International Journal of Advanced Engineering, Management and Science (IJAEMS)
Peer-Reviewed Journal
ISSN: 2454-1311 | Vol-12, Issue-1; Jan-Feb, 2026
Journal Home Page: https://ijaems.com/
DOI: https://dx.doi.org/10.22161/ijaems.121.3

Health Financing, Privatization and Equity in Haryana's Healthcare System

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Received: 20 Dec 2025; Received in revised form: 18 Jan 2026; Accepted: 23 Jan 2026; Available online: 27 Jan 2026

***Abstract*— *Over the last twenty years, healthcare delivery in Haryana has undergone notable change as a result of health-financing reforms and the expanding role of private providers. Increased government spending, the introduction of publicly funded insurance schemes and reliance on private healthcare institutions have collectively improved the availability of services for large sections of the population. For households covered under insurance programmes, dependence on direct out-of-pocket payments has declined, while access to institutional care has improved. These shifts are reflected in better health infrastructure, a rise in institutional deliveries and gradual improvement in indicators such as infant and maternal mortality. However, these gains have not been uniform. Persistent disparities remain due to unequal spatial distribution of facilities, shortages of healthcare personnel in public institutions, administrative challenges in insurance execution and limited oversight of private providers. The experience of Haryana demonstrates that although publicly financed privatization can widen access to healthcare, achieving equity requires continuous public investment, stronger regulatory mechanisms and focused attention on underserved areas.*

Keywords*— health financing reforms, private sector participation, healthcare equity, public-private partnership.

I. INTRODUCTION

India operates a healthcare system that combines public and private provision, with the private sector accounting for the larger share of healthcare services delivered across the country. Since the 1990s economic liberalization, policies have promoted private investment and public-private partnerships. By 2020, about 62% of hospitals were privately owned and 70-80% of outpatient care was delivered by private providers (Koli, 2024; Alayed et al., 2024). While privatization has expanded service availability and corporate hospital networks, evidence shows risks of cost escalation, exclusion of low-income groups and uneven quality (Duggan et al., 2023; Goodair, 2024). India's total health expenditure was 3.8% of GDP in 2021-22, with out-of-pocket spending still at 39.4%, despite a decline due to insurance expansion. Government health spending remains below 1.5% of GDP, far short of the National Health Policy (2017) target of 2.5% by 2025 and most states have not achieved the 8% budget allocation target. Haryana illustrates this financing structure clearly. Although the state has increased health spending and infrastructure, it relies heavily on private provision. Under PM-JAY, Haryana has empanelled more than 700 private hospitals that provide most inpatient services. Access has improved in urban areas such as Gurugram and Faridabad but rural regions remain underserved. Reliance on private providers also raises issues related to cost regulation, delayed reimbursements and quality control, highlighting the

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equity risks within Haryana's health financing model.

