healthcare professionals and community representatives.

5. Socioeconomic and Demographic Factors Influencing Utilisation:

The utilisation of government health insurance schemes is influenced by individual and household characteristics.

5.1. Age:

Older adults may have greater healthcare requirements because of chronic illnesses, disabilities and age-related conditions.

However, older beneficiaries may also face difficulties in travelling, using digital systems and completing documentation.

Family support and accessible assistance are therefore important determinants of utilisation.

5.2. Educational Status:

Education influences the ability to understand eligibility criteria, interpret scheme information and complete administrative procedures.

Individuals with higher educational attainment may be better equipped to use digital portals and identify appropriate healthcare facilities.

Khan et al. (2023) demonstrated that educational attainment was associated with awareness of PM-JAY.

5.3. Occupation:

Occupation influences income stability, time availability and healthcare-seeking behaviour.

Agricultural workers and daily-wage earners may experience income loss when travelling to hospitals or completing registration procedures.

Households with irregular employment may find it difficult to arrange money for indirect treatment expenses.

5.4. Household Income:

Although publicly funded insurance is designed to protect economically vulnerable families, lower-income households may experience greater difficulties in reaching hospitals and meeting non-covered expenses.

Financial constraints can therefore affect actual utilisation even when direct hospitalisation costs are covered.

5.5. Social Group and Community Background:

Marginalised communities may experience unequal access to information, documentation support and healthcare institutions.

Social exclusion can interact with poverty, educational disadvantage and geographical isolation.

Equitable programme implementation should therefore examine differences in utilisation across social groups.

5.6. Family Size and Household Structure:

Larger households may have greater healthcare needs and more complex documentation requirements.
In some families, the person who controls household documents or mobile communication may not be the person who requires treatment.
Independent verification and clear communication with all eligible family members can reduce such difficulties.

6. Consequences of Low Utilisation of Government Health Insurance Schemes:
Low utilisation has important consequences for individuals, families, healthcare institutions and society.

6.1. Delayed Healthcare-Seeking:
When beneficiaries do not understand how to access insurance benefits, they may postpone medical treatment.
Delayed care can lead to worsening symptoms, complications, prolonged hospitalisation and higher treatment costs.

6.2. Increased Financial Hardship:
Families that fail to access available benefits may pay directly for treatment.
This can result in borrowing, asset sales, reduced household consumption and long-term debt.

6.3. Increased Burden on Government Healthcare Facilities:
When insurance arrangements do not function effectively, patients may continue to depend on already overburdened public hospitals.
Unequal distribution of healthcare facilities may further increase pressure on district-level institutions.

6.4. Health Inequalities:
Households with better education, greater financial resources and stronger social networks may find it easier to utilise available benefits.
Consequently, individuals with the greatest healthcare needs may remain less likely to receive services.

6.5. Reduced Confidence in Government Programmes:
Repeated difficulties during enrolment, verification and hospitalisation can reduce community confidence.
This may discourage other eligible households from attempting to use the scheme.

6.6. Increased Risk of Poverty:
Serious illness can affect household income through medical expenses and lost employment.
When insurance benefits remain inaccessible, families may experience prolonged financial instability.

7. Evidence from Previous Studies:
Research concerning government health insurance programmes in India provides important insights into the relationship between insurance coverage, awareness and utilisation.

7.1. Studies on Awareness of PM-JAY:
Khan et al. (2023) examined awareness of PM-JAY using household survey data from six Indian states. Their findings showed that awareness varied across socioeconomic and demographic groups. Educational attainment and employment characteristics influenced the likelihood of knowing about the scheme.
The study highlights the need for targeted communication rather than relying on uniform information campaigns.

7.2. Studies on Beneficiary Experience:
Trivedi et al. (2022) studied the experiences of beneficiaries receiving treatment under PM-JAY in Gujarat and Madhya Pradesh. Their research examined helpdesk performance, information access, hospital responsiveness, additional payments and beneficiary satisfaction.
The findings demonstrated differences between states and between public and private hospitals. The study emphasised the importance of beneficiary education, improved hospital support and stronger implementation mechanisms.

7.3. Studies on Organisational and Administrative Barriers:

Srivastava et al. (2023) explored the early implementation of PM-JAY in three Indian states. They identified organisational, technological, workforce and administrative challenges.
The study highlighted difficulties involving beneficiary identification, incomplete data, internet connectivity, staffing arrangements, claims processing and communication between programme administrators and hospitals.
These findings indicate that insurance utilisation depends on the capacity of the healthcare system to implement the programme effectively.

