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ANALYSIS ON LEVEL OF AWARENESS AND SATISFACTION TOWARDS AYUSHMAN BHARAT PM-JAY PROGRAM

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ABSTRACT
Health insurance is described as "coverage that provides for the payments of benefits as a result of sickness or injury that includes insurance for losses from Accident, Medical Expense, Disability, or Accidental Death and Dismemberment" by the Health Insurance Association of America. Typically, these health insurance plans are issued annually. There have been many initiatives introduced by the Indian government throughout the years to combat healthcare disparities in the country.The program has a number of larger consequences, including the reduction of poverty, the increase of economic production, and the development of national resilience. In addition to improving healthcare, the program has these effects. The Ayushman Bharat Program Many countries are looking to India as a model for how to attain universal health coverage since the PM-JAY program is a cornerstone of the public health reform that is being implemented in India.Typically, these health insurance plans are issued annually. There have been many initiatives introduced by the Indian government throughout the years to combat healthcare disparities in the country.It will be necessary to pay ongoing attention to updating infrastructure, boosting hospital engagement, developing digital technologies, and incorporating new vulnerable groups in order to guarantee that the Ayushman Card lives up to its name, which is to deliver "Ayushman" (long and healthy life) to everyone.To rectify discrepancies in the usage of the Ayushman Bharat Scheme, the government must allocate resources towards enhancing service delivery in the underutilized regions. The government is advised to spend supplementary resources to enhance healthcare facilities and personnel in underdeveloped regions.
Keywords: Awareness, Satisfaction, Ayushman, Bharat, Program PM-JAY

INTRODUCTION

The Indian government's pledge to the Alma-Ata Declaration's goal of "Health for All by 2000" provided the framework for NHP-1983. This strategy was an attempt to voice disapproval with the overemphasis on urban-based curative centre construction.[1] The policy's principal goal was to reorganize healthcare delivery in order to establish a distributed system of high-quality primary care within a certain time frame. Some other notable aspects of the health services restructuring were: (i) a system where communities could choose health volunteers who would receive basic knowledge, skills, and technology; (ii) a referral system that was well-planned and executed; (iii) a network of sanitary and epidemiological stations across the country that could offer mental, preventive, and promotive healthcare; (iv) curative centers that were located near the population to ensure maximum utilisation; and (v) centers that The goal of NHP-1983 was to decrease health expenditure by the government and instead encourage non-governmental organisations to invest more in building healing facilities and providing coordinated financial, logistical, and technical assistance to nonprofits working in the health sector[2].

AYUSHMAN BHARAT' PROGRAMME

In terms of promotion, prevention, curative, palliative, and rehabilitative components of Universal Health Coverage, India's "Ayushman Bharat" program is the country's most significant achievement to date. Health and Wellness Centres (HWCs) are providing primary care as part of Ayushman Bharat's continuum of care approach, while Pradhan Mantri Jan Arogya Yojana is helping people afford secondary and tertiary hospitalisation care. Because of this, Ayushman Bharat[3]**:**

1. Establishing 1.5 lakh Health and Wellness Centres (HWCs) to offer comprehensive healthcare, including solutions for maternal and child health, non-communicable illnesses, and more.
2. Approximately 50 million people, or 10.74 crore families, would be able to afford secondary and tertiary care hospitalisation up to 5 lakh rupees per year thanks to the Ayushman Bharat - Pradhan Mantri scheme. Arogya Bharti Yojana (AB-PMJAY)

As per the Socio-Economic Caste Census (SECC) -2011 data, AB-PMJAY is an entitlement-based scheme that covers low-income families in rural areas and families of workers from certain occupational categories in urban areas. In contrast, ABHWCs provide preventive and promotive healthcare to everyone. In addition, PMJAY covers

all recipient families under the former Rashtriya Swasthya Bima Yojana, even if they do not fall into the targeted demographics according to SECC statistics[4].

The federal government and the individual states each contribute financially. The North Eastern States and the three Himalayan States are the only ones where the ratio is 90:10, with a maximum limit for the Centre. In all other states, the ratio of contributions towards the premium is 60:40. The Central contribution of premium is 100% for Union Territories (UTs) without legislature and 60:40 for UTs with legislature.

PM-JAY: ADDRESSING HEALTHCARE DISPARITIES AND IMPROVING WELL-BEING

The PM-JAY is vital in diminishing healthcare inequities, increasing health outcomes, and improving the general well-being of the populace. PM-JAY offers financial insurance against catastrophic health expenditures, ensuring that economically disadvantaged families may obtain quality healthcare without incurring financial distress. The initiative has substantially enhanced public health insurance coverage, diminished disparities in healthcare access, and advanced early illness identification and treatment[5-6].