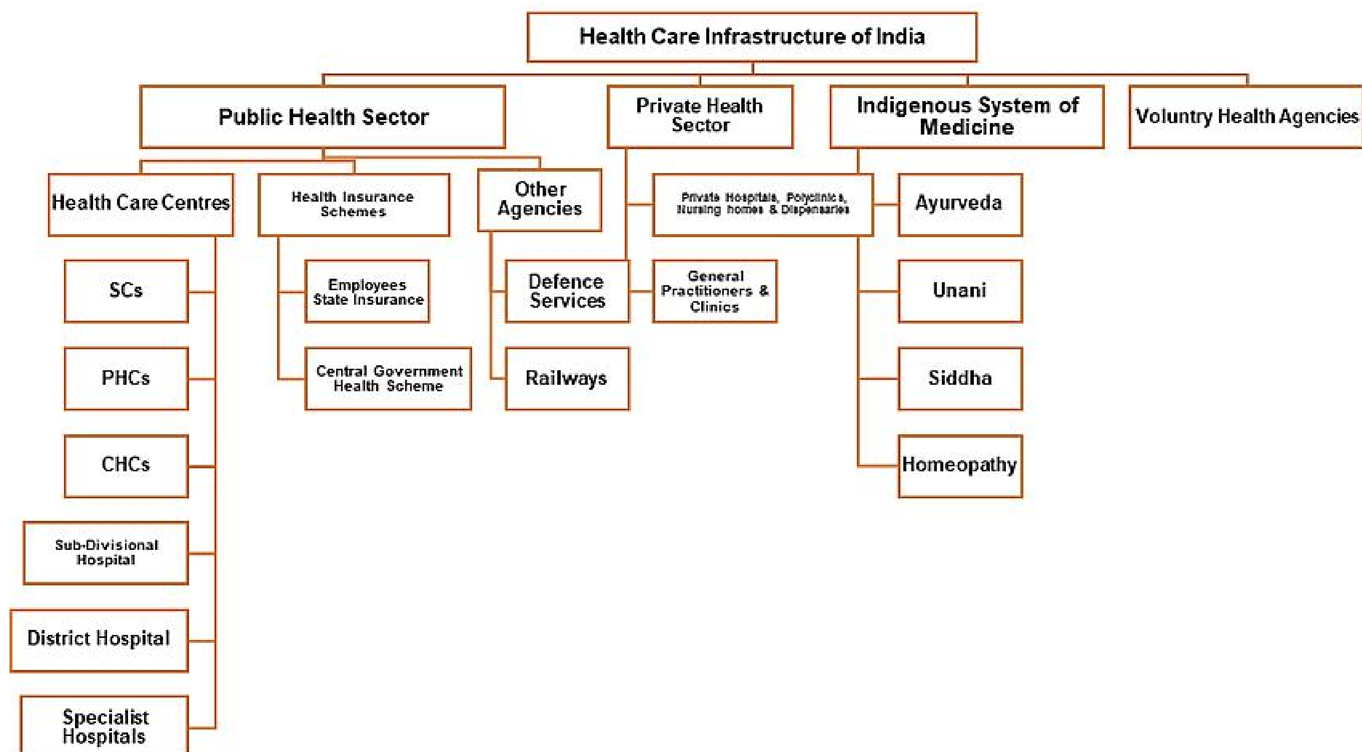

Fig.1: Health Care Infrastructure of India

Source: https://www.researchgate.net/figure/Health-Care-Infrastructure-in-India_fig1_342170461

II. DEFINITIONS AND CONCEPTUAL FRAMEWORK

2.1. Privatization in Healthcare: Privatization involves expanding private roles in healthcare ownership, financing, or service delivery through asset transfer, PPPs, outsourcing, private insurance and corporatization of public hospitals (Braithwaite et al., 2011). In Haryana, it occurs mainly via private hospitals under insurance schemes, outsourced diagnostics and private investment encouraged by national PPP policies.

2.2. Health Financing: Health financing covers revenue collection, risk pooling and purchasing. India follows a mixed model with public budgets, insurance and out-of-pocket spending. Schemes such as RSBY and PM-JAY aim to reduce direct payments. Haryana's system combines state health budgets, NHM transfers and PM-JAY/Chirayu Haryana, largely paying private providers.

2.3. Equity in Healthcare: Equity means need-based access regardless of ability to pay, including horizontal and vertical equity. In Haryana, urban-rural gaps, uneven facility distribution and high out-of-pocket costs among uninsured households persist. Financing and privatization jointly influence equity; without regulation, market-driven care disadvantages poorer groups (Hooda, 2020; Prinja et al., 2017).

III. OBJECTIVES OF THE STUDY

- > To examine health financing and privatization in Haryana's healthcare system.
- > To analyse public health spending and out-of-pocket expenditure trends.
- > To assess the equity implications of private participation in publicly financed healthcare.
- > To evaluate whether privatization improves access or widens healthcare disparities.

IV. RESEARCH METHODOLOGY

This study uses secondary quantitative analysis supported by document-based qualitative interpretation. Year-wise data on Haryana's health expenditure (2000-2024) were collected from state budget documents (revenue and capital heads) to

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compute health spending as a percentage of GSDP and total state expenditure. National Health Accounts data were used to contextualize Haryana, particularly out-of-pocket expenditure trends. Health infrastructure and service delivery indicators were obtained from the Haryana Department of Health and Family Welfare, National Health Mission and National Health Authority. These include the number of health facilities, workforce, PM-JAY beneficiary coverage, hospital admissions and claims. PM-JAY information was drawn from official reports of the National Health Authority and the Haryana Economic Survey. The analysis follows a descriptive and comparative approach, examining temporal trends and contrasts with national averages. Equity was assessed through indicators of service use across urban and rural areas, along with measures of financial protection such as out-of-pocket expenditure and proxy indicators of catastrophic health spending based on NSS and other official sources.