7.4. Studies on Financial Protection under RSBY:

Karan et al. (2017) evaluated the impact of RSBY on household out-of-pocket expenditure. Their findings suggested that the programme did not produce significant reductions in several important categories of healthcare expenditure.
The study raises an important question regarding whether hospitalisation coverage alone is sufficient to protect households against the broader costs of illness.

7.5. Studies on Rural Healthcare Utilisation:

Azam (2018) examined the relationship between RSBY and healthcare utilisation using household panel data.
The findings indicated some positive effects on healthcare utilisation among rural beneficiaries, although there was no corresponding evidence of reduced per-person out-of-pocket expenditure.
This suggests that increased utilisation does not automatically result in complete financial protection.

7.6. Studies on the Evolution of Government-Funded Health Insurance:

Srivastava et al. (2023) reviewed the evolution of government-funded health insurance in India, particularly RSBY and PM-JAY.
Their analysis highlighted improvements in financial coverage under PM-JAY while identifying continuing differences in service supply, geographical distribution and utilisation.
The findings reinforce the need to consider equity and healthcare delivery alongside insurance expansion.

8. Strategies to Improve Utilisation Among Rural Households:

Improving utilisation requires coordinated action by government authorities, healthcare institutions, health professionals, community organisations and local administrative bodies.

8.1. Strengthening Community-Based Awareness Programmes:

Awareness programmes should be conducted regularly at the village level.
Information should be provided through:

1. Gram Sabha meetings.
2. Village Health, Sanitation and Nutrition Days.
3. Panchayat offices.
4. Anganwadi centres.
5. Primary healthcare facilities.
6. Schools and community organisations.
7. Self-help groups.
8. Local radio and community communication channels.

Information should be delivered in simple regional languages.
Demonstrations explaining how to identify eligibility, locate hospitals and access covered services may be more effective than distributing written information alone.

8.2. Strengthening the Role of ASHA Workers:

Accredited Social Health Activists (ASHAs) have an important position within rural communities.
They maintain contact with families and frequently assist individuals in accessing maternal, child and community healthcare services.
Their role in insurance awareness can be strengthened through appropriate training.
ASHA workers may assist eligible households by:

1. Providing basic information about government health insurance.
2. Explaining available eligibility-checking procedures.
3. Directing families to authorised verification centres.

4. Helping identify nearby participating hospitals.
5. Explaining referral procedures.
6. Informing beneficiaries about grievance mechanisms.
7. Following up with families after hospitalisation.

However, additional responsibilities should be supported through adequate training, supervision and appropriate incentives.

8.3. Involvement of Nurses and Community Health Professionals:

Nurses play a significant role in health education, patient counselling and continuity of care.

Community health nurses can help identify vulnerable households and explain available government health benefits during outreach activities.

Hospital nurses can guide patients and family members towards insurance helpdesks and explain the administrative steps required for accessing entitled services.

Nurses can also identify situations in which patients are unable to obtain treatment because of documentation difficulties or inadequate information.

Their involvement can improve communication between patients, hospitals and community-level health workers.

8.4. Simplification of Eligibility Verification:

The beneficiary identification process should be transparent and accessible.

Recommended measures include:

1. Regular updating of beneficiary records.
2. Clear communication of eligibility conditions.
3. Assistance for correcting demographic errors.
4. Accessible verification facilities.
5. Support for older adults and persons with disabilities.
6. Appropriate alternative arrangements when biometric authentication fails.
7. Clear procedures for adding or updating eligible household members.

Eligibility verification should not become an unnecessary obstacle for individuals who are entitled to benefits.

8.5. Strengthening Common Service Centres:

Common Service Centres (CSCs) can support rural residents who lack access to digital devices or internet facilities.

These centres can assist with authorised digital services, information retrieval and beneficiary-related procedures.

Their effectiveness depends on staff training, transparent service charges, reliable internet connectivity and clear communication regarding the services they are authorised to provide.

8.6. Expanding the Rural Hospital Network:

The geographical distribution of empanelled hospitals should be reviewed regularly.

Priority should be given to underserved districts and remote areas.

Government authorities should encourage eligible healthcare facilities to participate in the scheme while maintaining appropriate standards of quality and patient safety.

Strengthening district hospitals, community health centres and referral systems can improve access to specialised treatment.

8.7. Improving Transportation and Referral Facilities:

Transport-related barriers should be addressed through better coordination between ambulance services, primary healthcare institutions and referral hospitals.

Patients requiring specialist treatment should receive clear referral information.

The location of appropriate hospitals, available transport arrangements and emergency contact details should be communicated to beneficiaries.

Special attention should be given to pregnant women, older adults, persons with disabilities and patients requiring emergency treatment.