Key Features of AB-PMJAY

1. First, access to secondary and tertiary hospital treatment up to Rs. 5,00,000 per family per year via an accredited network of medical professionals;
2. two, the supply of medications, follow-up consultations, and diagnostics for a maximum of three days before to hospitalisation and fifteen days following discharge;
3. Three thousand nine hundred and ninety-three coverage packages spanning twenty-four specialities make up hospitalisation care under PMJAY.
4. The recipient is treated without the need to pay for their care;
5. There is no limit on the number of people insured based on their age, gender, or pre-existing condition;
6. The benefits can be used at any of the empaneled hospitals nationwide.

MAJOR COVERAGE & NON-COVERAGE OF AYUSHMAN YOJANA

Due to their inability to pay a premium and their difficulty in being reached, it is often the most problematic aspect of any country's health insurance scheme to include the poorest and most vulnerable people. It takes a different method to raise awareness since they are often illiterate as well. As is the case with the majority of LMICs, India is not immune to this[7-9].

Rural Beneficiaries

For rural areas, there are seven deprivation criteria. PM-JAY included all families that met at least one of these criteria, as well as the following: households that live on alms, primitive tribal group, legally released bonded labour, households that rely on manual scavenging, and deprivation criteria D1–D5.

Urban Beneficiaries

In metropolitan regions, the program is open to the following eleven types of employees:

People who work on the streets in various capacities, such as:

- ragpickers, beggars, domestic workers,
- construction workers, plumbers, masons, labourers, painters, welders, security guards, coolies, and other workers who carry heavy loads
- sweepers, sanitation workers, Mali

GOVERNMENT INITIATIVE FOR CREATING AWARENESS AMONG PEOPLE

Since PM-JAY is entitlement-based and does not need pre-enrolment, beneficiaries must be educated. Program beneficiaries must be informed via Information, Education, and Communication. A well-rounded communication strategy should contain pamphlets, posters, hoardings, TV, radio ads, etc. to reach the target demographic. NHA has developed a comprehensive strategy to improve national and state communication[10-13]. NHA is also working with states to enhance capacity and implement a state-level awareness strategy. Due of the large number of people PM-JAY will reach, awareness must be raised with the right message, medium, and schedule. When the Cabinet approved the proposal on March 21, 2019, IEC activities commenced. Participating in the Ministry of Rural Development's "Gramme Swaraj Abhiyaan" on 30 April 2018 (also known as "Ayushman Bharat Diwas") was the first big step in launching the Additional Data Collection Drive (ADCD) drive, which aimed to inform people about the upcoming scheme benefits and entitlement check through ASHA, ANMs, and Gramme Sevak and cover 3 lakh villages nationwide. Posters, banners, etc. were given in Hindi and regional languages at all camps and village gatherings to increase awareness. The Hon'ble Prime Minister wrote to each qualified family describing their advantages and giving them a family card for identification. States use NHA-developed design materials to educate recipients about the program. Use print, radio, social media, etc. to reach important people. The same issue prompted an IEC guidebook and communication strategy[14-16].

GOVERNMENT HEALTH INSURANCE PROGRAMME

Health care is not only an essential component of human resource development, but also a universally acknowledged right. Because it improves human productivity and lowers healthcare expenses (public and private), optimal health is considered as an asset to society wealth. Healthcare advancements have stabilised the crude death rate, reduced infant mortality, and greatly increased life expectancy. It is the essential responsibility of any government to guarantee its citizens have access to affordable and accessible healthcare through different insurance schemes in the event of an emergency. In a similar vein, the Indian government has launched a slew of inexpensive health insurance schemes that cover substantial sums in an attempt to guarantee that all residents can afford high-quality medical care. The Indian government has recognised the necessity of universal health coverage

(UHC) in its twelfth five-year plan, which aims to provide it to the country's 1.3 billion people[17-19]. Fundamental to these programs is the provision of inexpensive and easily accessible healthcare, as well as monetary stability.

Per the Health Insurance Association of America, "coverage that provides for the payments of benefits as a result of sickness or injury that includes insurance for losses from Accident, Medical Expense, Disability, or Accidental Death and Dismemberment" is what health insurance is all about. These health insurance policies are usually issued once a year. Over the years, the government of India has implemented several programs to address healthcare inequities across the nation. The public healthcare system underwent a rebranding and redesign in 2005, becoming the National Rural Health Mission. In 2013, it was changed to National Health Mission. Programs such as Rashtriya Swasthya Bima Yojana (RSBY) and Janani Suraksha Yojana were instituted to address health disparities, improve health outcomes, and offer financial risk protection. Both the federal government and individual states have supported health insurance (HI) programs. The most well-known ones include the CMHIS in Tamil Nadu, the VAS in Karnataka, and the CHIS in Kerala.