V. SCHEMES, POLICIES & INSTITUTIONAL FRAMEWORK IN HARYANA

Haryana has established an institutional framework that brings private providers into the public health system through state schemes, public-private partnerships and regulatory arrangements. One of the major initiatives is the Comprehensive Cashless Health Facility (CCHF), which provides coverage to government employees, pensioners and their dependents. Under this scheme, eligible beneficiaries can access cashless treatment at empanelled private hospitals. To operationalise this, the state government has issued a "Package Master" which lists fixed rates for more than 1,300 medical procedures, including implant costs. Private hospitals providing services under this scheme must strictly adhere to these standardised rates, ensuring uniformity in pricing and preventing arbitrary overcharging.

Further strengthening the framework, the Department of Health and Family Welfare in Haryana has published detailed empanelment guidelines for private hospitals. As of March 2024, private hospitals can apply for empanelment under the CCHF and other state-run schemes through a structured application and verification process. Empanelled hospitals are listed on the official state health dashboard, which is regularly updated and publicly accessible. These hospitals are allowed to treat scheme beneficiaries for secondary and tertiary-level care on a cashless basis and the treatment costs are reimbursed directly by the government as per the approved package rates. Additionally, Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (PM-JAY) is implemented in the state with active private hospital participation, offering ₹5 lakh of annual coverage per family for hospitalisation. The state has formally defined criteria for hospital empanelment under PM-JAY and the CCHF, which include infrastructure benchmarks, service availability and compliance with national quality standards.

To oversee private hospitals involved in public health programmes, Haryana has implemented the Clinical Establishments (Registration and Regulation) Act, 2018. The Act requires all private health facilities to register and adhere to prescribed minimum standards related to infrastructure, staffing, equipment and record maintenance. Quality oversight is supported through periodic notifications and operational guidelines issued by the Department of Health. Alongside this, the Haryana PPP Policy facilitates private participation in health services through formal contractual arrangements. The policy defines risk-sharing provisions, sets performance benchmarks and provides for regulatory supervision by designated state authorities.

Private providers in Haryana also participate in disease-specific programmes, including those focused on non-communicable diseases, HIV/AIDS and maternal and child health. In such programmes, private laboratories and hospitals are engaged for diagnostic services, specialist care and hospital-based treatment where public facilities are insufficient. These arrangements are managed by the state health department through formal contracts that specify services, payment terms and reporting obligations. However, difficulties persist in maintaining timely reimbursements and enforcing quality standards. Past delays in payments have created friction with private providers, indicating the need for stronger financial management within the system.

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VI. RESULTS AND ANALYSIS

6.1. Health Expenditure Trends in India and Haryana:

Health financing in India has improved but public spending remains limited. Table 1 shows OOPE declined from over 64% of Total Health Expenditure in 2010-11 to 39.4% in 2021-22, reflecting increased risk pooling and public financing. The sharpest decline occurred post-2015, aligning with PM-JAY (2018) and COVID-19-related health spending (2020-21). Lower OOPE indicates better financial protection but at 39.4%, household burden remains high by international standards.

Table 1: Out-of-Pocket Expenditure (OOPE) as % of Total Health Expenditure, India (2010-2022)

Year	OOPE (% of THE) India
2010-11	64.2%
2014-15	62.6%
2016-17	49.9%
2018-19	48.2%
2020-21	44.4%
2021-22	39.4%

Source: National Health Accounts Estimates (2019-2024); Press Information Bureau, 2024.

