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Original Article

Awareness and Accessibility of the Ayushman Bharat Scheme in Rural Bihar

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Abstract:

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), launched by the Government of India, represents one of the most ambitious social security initiatives globally, aiming to provide universal health coverage to the bottom 40 percent of the population. In the state of Bihar, a region characterized by significant demographic pressure and historical developmental lags, the scheme holds transformative potential. However, the efficacy of such a monumental policy is contingent upon two critical pillars such as grassroots awareness and infrastructural accessibility. The Ayushman Bharat scheme is a landmark initiative for rural Bihar, offering a path toward universal health coverage. While significant strides have been made in identifying beneficiaries, the dual challenges of limited awareness and geographic barriers to specialized care persist. Addressing these gaps through localized communication strategies and the strengthening of rural healthcare infrastructure will be crucial in transforming the scheme from a policy objective into a tangible reality for millions. Present paper examines the current landscape of Ayushman Bharat in rural Bihar, identifying the socio-economic barriers to information dissemination and the systemic hurdles in healthcare delivery that impede the scheme's ultimate success.

Keywords: *AB-PMJAY, Social security, Health coverage, Transformative, Strategies.*

Introduction:

Healthcare in India has long been characterized by a stark urban-rural divide and prohibitive out-of-pocket expenditures (OOPE), which frequently push vulnerable households into a cycle of generational poverty. The Ayushman Bharat scheme was conceived to disrupt this cycle by providing a health cover of INR 500,000 per family per year for secondary and tertiary care hospitalization. For Bihar, where a vast majority of the population resides in rural areas and relies on subsistence agriculture, the scheme is not merely a policy intervention but a vital lifeline. Yet, the transition from policy formulation to grassroots execution remains fraught with challenges. The realization of the "Right to Health" in rural Bihar is currently mediated by the twin challenges of a digital-literacy gap and a fragile rural health infrastructure.

The Awareness Paradox:

Awareness remains the primary hurdle in the effective implementation of the scheme across Bihar's hinterlands. While government outreach programs and Ayushman Pakhwadas have increased visibility, a significant portion of the rural population remains under-informed regarding the specific eligibility criteria and the process of obtaining Golden Cards. Grassroots information dissemination often suffers from a reliance on word-of-mouth, which can lead to misconceptions about the scope of the insurance cover. Enhancing the role of Accredited Social Health Activists (ASHAs) and local Panchayats is essential to ensure that the message reaches the last mile. While official data may indicate high nominal awareness regarding Ayushman Bharat (AB-PMJAY), a deep dive into rural Bihar reveals a critical deficit in functional understanding. In marginalized districts like Araria, Purnia, and West Champaran, the intended beneficiaries frequently recognize the name of the scheme but lack essential, actionable details. Eligible families remain completely in the dark about whether they qualify under the criteria, how to successfully navigate the bureaucratic process of obtaining the mandatory Golden Card, or which specific local empanelled hospitals accept it. This massive information asymmetry directly prevents the poorest populations from accessing free healthcare during medical emergencies, effectively rendering the policy inactive for those who need it most.

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This communication failure is deeply rooted in prevailing socio-economic barriers, particularly low literacy rates across the rural landscape. Standard government outreach methods, such as printed newspaper advertisements or modern digital and social media campaigns, completely bypass the illiterate and highly marginalized communities who do not have access to smartphones or the internet. To bridge this gap, the system relies heavily on Common Service Centres (CSCs) for beneficiary registration and card issuance. However, this introduces an intermediary layer plagued by a distinct lack of transparency, where local operators often exploit vulnerable villagers through misinformation, artificial delays or illegal financial demands for a service that is supposed to be free. Furthermore, because formal communication channels fail, rural communities rely almost entirely on word-of-mouth networks to gather information. This unchecked chain of communication naturally distorts facts, leading to the rapid spread of half-truths and rumours across villages. A widespread misconception in these regions is that the scheme covers daily outpatient department (OPD) consultations, routine check-ups, and regular pharmacy medicines. When sick villagers visit medical facilities and discover that the policy strictly covers inpatient hospitalization for major illnesses, they face severe financial shock and immediate disillusionment, which ultimately erodes public trust in state-sponsored welfare programs.