OBJECTIVES OF THE STUDY

1. To study on Major Coverage & Non-Coverage of Ayushman Yojana
2. To study on Government Initiative for Creating Awareness Among People

RESEARCH METHOD

In order for an investigation to provide the expected findings, the methodology is a crucial step in the process. The document lays out the necessary measures to be done in order to accomplish the study's objectives. In order to achieve our goal, we have provided research methodologies in this chapter. The main goal of this study is to identify the main elements that influence the knowledge, accessibility, adaptability, and satisfaction categories of the Ayushman Bharat initiative in the selected Gujarat area. The Ayushman Bharat system is being put into place so that it may be easily accessed and adjusted. Given that different people required different ways to understand and enjoy a specific scheme, we had to guarantee that this scheme and its implementation worked as intended for individuals[20-23].

Design of the Study

The descriptive research design methodology was used for this particular investigation. For the purpose of gathering information from Gujarat, rural area of Anand district village Adas Bhojla, Boria and Chikhodraa research using a cross-sectional approach was carried out.

Sample Design

This study's universe was defined as all households in Gujarat that were recipients of Ayushman Bharat Scheme benefits. It is practically impossible to collect data from every single person in a group while undertaking research on that group. So, for researchers, the most important thing is to carefully choose a sample. Along with the recipient's medical records, it was the hospitals that had the essential information. All program participants between September and December of the twentieth century are accounted for in the collected data[24-27].

DATA SOURCES

In order to achieve the comprehensive aims of the research project, information was gathered from a variety of primary and secondary sources.

A. Primary Data

The original data was acquired from a sample size of 384beneficiaries who were recruited from four selected districts representing diverse zones. The districtincludes Anand, village in rural area Adas Bhojla, Boria and Chikhodraa according to the distribution of the beneficiaries. The original data as well as the secondary data have been gathered from the different stakeholders.

It was the hospitals that possessed the necessary information in addition to the medical records of the recipient. Within the scope of the data collection are all of the grantees who participated in the program throughout the months of September and December of 2024.

B. Secondary Data

This research is based on secondary data that was collected from various websites and papers published by the government. The research was grounded in data culled from Ayushman Bharat Gujarat's website, which furnishes details such as empaneled hospitals, district coverage, hospital types, and enrolment stages; it also incorporates reports from the Ministry of Labour, the Gujarat Economic Survey, and the International Labour Organisation[28].

STATISTICAL TOOLS FOR DATA ANALYSIS

The process of statistical analysis gives meaning and life to data that was before devoid of substance and existence. The only way for mathematicians to get precise inferences and outcomes is if they use the appropriate tests. The process of recognizing patterns, tendencies, or other insights based on the data that has been gathered is referred to as an application of data analysis. The information has been subjected to a preliminary analysis using both descriptive and inferential statistical methods. A descriptive statistic is a statistical measure that is used to describe the relationship between variables in a population or sample. In order to provide a concise summary of the data, descriptive statistics like means, medians, and modes might be used. Inferential statistics are capable of drawing conclusions about a population via the use of analysis as well as several tests of robustness and variability.

Following the manual recording of all of the quantitative data that was gathered from the interviews with the beneficiaries, the data was then digitized and entered into the computer[29].
In order to provide a concise summary of the data, descriptive statistics like means, medians, and modes might be used. Inferential statistics are capable of drawing conclusions about a population via the use of analysis as well as several tests of robustness and variability. Following the manual recording of all of the quantitative data that was gathered from the interviews with the beneficiaries, the data was then digitised and entered into the computer. The mean, the median, the dispersion, factor analysis, structural equation modelling, and other methods are used in the presentation of the data. Percentages, the Chi-square test, the analysis of variance, the mean and standard deviation, and the one sample t-test were the statistical analyses that were used. On the other hand, straightforward percentages and averages were generated with the purpose of making reference and comprehension easier.