Table 2: Haryana's Health Expenditure and Budget Share

Year	Health Outlay (₹ crore)	Health as % of State Budget
2002-03 (A)	351.1	3.0%
2010-11 (BE)	1,125.5	2.85%
2015-16 (A)	2,700.0	3.20%
2020-21 (BE)	6,533.8	4.57%
2024-25 (BE)	9,835.4	5.02%

Sources: Government of Haryana Budget Documents (Actuals and Budget Estimates). A = Actual, BE = Budget Estimate.

Haryana's health expenditure increased from under ₹300 crore in 2000-01 to nearly ₹10,000 crore in 2024-25, a more than thirty-fold nominal rise (Figure 1; Table 2). However, health spending remained around 0.5% of GSDP for most of the 2000s, rising only to about 0.7% in 2024-25. The budget share of health increased from 3% in the early 2000s to 5% by the mid-2020s, crossing 4% only after 2016. This remains below the National Health Policy 2017 target of 8% of state budgets, indicating limited fiscal prioritization despite higher absolute spending.

Haryana's rise in health spending accelerated after 2015 due to NHM funding, budget integration of health-related departments (2016-17) and COVID-19 emergency spending post-2020. Health expenditure peaked at 0.9% of GSDP in 2023-24 and 5% of the state budget, the highest to date but below benchmarks: Kerala and Tamil Nadu spend 5-6% and international norms suggest 2-3% of GDP. Per capita health expenditure rose from ₹167 in the early 2000s to ₹2,400 in 2022-23, with a sharp COVID-19 jump (₹1,531 in 2019-20 to ₹1,916 in 2020-21) (Table 3). Higher per capita spending indicates increased resources but does not ensure equity, which depends on allocation across urban-rural services.

Table 3: Per Capita Health Expenditure in Haryana

Year	Per Capita Expenditure on Health (₹)
2000-01	166.8
2010-11	442.1
2015-16	1,082.3
2020-21	1,916.1
2022-23	2,399.4

Source: Department of Health Services, Haryana. Figures are in current rupees.

Increased health spending in Haryana has improved infrastructure and outcomes. District hospitals increased from 7 in 2005, alongside new medical colleges and tertiary centres, including PPP facilities. Ambulance coverage expanded to 364 by 2019 and institutional deliveries reached 92.1% by 2020. Health outcomes improved: IMR declined from 41 (2013) to 28 (2020) and MMR fell from 127 (2011-13) to 110 (2018-20) (Table 4). While these gains reflect better coverage and quality, rural districts continue to record higher IMR than urban areas, indicating persistent

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equity gaps.

6.2. Privatization and Private Sector Involvement:

Privatization in Haryana occurs mainly through publicly funded private provision, not sale of public hospitals. Under Ayushman Bharat-PM-JAY, expanded as Chirayu Haryana (2022), over 700 private hospitals are empanelled. By early 2025, 736 of 1,238 empanelled hospitals were private and they treated 90% of beneficiaries. PM-JAY coverage expanded rapidly: Ayushman cards increased from 0.89 million (2018-19) to 5.37 million (2022-23). Scheme payouts rose from ₹88 crore (2019-20) to ₹252 crore (2022-23), with private hospitals receiving most payments (Table 5). This model has expanded inpatient access, especially tertiary care, for low-income households.

Table 4: Health Outcomes in Haryana - Progress Over Time

Sr. No.	Indicator with source	Year	Year
		2013-14	2023-24
1	Neonatal Mortality Rate (NMR)	26 (SRS 2013)	19 (SRS 2020)
2	Infant Mortality Rate (IMR)	41 (SRS 2013)	28 (SRS 2020)
3	Maternal Mortality Ratio	127 (SRS 2011-13)	110 (SRS 2018-20)
4	First Referral Unit	40 (including 2 urban FRU in Faridabad)	56 (including 2 urban FRU in Faridabad)
5	Under-5 mortality rate	45 (SRS 2013)	33 (SRS 2020)
6	Sex ratio at birth (CRS)	868 (CRS 2013)	910 (upto December, 2024)
7	Institutional delivery (HMIS)	90.37% (2017)	98.3% (Till December, 2024, SourceHMIS)
8	Full Immunization (Source - HMIS)	85.7%	91.7% (2023-24) against GoI Target
9	ASHA	16861 (92.67%)	20354 (97.36%) (upto 31st December,2024)
10	Special New born Care Units (SNCU)	15	28 (2024-25 till date)
11	New Born Stabilizing Units (NBSU)	52	62 (2023-24 till date)
12	New Born Care Corners (NBCC)	192	439 (2023-24 till date)

Sources: Sample Registration System (SRS) Statistical Report; Civil Registration System; National Family Health Survey; Haryana Health Department. *Institutional delivery from HMIS via Economic Survey.