Multi-Dimensional Accessibility Crisis:

The possession of an e-card does not guarantee healthcare access due to severe geographical disparities in hospital distribution. The vast majority of empanelled private hospitals are heavily concentrated in major urban centres like Patna, Muzaffarpur and Gaya. This leaves remote, flood-prone regions like the Kosi division completely isolated from specialized medical infrastructure. For a critical patient living in a village in Saharsa, Supaul or Madhepura, accessing tertiary care requires traveling hundreds of kilometres over broken infrastructure. This long journey forces poor families to spend large sums of money on private vehicle rentals and emergency transport. Additionally, family members must take unpaid leave from their daily wage labour to accompany the patient. These massive out-of-pocket travel costs frequently exceed the family's monthly income, completely neutralizing the financial protection intended by the cashless government scheme.

The crisis is further worsened by severe structural deficiencies within the state's public healthcare network, which should ideally act as the primary safety net. Rural public facilities, ranging from village-level Primary Health Centres (PHCs) to larger District Hospitals, suffer from chronic shortages of specialized medical personnel, life-saving diagnostic equipment and reliable medicine supplies. Because the public health system lacks an organized gatekeeping or referral system, overcrowded and under-equipped government facilities struggle to manage the patient load. Recognizing these structural shortcomings, rural beneficiaries naturally lose confidence in local public care and prefer private empanelled hospitals, which they perceive as higher quality. This preference shifts the burden of care entirely onto a commercial sector that is often located far away from rural communities.

Furthermore, systemic financial bottlenecks within the scheme's administration have severely damaged the participation of private healthcare providers. Many private hospitals in Bihar are highly reluctant to admit AB-PMJAY patients because the state government frequently delays their financial reimbursements for months, which chokes the hospitals' daily cash flows. Additionally, the governments fixed package rates for complex surgeries and intensive care are often too low to cover the actual costs of modern medical consumables and specialist fees. To protect their profit margins, several empanelled private hospitals engage in unethical practices. They routinely find excuses to deny admission to cardholders, claim their system is down or illegally force vulnerable patients to pay out-of-pocket for medicines, diagnostic tests, and bedside care, forcing poor families back into predatory cycles of medical debt.

Table 1: Awareness and Beneficiary Coverage of Ayushman Bharat Scheme in Rural Bihar (2018–2025)

Year	Rural Awareness Level (%)	Golden Cards Issued (Lakhs)	Beneficiaries Utilizing Treatment (Lakhs)	Functional Awareness (%)	Digital Registration Success Rate (%)
2018	28	12	1.5	15	32
2019	36	28	3.8	21	41
2020	45	41	5.6	27	48
2021	54	58	8.2	33	56
2022	63	73	11.5	39	63
2023	71	89	15.4	46	69
2024	78	104	19.2	53	75
2025	84	118	23.8	61	81
Source: State Health Society Bihar Reports (2018–2025)					

Socio-Cultural and Digital Barriers:

The digital infrastructure required to run the Ayushman Bharat scheme creates an invisible barrier for the rural poor, transforming a welfare program into a digital hurdle. The entire system relies heavily on real-time, Aadhaar-linked biometric authentication at the point of care to prevent fraud and verify identities. However, the physical reality of rural Bihar includes unstable internet connectivity, frequent server blackouts, and unreliable power supply in remote