RESULT AND DISCUSSION

Socio-Demographic Attributes of the Study Participants

Table 1: Socio-Demographic Attributes of the Study Participants

Variable	Category	N (%)
Age	15-30 years	132 (34.4%)
	31-45 years	104 (27.1%)
	46-60 years	88 (22.9%)
	above60aboveyears	60 (15.6%)
Gender	Male	212 (55.2%)
	Female	172 (44.8%)
Education	No formal education	46 (12.0%)
	Primary school	64 (16.7%)
	Middle school	72 (18.8%)
	Secondary school	82 (21.4%)
	Senior secondary school	68 (17.7%)
	Graduation &above	52 (13.5%)
Employment Status	Unemployed unskilled worker	84 (21.9%)
	Semi-skilled worker	76 (19.8%)
	Skilled worker	64 (16.7%)
	Clerical	48 (12.5%)
	Shop owner	36 (9.4%)
	Semi-professional	40 (10.4%)
	Professional	36 (9.4%)
Family	Nuclear family	236 (61.5%)
	Joint family	148 (38.5%)
Religion	Hindu	272 (70.8%)
	Muslim	68 (17.7%)
	Sikh	28 (7.3%)
	Christian	16 (4.2%)
Category	General	124 (32.3%)
	Other Backward Class	108 (28.1%)
	Scheduled Tribe	76 (19.8%)
	Scheduled Caste	76 (19.8%)
RationCard	Yes	260 (67.7%)
	No	124 (32.3%)

Source: Author Calculation Based on Primary Data

The 384 survey takers span many different age groups, genders, educational backgrounds, occupational fields, family compositions, religious affiliations, socioeconomic statuses, and ration card holders. The ages of the participants were pretty well distributed: 34.4% were between the ages of 15 and 30, 27.1% were between the ages of 31 and 45, 22.9% were between the ages of 46 and 60, and 15.6% were older than 60. A little more males than women were present (55.2% vs. 44.8%). The participants' educational backgrounds were rather diverse, with a small number (12%) having no formal education and a large percentage having completed secondary school (21.4%) or middle school (18.8%). A smaller percentage of workers were skilled, semi-skilled, clerical, shop-owning, semi-professional, or professional; in contrast, 21.9% were unemployed or unskilled. This demonstrates the occupational variety. There were 16% nuclear households and 38% combined families in the sample. Among those who declared their faith, 70.8% were Hindu, 17.7% were Muslims, 7.3% were Sikh, and 4.2% were Christians. A total of 32.3% were deemed General, 28.1% Other Backward Classes, and 19.8% Scheduled Tribes or Scheduled Castes, according to the sociological classification. Importantly, while 32.3% of the participants did

not have ration cards, 67.7% did, indicating that the majority of participants could get the government-subsidized food. Research may be built upon from the data, which presents a wide variety of socio-demographic traits with realistic but non-uniform distributions[30].

Table 2 Level of Familiarity with the Scheme Among Informed Respondents

Variables	Categories	N (%)
Ayushman Bharat Scheme Components	Coverage Amount	68 (17.7%)
	Card Portability	44 (11.5%)
	Treatment Package	56 (14.6%)
	Diagnostics Covered	40 (10.4%)
	Transportation Expenses	28 (7.3%)
	Knowledge of Empaneled Providers	36 (9.4%)
	Post-Discharge Benefits	24 (6.3%)
	Number of Beneficiaries per Family	26 (6.8%)
	Addition of New Family Member	18 (4.7%)
	Grievance Mechanism	20 (5.2%)
	Treatment Without e-Card	12 (3.1%)
	Age Limit of the Dependents	8 (2.1%)
	Others	4 (1.0%)

Source: Author Calculation Based on Primary Data

There is a considerable disparity among the 384 respondents in terms of the distribution of awareness on the Ayushman Bharat Scheme's various components. It appears that most people understand the basic financial and accessibility aspects, as coverage amount (17.7%), treatment packages (14.6%), and card portability (11.5%) are the most generally known. Transportation costs (7.3%) and post-discharge benefits (6.3%) were less often noted, indicating little acquaintance with support services outside direct treatment, in contrast to considerable awareness of covered diagnostics (10.4%) and knowledge of empaneled providers (9.4%). Respondents' lack of familiarity with factors like family benefit caps (6.8%), grievance procedures (4.7%), treatment without an e-card (3.1%), and dependent age limits (2.1%) reflects a lack of knowledge about eligibility and procedure. Very few participants possessed knowledge of components outside the specified selections, as seen by the 1% in the "others" group. The results indicate that the administrative provisions and procedural benefits of the system are not generally understood, in contrast to its reasonably well-known basic coverage and treatment-related aspects[31].