Table 5: Expansion of Ayushman Bharat (PM-JAY) in Haryana and Private Sector Role

Year	Ayushman Cards Issued (lakh)	Persons Treated under PM-JAY	Total Claims Amount Paid (₹ crore)
2018-19	8.92	0.07 lakh (7,000)	₹9.7 crore
2019-20	12.99	0.73 lakh (72,696)	₹88.3 crore
2022-23	53.69 (Chirayu launched)	1.18 lakh (118,130)	₹252.4 crore

Source: Haryana Health Department Records (Ayushman Bharat/Chirayu Haryana data). Note: 1 lakh = 100,000. Figures for 2022-23 are higher due to scheme expansion under *Chirayu Haryana*.

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Beyond PM-JAY, Haryana has expanded privatization through PPP diagnostics and outsourcing. CT scans operate via PPP in 15 district hospitals, MRI services in 4 hospitals and dialysis centres in several civil hospitals. The 108 ambulance service is privately operated under contract. These models improved service availability but raised cost and sustainability concerns. The private sector dominates the health workforce, especially in urban areas. In 2022-23, only 13,579 staff were in position against 18,586 sanctioned posts, leaving 27% vacancies, worst in rural areas. Nearly one-third of Primary Health Centres operate without a full-time doctor, which forces many rural residents to depend on expensive private healthcare services.