8.8. Strengthening Hospital Helpdesks:

Every participating hospital should maintain a functional beneficiary assistance system.
Helpdesk personnel should be trained in:

1. Eligibility verification.
2. Beneficiary identification.
3. Treatment package information.
4. Admission procedures.
5. Pre-authorisation requirements.
6. Discharge documentation.
7. Grievance registration.
8. Local-language communication.

The helpdesk should be clearly identifiable and accessible to patients and their relatives.

8.9. Improving Digital Infrastructure:

Digital systems should be designed to work effectively in rural settings.
Important measures include improving internet connectivity, ensuring regular software maintenance, reducing unnecessary data-entry requirements and providing technical support to healthcare institutions.
Digital services should also have accessible alternatives for individuals who cannot independently use online systems.

8.10. Increasing Transparency in Treatment Packages:

Beneficiaries should receive understandable information regarding covered services.
Hospitals should display updated information about applicable packages, patient entitlements and procedures for reporting additional charges.
Patients should be informed when a service is not covered and should receive an explanation of the applicable alternative arrangements.

8.11. Strengthening Grievance Redressal:

The grievance redressal system should be easy to access and responsive.
Beneficiaries should be informed about authorised complaint channels through hospitals, community health workers and official communication materials.
Complaints should be recorded, investigated and resolved within defined administrative timelines.
The complainant should receive information regarding the action taken.

8.12. Improving Financial Protection:

Monitoring should examine whether beneficiaries continue to incur expenses despite receiving treatment under the scheme.
Regular assessment should consider:

1. Transportation expenses.
2. Medicine expenditure.
3. Diagnostic expenses.
4. Accommodation costs.
5. Informal payments.
6. Uncovered treatment costs.
7. Loss of household income.

The findings should inform changes in programme design and implementation.

8.13. Strengthening Public-Private Coordination:

Public and private hospitals participating in government insurance programmes should follow transparent service standards.
Regular communication between hospitals, district implementation units and state health agencies can improve operational efficiency.
Monitoring should identify facilities that repeatedly deny entitled services or impose inappropriate charges.

8.14. Improving Community Participation:

Village-level institutions and community organisations should participate in identifying local barriers.
Gram Panchayats, self-help groups, community leaders and health committees can help communicate

programme information and identify households that remain unaware of their benefits.
Community participation also strengthens accountability by allowing residents to communicate their experiences to local authorities.

8.15. Special Assistance for Vulnerable Groups:

Specific support should be provided to:

1. Older adults.
2. Women-headed households.
3. Persons with disabilities.
4. Scheduled Caste and Scheduled Tribe communities.
5. Migrant workers.
6. Remote tribal populations.
7. Individuals with limited literacy.
8. Families without regular access to digital devices.

A uniform implementation strategy may not adequately address the needs of all rural households.

9. Role of Healthcare Professionals in Improving Utilisation:

Healthcare professionals are important in connecting government health insurance policies with the actual needs of rural communities.

9.1. Role of Community Health Nurses:

Community health nurses can conduct awareness activities and explain the importance of financial protection.
They can identify families that have limited knowledge of available health insurance programmes and direct them towards authorised information and verification services.

9.2. Role of Hospital Nurses:

Hospital nurses can guide beneficiaries towards the insurance helpdesk and support communication between patients, relatives and administrative personnel.
They should ensure that financial and administrative concerns do not interfere unnecessarily with clinical assessment and emergency treatment.

9.3. Role of ASHA Workers:

ASHA workers can provide information during household visits, community meetings and outreach programmes.
They can help beneficiaries understand where to obtain assistance and how to identify participating hospitals.

9.4. Role of Medical Officers:

Medical officers can strengthen referral pathways and ensure that patients receive appropriate information about available treatment facilities.
They can also participate in local programme monitoring and identify gaps affecting access to healthcare.

9.5. Role of Hospital Administrators:

Hospital administrators should ensure that insurance-related procedures are implemented transparently.
They should maintain trained helpdesk personnel, monitor patient complaints and coordinate with relevant government agencies.

9.6. Role of Public Health Authorities:

Public health authorities should monitor scheme performance and identify populations experiencing low awareness or utilisation.
They should also examine geographical differences in hospital availability and strengthen the coordination between insurance programmes and public healthcare facilities.

10. Suggested Framework for Assessing Barriers to Utilisation:

A systematic assessment framework can help researchers, public health professionals and policymakers identify the factors influencing utilisation among rural households.
The assessment may be divided into the following domains.