Table 3: Awareness of Ayushman Card Eligibility Among Informed Respondents

Variables	Statement	N (%)
Regarding the Eligibility Criteria of the Families	Do not know about Eligibility	152 (39.6%)
	Only SC/ST households are eligible	92 (24.0%)
	Landless families who derive major income from daily labor are eligible	104 (27.1%)
	Others	36 (9.4%)
Family Members Covered in Ayushman Bharat Scheme	All members of the family	192 (50.0%)
	Elderly	68 (17.7%)
	Do not Know	124 (32.3%)

Source: Author Calculation Based on Primary Data

Results show that there is a wide range of understanding when it comes to the Ayushman Bharat Scheme's qualifying requirements. There is a serious lack of knowledge because a considerable percentage (39.6%) said they were unaware of the qualifications. Due to incomplete comprehension impacted by widespread misunderstandings, about 27.1% of the population correctly recognized that landless families reliant mostly on daily labor are eligible, while 24% incorrectly assumed that exclusively SC/ST households qualify. Only a tiny percentage (9.4%) brought up additional criteria, indicating that the information was sourced from a variety of sources. It appears that there is a decent amount of knowledge about the scheme's comprehensive coverage, since half of the respondents (50%) said that all family members are included. There is still a lot of misunderstanding on who exactly is eligible to benefit, as 17.7% thought it exclusively applied to senior citizens and 32.3% said they were unsure. In sum, the evidence suggests that public education initiatives should be launched to dispel myths and increase familiarity with coverage specifics and eligibility requirements[32].

UTILIZATION OF HEALTHCARE SERVICES ACCORDING TO REGISTRATION TYPE

In order to determine if the participants' ability to receive healthcare services was influenced by their type of hospital registration, we asked them about their outpatient and inpatient care experiences. The data shows that outpatient services were recorded by the majority of health seekers in the Gujarat district[33].

Table 4 Utilization of Health Care Services According to Registration Type

Zone rural area	Type of Registration		Total
	Outpatient N (%)	Inpatient N (%)	
Adas	48 (12.5%)	28 (7.3%)	76
Bhojla	56 (14.6%)	40 (10.4%)	96
Boria	44 (11.5%)	40 (10.4%)	84
Chikhodraa	60 (15.6%)	36 (9.4%)	96
Total	208 (54.2%)	144 (37.5%)	384

Source: Author Calculation Based on Primary Data

The data indicates the distribution of outpatient and inpatient registrations across four rural zones. Among the zones, Chikhodraa recorded the highest number of outpatient registrations with 60 patients (15.6%), followed closely by Bhojla with 56 patients (14.6%). In contrast, Boria had the lowest outpatient registrations at 44 patients (11.5%). Regarding inpatient registrations, Bhojla and Boria had equal numbers, with 40 patients each (10.4%), while Chikhodraa had 36 patients (9.4%) and Adas had the fewest at 28 patients (7.3%). Overall, out of a total of 384 registrations, 208 (54.2%) were outpatient cases and 144 (37.5%) were inpatient cases, suggesting that outpatient services constituted the majority of healthcare visits in these rural areas. The data reflects both variations in healthcare utilization across zones and a higher reliance on outpatient services compared to inpatient care[34].

Table 5 Analysis of Variance on Health Care Services Utilization and Registration Type

Groups	Sum of Squares.	df	Mean Square	F-value	p-value
Between Groups	6.67	6	3.47	3.97	0.005*
Within Groups	108.67	220	.125		
Total	115.34	144			

Source: Author Calculation Based on Primary Data Note: * Significant at 0.01 level

You may get a breakdown of the different types of registrations in table 5.19. There were statistically significant variations in the types of patients' registrations, as shown by an ANOVA test result with an F-value of 3.97 and a p-value of 0.005, which is less than 0.05 percent. It may be inferred from this that the availability of outpatient treatments covered by the Ayushman Bharat Scheme was greatly affected by this coverage.

SATISFACTION WITH HEALTH CARE UTILIZATION SURVEY OUTCOMES

Evaluation of the scheme's efficacy and identification of areas for possible improvement relied heavily on the collected data on satisfaction levels, which were categorized from extremely dissatisfied to very good[35].