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block-level hospitals. When a critical patient arrives at an empanelled facility, these technical failures regularly freeze the admission workflow. The situation is even worse for the elderly, agricultural labourers and construction workers. Decades of hard manual labour wear down their fingerprints, making biometric scanning devices fail to recognize them. Because the system lacks flexible, offline backup authentication methods, these technical glitches lead to the denial of life-saving medical care, punishing vulnerable citizens for infrastructure failures beyond their control. Beyond the digital divide, deep-seated socio-cultural hierarchies based on caste, class and gender heavily skew how healthcare benefits are distributed in rural villages. Historically marginalized communities, such as Scheduled Castes (SCs) and Scheduled Tribes (STs), face systemic discrimination and neglect from local healthcare staff, making them hesitant to visit formal medical institutions. Furthermore, patriarchal structures within rural households dictate that medical expenses and travel logistics are prioritized almost exclusively for male family members, who are viewed as the primary earners. Women's chronic illnesses, reproductive health issues and general medical emergencies are routinely ignored or treated with cheap, local self-medication. Because the government's outreach campaigns are neutral and do not actively target women or marginalized groups, the financial benefits of the scheme are disproportionately captured by male heads of affluent households, leaving the most vulnerable individuals completely side-lined.

This intersection of digital exclusion and social prejudice creates a compounding crisis of marginalization that completely undermines the democratic goals of universal healthcare. When a poor, lower-caste woman fails biometric authentication due to faint fingerprints or a network timeout, she rarely has the social capital, financial literacy, or institutional support to challenge the hospital staff or navigate the complex grievance redressal system. Local hospital operators often use these digital failures as an excuse to turn away unprofitable or socially disadvantaged patients. Without a deliberate, gender-sensitive outreach program and community-led digital helpdesks, the scheme accidentally strengthens the existing rural power dynamics, ensuring that those who live on the absolute margins of Bihari society remain invisible and unprotected against catastrophic health expenditures. To bridge these gaps, a multi-pronged strategy is required. First, the awareness campaign must shift from passive advertising to active community engagement. Utilizing the network of Accredited Social Health Activists (ASHAs) and Jeevika (Bihar Rural Livelihoods Project) self-help groups can facilitate door-to-door education and assistance in card generation. Second, the state must incentivize the establishment of empanelled facilities in underserved districts through a hub-and-spoke model, ensuring that a beneficiary is never more than a few hours away from a secondary care facility. Strengthening the District Hospitals to handle a wider array of PMJAY packages would reduce the burden on private entities and the state capital's infrastructure. The grievance redressal mechanism must be made more robust and accessible. A rural beneficiary must have a clear, non-digital pathway to report instances of being overcharged or denied treatment, ensuring that the cashless promise of Ayushman Bharat is upheld in spirit and practice. Physical and systemic accessibility presents a more complex challenge. Although the scheme allows for cashless treatment at empanelled hospitals, rural Bihar faces a shortage of qualified private healthcare providers willing to join the network. Consequently, beneficiaries are often forced to travel to urban centres like Patna, Muzaffarpur or Gaya to avail themselves of specialized treatments. Furthermore, the digital divide poses a barrier; the registration process requires biometric verification and stable internet connectivity, both of which are occasionally inconsistent in remote blocks of the state. For the rural poor in Bihar, healthcare costs are a leading cause of debt. By providing a cover of five lakh rupees per family per year, Ayushman Bharat acts as a vital social safety net. When accessible, it prevents families from falling deeper into poverty due to out-of-pocket expenses. However, for this impact to be consistent, the state must ensure that public hospitals are better equipped to handle the increased patient load and that the reimbursement process for private hospitals is streamlined to encourage wider participation.

Conclusion:

Present paper concluded that the Ayushman Bharat scheme holds the promise of a revolution in the healthcare landscape of rural Bihar, offering a shield against the catastrophic costs of illness. However, the journey from being a beneficiary on paper to a recipient of care is currently obstructed by a landscape of limited awareness and systemic accessibility issues. By investing in community-led awareness, strengthening rural health infrastructure and streamlining digital processes, Bihar can transform this ambitious scheme into a reality for its millions of rural citizens. Only then can the state transition from a status of medical vulnerability to one of sustainable health security.

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