10.1. Sociodemographic Characteristics:

Information may include:

1. Age of the household respondent.
2. Gender.
3. Educational attainment.
4. Occupation.
5. Monthly household income.
6. Family size.
7. Social group.
8. Type of household.
9. Residential location.

10.2. Awareness and Knowledge:

Assessment should examine whether household members know:

1. The name of the applicable insurance scheme.
2. The eligibility requirements.
3. The available financial benefits.
4. The covered treatment services.
5. The participating hospitals.
6. The beneficiary verification process.
7. The grievance redressal system.

10.3. Enrolment and Documentation:

The researcher may assess:

1. Whether the household has verified its eligibility.
2. Whether eligible members have beneficiary identification.
3. Whether required documents are available.
4. Whether any demographic discrepancies exist.
5. Whether registration difficulties have been experienced.
6. Whether assistance was required during enrolment.

10.4. Accessibility of Healthcare Facilities:

Important indicators include:

1. Distance to the nearest empanelled hospital.
2. Travel time.
3. Transportation availability.
4. Cost of transportation.
5. Availability of the required medical speciality.
6. Referral arrangements.
7. Availability of emergency services.

10.5. Administrative Barriers:

Assessment may include:

1. Difficulties during verification.
2. Delays in admission.
3. Problems with electronic authentication.
4. Lack of helpdesk support.
5. Unclear treatment package information.
6. Difficulties during discharge.
7. Problems with grievance registration.

10.6. Utilisation and Financial Protection:

The researcher should examine:

1. Whether the household has used the scheme.
2. Type of treatment received.
3. Hospital where treatment was obtained.

4. Frequency of utilisation.
5. Satisfaction with services.
6. Additional payments made.
7. Reasons for non-utilisation.
8. Perceived financial protection.

10.7. Suggested Conceptual Framework:

The following conceptual framework explains how household and health-system factors may influence insurance utilisation.

Household and individual factors:

1. Age and gender
2. Education and occupation
3. Income and socioeconomic status
4. Social and cultural background

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Awareness and knowledge:

1. Knowledge of the scheme
2. Understanding of eligibility
3. Knowledge of benefits
4. Awareness of empanelled hospitals

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Enrolment and verification:

1. Documentation
2. Beneficiary identification
3. Digital literacy
4. Administrative assistance

↓

Healthcare accessibility:

1. Distance and transportation
2. Hospital availability
3. Specialist services
4. Referral systems
5. Hospital responsiveness

↓

Utilisation of Government Health Insurance Benefits

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Treatment access, beneficiary satisfaction and financial protection.

Cross-cutting influences: Government administration, healthcare infrastructure, gender equity, social inclusion, community participation and grievance redressal.

11. Research Gaps and Future Directions:

Despite the expansion of government health insurance programmes, several areas require further research.

11.1. Limited Understanding of Non-Utilising Eligible Households:

Many evaluations focus on beneficiaries who have already received treatment.

However, households that are eligible but have never used the scheme may experience different barriers.

Future research should examine the experiences of both users and non-users to identify the reasons behind non-utilisation.

11.2. Need for More Village-Level Studies:

State-level and national studies may not adequately represent differences between villages.

Remote tribal communities, geographically isolated settlements and villages with limited healthcare facilities may experience distinct barriers.

More community-based research is needed to identify local determinants.

11.3. Need for Gender-Specific Research:

Future studies should examine whether women experience different barriers from men during awareness, verification and utilisation.
Research should also investigate the influence of household decision-making, financial dependence and access to mobile communication.

11.4 Need to Examine Indirect Expenditure
Financial protection should be assessed beyond the amount paid for hospital treatment.
Studies should include transportation, food, accommodation, lost wages and expenses associated with accompanying family members.

11.5. Need for Research on Digital Exclusion:
The increasing use of digital health insurance systems requires further examination of digital literacy and technology-related inequalities.
Research should explore whether digital procedures improve access equally for older adults, women, and persons with disabilities and individuals with limited education.

11.6. Need for Longitudinal Studies:
Cross-sectional studies provide information about conditions at a particular time.
Longitudinal research can examine changes in awareness, enrolment, utilisation and financial protection over time.
Such studies can help determine whether awareness campaigns and administrative reforms produce sustained improvements.

11.7. Need for Comparative State-Level Studies:
Different states have different healthcare infrastructures and insurance implementation models.
Comparative research can identify successful approaches that may be adapted to other regions.

11.8. Need for Evaluation of Beneficiary Satisfaction:
Beneficiary satisfaction should be evaluated in relation to communication, waiting time, treatment quality, administrative support, additional expenditure and grievance resolution.
This can provide a more complete understanding of the effectiveness of government insurance schemes.