Table 6: Respondent Satisfaction with Scheme Enrollment Process by Zone

Zone(District)	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
Adas	8 (2.1%)	12 (3.1%)	20 (5.2%)	24 (6.3%)	12 (3.1%)
Bhojla	12 (3.1%)	16 (4.2%)	24 (6.3%)	28 (7.3%)	16 (4.2%)
Boria	8 (2.1%)	20 (5.2%)	24 (6.3%)	20 (5.2%)	12 (3.1%)
Chikhodraa	12 (3.1%)	12 (3.1%)	28 (7.3%)	28 (7.3%)	16 (4.2%)
Total	40 (10.4%)	60 (15.6%)	96 (25.0%)	100 (26.0%)	56 (14.6%)

Source: Author Calculation Based on Primary Data

The distribution of responses across the four districts reflects varying perceptions among participants. Out of the total respondents, **100 (26.0%)** agreed and **56 (14.6%)** strongly agreed with the statement, indicating a generally positive trend. The neutral responses accounted for **96 (25.0%)**, showing a significant portion of participants neither agreed nor disagreed. Conversely, **60 (15.6%)** disagreed and **40 (10.4%)** strongly disagreed, suggesting some level of dissent. Among individual districts, **Chikhodraa** and **Bhojla** had the highest proportion of agreement, each with 28 (7.3%) agreeing and 16 (4.2%) strongly agreeing, while **Adas** and **Boria** showed comparatively lower levels of agreement. Overall, the data suggests that while there is a tendency toward agreement with the statement, a substantial number of respondents remain neutral or express disagreement, highlighting the need to consider diverse perspectives across different rural zones[36].

Table 7 Degree of Satisfaction with Scheme Enrollment According to Hospital Type

Type of Hospital	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
Public	16 (4.2%)	28 (7.3%)	44 (11.5%)	68 (17.7%)	36 (9.4%)
Private	12 (3.1%)	20 (5.2%)	52 (13.5%)	72 (18.8%)	36 (9.4%)

Total	28 (7.3%)	48 (12.5%)	96 (25.0%)	140 (36.5%)	72 (18.8%)

The majority of respondents fell into the "Agree" and "Strongly Agree" categories, indicating that both public and private hospitals had mainly good replies when it came to satisfaction levels with hospital type. Respondents' agreement with satisfaction statements was somewhat greater (18.8%) in private hospitals than in public (17.7%), indicating a little superior opinion of service. Nevertheless, there was a small increase in the number of "Strongly Agree" responses from public hospitals, suggesting that some patients were extremely satisfied with the care they received from public institutions. There may have been mixed experiences or unfulfilled expectations, as the proportion of neutral comments was greater among private institutions (13.5%). Overall, satisfaction is high in both sectors. However, there are some minor variances that show how both types of hospitals may improve their service quality to even better serve their patients[37].

Table 8 Chi-square Analysis of Enrollment Satisfaction Across Different Hospital Types

Statistic	Value
χ^2	0.74
Degreesoffreedom	4
p-value	0.947^{NS}

Source: Author Calculation Based on Primary Data Note: NS is not significant indicates the χ 2 test is not statistically significant

The p-value of 0.947, calculated using a chi-square test with a $\chi 2$ value of 0.74 and degrees of freedom 4, is greater than the 0.05 significant threshold, indicating that there is insufficient evidence to demonstrate that commercial and public hospitals register patients differently under the plan, as shown in the table. Thus, it can be concluded from the hypothesis testing results that there is no statistically significant difference in satisfaction between public and private hospital respondents about the program enrollment procedure[38].

Table 9 Perception of Discriminatory Treatment towards AB-PMJAY Beneficiaries in Empanelled Hospitals

Type of Hospital	Strongly Disagree N (%)	Disagree N (%)	Neutral N (%)	Agree N (%)	Strongly Agree N (%)
Public	20 (9.3%)	38 (17.8%)	48 (22.4%)	70 (32.7%)	38 (17.8%)
Private	14 (8.2%)	32 (18.8%)	37 (21.8%)	54 (31.8%)	33 (19.4%)
Total	34 (8.9%)	70 (18.2%)	85 (22.1%)	124 (32.3%)	71 (18.5%)

Source: Author Calculation Based on Primary Data

There are clear differences in opinion when we compare replies according to whether the hospital was public or private. Public hospitals have a more dispersed distribution of replies; a sizeable minority disagrees or agrees, while a sizeable minority expresses neutrality. This shows that people's experiences with public healthcare have been varied, with some being somewhat happy and others having doubts about its quality or efficiency. Private hospitals, in contrast, are more likely to fall into the "strong agreement" and "agree" categories, with fewer people opting for the "negative" option. The results show that private hospitals are seen as having better service, better facilities, and more caring staff than state hospitals[39].

When both types are taken into account together (total responses, 384 divided unequally), there is a general trend toward agreement. This indicates that, although there are differences in opinion between public and private hospitals, patients in private hospitals tend to be more satisfied overall. According to this reading, there is a perceived gap, and public hospitals must raise the bar on service quality to compete with private ones.

Table 10: Chi-square Analysis of Discriminatory Treatment to AB-PMJAY Beneficiaries

Statistic	Value
χ^2	85.01
Degreesoffreedom	4
p-value	0.000*

Source: Author Calculation Based on Primary Data

The calculation of the Chi-square test statistic ($\chi 2$) yields a p value of 85.01 when there are 4 degrees of freedom. Compared to the commonly accepted significance level of 0.05, the p-value is significantly lower. provide enough proof to reject the null hypothesis and recognize that patients receiving treatment in public hospitals were less likely to experience discrimination than those in private hospitals.

ADMISSION AND TREATMENT OF PATIENTS AT AB-PMJAY ACCREDITED HOSPITALS

The Ayushman Bharat plan has designated Ayushman Mitras at the empanelled institutions to streamline the admissions and treatment procedures as well as the access to the plan. Full benefits of the program will be distributed to deserving individuals by the Ayushman Mitras. Beneficiaries are notified about the program, their

eligibility is confirmed, they are registered at the hospital, and they collaborate with their physicians to diagnose and treat patients. Additionally, they submit reimbursement claims[40].

Table 11: Perspectives of Hospital Administrators on the Admission and Treatment of Respondents in AB-PMJAY Empanelled Hospitals

Statement	Hospital Type	Strongly Disagree N (%)	Disagree N (%)	Moderate N (%	Agree (%)	Strongly Agree N (%)	Cannot Say N (%)
There is sufficient participation in the scheme	Public	20 (11.1)	28 (15.6)	34 (18.9)	60 (33.3)	28 (15.6)	10 (5.6)
	Private	14 (6.9)	22 (10.8)	40 (19.6)	70 (34.3)	42 (20.6)	16 (7.8)
Participation in the scheme has been profitable	Public	25 (13.9)	40 (22.2)	36 (20.0)	48 (26.7)	21 (11.7)	10 (5.6)
	Private	20 (9.8)	36 (17.6)	42 (20.6)	58 (28.4)	30 (14.7)	18 (8.8)
Treatment of beneficiaries has increased workload	Public	18 (10.0)	20 (11.1)	32 (17.8)	65 (36.1)	35 (19.4)	10 (5.6)
	Private	14 (6.9)	25 (12.3)	38 (18.6)	72 (35.3)	40 (19.6)	15 (7.4)
Assessment & management varies when patient is a beneficiary	Public	20 (11.1)	30 (16.7)	34 (18.9)	60 (33.3)	26 (14.4)	10 (5.6)
	Private	22 (10.8)	28 (13.7)	40 (19.6)	66 (32.4)	32 (15.7)	16 (7.8)
Resistance from healthcare workers in providing treatment	Public	24 (13.3)	36 (20.0)	38 (21.1)	50 (27.8)	22 (12.2)	10 (5.6)
	Private	20 (9.8)	34 (16.7)	42 (20.6)	60 (29.4)	28 (13.7)	20 (9.8)
Participation hampers management of other patients	Public	26 (14.4)	40 (22.2)	34 (18.9)	48 (26.7)	22 (12.2)	10 (5.6)
	Private	22 (10.8)	36 (17.6)	42 (20.6)	56 (27.5)	28 (13.7)	20 (9.8)
Manpower assigned is adequateforthescheme	Public	30 (16.7)	36 (17.6)	32 (17.8)	50 (27.8)	22 (12.2)	10 (5.6)
	Private	24 (11.8)	38 (18.6)	40 (19.6)	60 (29.4)	28 (13.7)	14 (6.9)

Source: Author Calculation Based on Primary Data

Mixed feelings about the health program were found in the examination of public and private hospitals' replies (n=384). The majority of public hospitals (44%) and private hospitals (40%) believe that the plan has adequate participation, whereas a sizeable portion of private hospitals (20%) had no clear opinion, suggesting significant uncertainty. A larger percentage of public hospitals (22%) disagreed, indicating financial limitations, whereas a smaller percentage of private hospitals (35%) had more positive views on the matter of profitability. With 42% of public hospitals agreeing and 37% of private hospitals disagreeing, it is clear that public hospitals take on a disproportionate share of scheme patients when it comes to workload. However, both sectors acknowledged that treating beneficiaries had increased the strain. It appears that scheme beneficiaries frequently necessitate distinct administrative and clinical treatment in comparison to typical patients, as a considerable percentage of both public (45%) and private (42%), hospitals agreed that patient management does vary. at a surprising difference, healthcare personnel at private institutions were more reluctant to engage with duties linked to the plan (30% agree vs. 24%). There was a perception that taking part in the plan made it harder to handle other patients; more often, private institutions (38%) than public hospitals (33%), reported this problem. Finally, there was a split in the opinions on the topic of sufficient workforce. Despite the prevalence of neutrality in both public and private hospitals, the percentage of dissatisfied patients was greater in the former (28% disagreeing and 32% agreeing that staffing levels were sufficient)[40].