12. Recommendations:
Based on the reviewed evidence, the following recommendations are proposed:
1. Conduct regular village-level awareness campaigns in local languages.
2. Provide clear information regarding eligibility, treatment packages and hospital locations.
3. Simplify beneficiary verification and correction of demographic details.
4. Strengthen Common Service Centres and other authorised assistance facilities.
5. Provide offline support for beneficiaries with limited digital literacy.
6. Increase the availability of appropriately equipped empanelled hospitals in underserved areas.
7. Improve transportation and referral arrangements for remote villages.
8. Train hospital helpdesk personnel in beneficiary assistance and communication.
9. Strengthen the role of ASHA workers and community health nurses in insurance awareness.
10. Ensure that eligible women, older adults and persons with disabilities receive independent assistance.
11. Improve transparency regarding covered and non-covered services.
12. Monitor additional payments and inappropriate charges.
13. Strengthen grievance redressal and provide clear information about complaint procedures.
14. Improve coordination between primary healthcare facilities, district hospitals and specialist centres.
15. Conduct regular assessments of beneficiary satisfaction and financial protection.
16. Develop district-level monitoring indicators to identify communities with low utilisation.
17. Improve data quality and ensure timely updating of beneficiary information.
18. Encourage meaningful community participation in monitoring programme implementation.

13. Implications for Nursing Practice:
The findings of this review have important implications for nursing education, nursing practice, community health nursing and public health administration.

Nurses are often among the first healthcare professionals to interact with individuals and families. Their position within hospitals and community settings enables them to identify difficulties that prevent beneficiaries from receiving entitled services.

In community health nursing, students and practising nurses should be trained to understand the basic structure of government health insurance schemes and their role in healthcare accessibility.

Nursing professionals can contribute by providing health education, identifying vulnerable households, guiding families towards authorised assistance facilities and promoting awareness of patient entitlements.

In hospital settings, nurses can support beneficiaries by explaining admission-related procedures, directing them to appropriate administrative personnel and communicating concerns regarding treatment access.

Nurses should also recognise that patients may continue to experience financial difficulties even when they have insurance coverage. Understanding indirect expenses and social barriers is essential for providing patient-centred care.

Nursing institutions can incorporate government health insurance awareness into community postings, health education programmes and public health assignments.

The involvement of nurses in community-based monitoring may also help identify gaps in implementation and improve communication between healthcare facilities and rural populations.

14. Limitations of the Review:

This article is based on a narrative review of available published literature, government reports and policy documents. It does not present primary data collected directly from rural households.

The evidence reviewed includes studies conducted in different states, populations and implementation periods. Therefore, findings from one geographical area may not be directly applicable to all rural communities.

Government insurance schemes also undergo periodic changes in eligibility rules, benefit packages, hospital networks and administrative procedures. Consequently, programme-specific information should be interpreted according to the applicable guidelines at the time of implementation.

Further systematic reviews and community-based studies are required to quantify the relative contribution of individual barriers and examine differences between states and population groups.

15. Conclusion:

Government health insurance schemes represent an important strategy for improving financial protection and access to hospital-based healthcare among economically vulnerable households in India. Programmes such as RSBY, Ayushman Bharat–PM-JAY and various state-sponsored initiatives have contributed to the expansion of publicly funded healthcare coverage.

However, the availability of insurance benefits does not automatically ensure their utilisation. Rural households may encounter several barriers, including limited awareness, uncertainty regarding eligibility, documentation difficulties, low digital literacy, geographical isolation, transportation expenses, inadequate hospital availability, administrative delays and incomplete understanding of covered treatment services.

Socioeconomic disadvantages, gender inequality, irregular household income and social exclusion may further restrict access. In addition, out-of-pocket expenditure may continue because of indirect costs and services that are not included in the applicable treatment packages.

The reviewed evidence suggests that improving insurance utilisation requires a comprehensive approach that addresses both demand-side and supply-side barriers. Community-based awareness, simplified verification, accessible digital and offline assistance, stronger rural healthcare infrastructure, effective referral arrangements and transparent grievance redressal should be prioritised.

Healthcare professionals, particularly nurses and ASHA workers, can contribute significantly by connecting eligible families with available services and supporting beneficiaries throughout the healthcare-seeking process.

Ultimately, the success of government health insurance should not be measured only by the number of eligible families or beneficiary cards generated. It should also be assessed through actual service utilisation, equitable access, quality of treatment, beneficiary satisfaction and meaningful financial protection. Strengthening these areas can help ensure that government health insurance schemes fulfil their intended purpose of reducing healthcare inequalities and improving the health and socioeconomic well-being of rural households.

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