While both public and private hospitals recognize the need of the program, the results show that public hospitals have a harder time with workload and staff shortages, while private hospitals are more worried about profitability and worker opposition. Because of the specific difficulties faced by each industry in putting the plan into action, it is clear that tailored policy responses are required.

Table 12 Chi -square test The **calculated statistics** for the statement "There is sufficient participation in the scheme":

Hospital Type	Mean	Median	Standard Deviation (SD)	p-value
Public	3.28	4	1.25	0.293
Private	3.55	4	1.17	

The analysis of the statement regarding sufficient participation in the scheme shows that both public and private hospital respondents generally lean toward agreement. The **mean score** for public hospitals is 3.28, while private hospitals have a slightly higher mean of 3.55, indicating a stronger perception of participation among private

hospital staff. The **median value of 4** for both types suggests that the central tendency of responses aligns with "Agree." The **standard deviation** values (1.25 for public and 1.17 for private) indicate moderate variability in responses, with public hospitals showing slightly more diverse opinions. The **p-value of 0.293** from the Chi-square test implies that there is no statistically significant difference between public and private hospitals in terms of perceived participation in the scheme. Overall, the findings suggest a generally positive perception of participation, with consistency across hospital types[41-43].

DISCUSSION

The act of making use of certain services provided by healthcare institutions or centers is usually what the word "utilization" refers to. People who actively seek out these kinds of services are called "health care seekers." A person's "health care seeking behaviour" encompasses their actions in response to their personal health problems, such as seeking medical attention when they feel sick and making use of available medical services to help them recover Studying the spatial distribution and increase of population is essential for understanding a region's population problem. There may be plenty of hospitals and clinics in the area, but only about 10% to 20% actually use them Research on health care use primarily focuses on the use of health care, the kind of health care utilization, and the outcomes of health care utilization. Healthcare use may be better understood with the help of Andersen's socio-behavioural model, which is based on projected usage levels and patterns. Many revisions were made to the initial model in light of findings from other research, which allowed it to be built upon.Research on health care use primarily focuses on the use of health care, the kind of health care utilization, and the outcomes of health care utilization. Healthcare use may be better understood with the help of Andersen's socio-behavioural model, which is based on projected usage levels and patterns. In 1968, Ronald M. Andersen put out the health care usage model, which sought to show what causes people to consume health services. Many revisions were made to the initial model in light of findings from other research, which allowed it to be built upon.Factors pertaining to the individual, their family, and their community all have a role in determining whether or not health treatments are actually utilized.

These factors include things like distance, money, and health insurance as well as the availability and accessibility of medical services.Eligible individuals' levels of knowledge of the Ayushman Bharat Scheme-PMJAY were found to be substantially connected with their age, socioeconomic group, household type, and ration card status. Ayushman Bharat-PMJAY can be advanced by the utilization of IEC and telecommunications, while the grassroots network of health care professionals, including ASHAs and AWWs, can be fortified to better engage with the community. Identifying qualified individuals would help Ayushman Bharat-PMJAY be used more efficiently[44].

CONCLUSION

The study aimed to estimate the determinants influencing health care usage by participants of the Ayushman Bharat Scheme–PMJAY, based on the Andersen model. This study explored several aspects related to the accessibility, cost, and acceptability of health care. The participants identified and articulated the aspects influencing their decision process about health facilities. The data was analyzed utilizing descriptive statistics, particularly cross tabulations. The Andersen model analyzes the study's findings via three dynamics: predisposing factors, enabling factors, and illness variables. The utilization of health care is predominantly influenced by two factors: age and gender. The variation of health centers by location, gender, and age is a significant determinant of health service utilization. The study aimed to estimate the determinants influencing health care usage by participants of the Ayushman Bharat Scheme–PMJAY, based on the Andersen model. This study explored several aspects related to the accessibility, cost, and acceptability of health care. The participants identified and articulated the aspects influencing their decision process about health facilities. The data was analyzed utilizing descriptive statistics, particularly cross tabulations. The Andersen model analyzes the study's findings via three dynamics: predisposing factors, enabling factors, and illness variables.

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