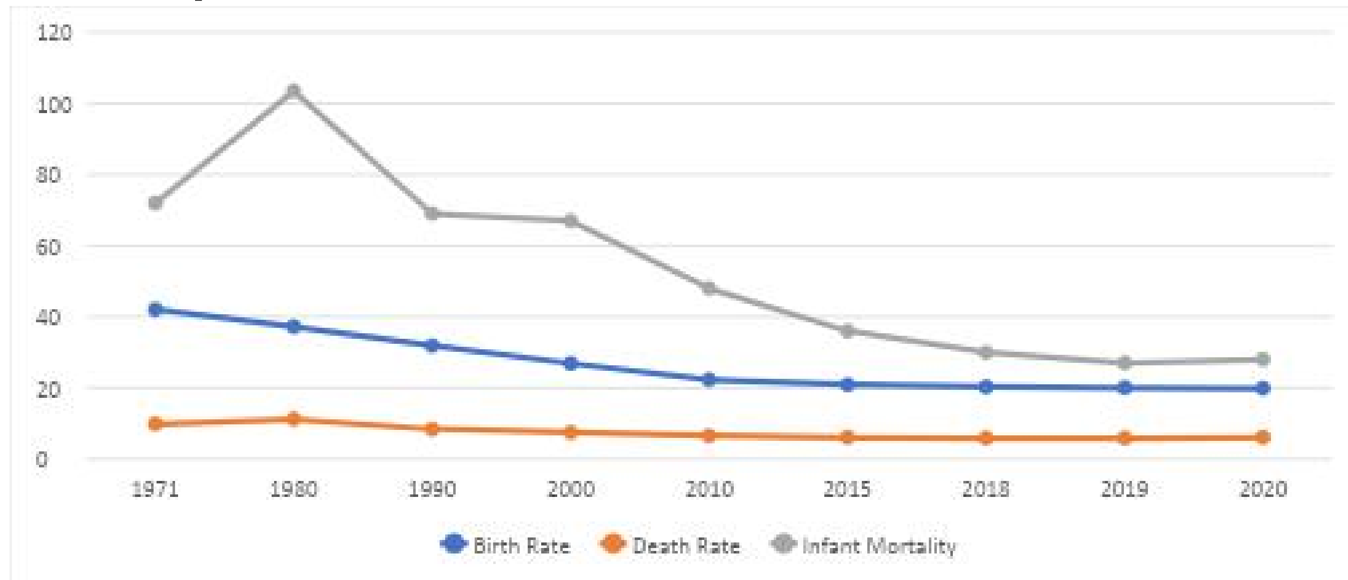

Fig.2 : Health Indicators - Vital and Demographic Statistics of Haryana

Source: Compiled from Haryana Government Health Department Records

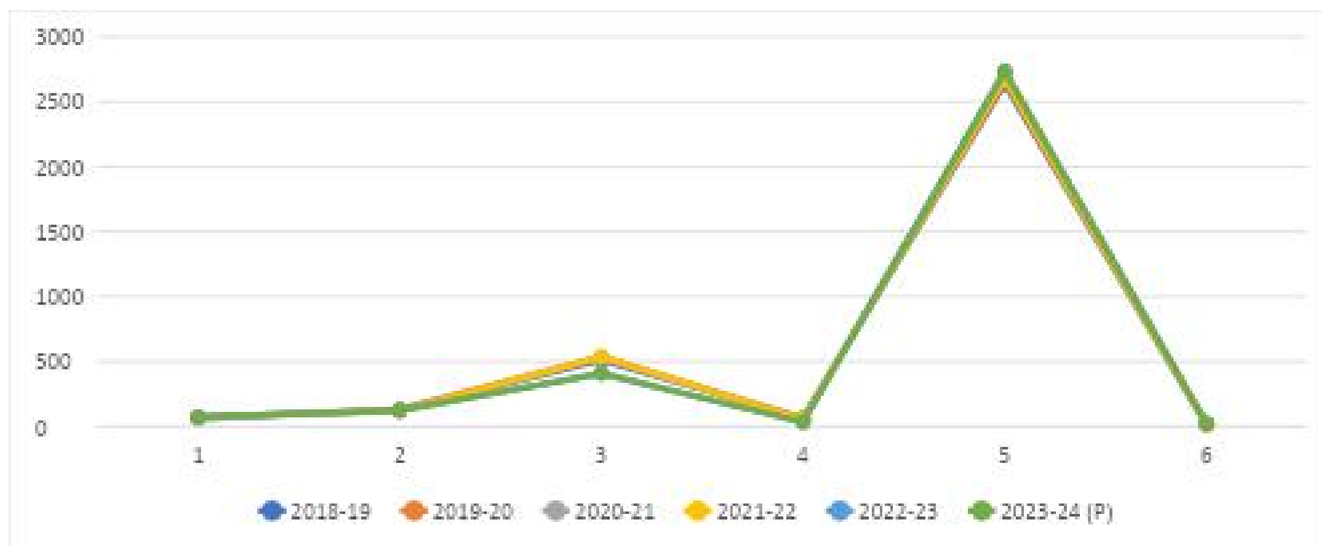

Fig.3: Expansion of Health Infrastructure in Haryana - Medical Institutions and Facilities

Source : Compiled from Department of Health Services, Haryana., PHCs : Primary Health Centres., CHCs : Community Health Centres, P : Provisional, # : District-wise information of T.B., Centres/Clinics is not available, - : Information included in district Bhiwani

Equity effects are mixed. PM-JAY increased inpatient access for insured poor households; uninsured patients paid nearly three times more out-of-pocket for similar hospitalizations than insured ones.

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However, governance failures persist: by mid-2025, private hospitals reported >₹500 crore in unpaid PM-JAY dues, with 650 hospitals threatening service withdrawal, directly affecting poor beneficiaries. Private facilities are geographically concentrated in Gurugram and Faridabad, while districts such as Nuh, Mahendragarh and Sirsa remain underserved. Weak enforcement of the Clinical Establishments Act has allowed pricing abuses and quality gaps, disproportionately harming low-income and rural patients.

Table 6: Chirayu Haryana Pardhan Mantri Jan Arogya Yojana Beneficiaries and Funds Released in Haryana (Rural and Urban)

District/Year	No. of Ayushman Cards Issued (Rural)	No. of Persons Benefitted (Rural)	Amount Released to Hospitals (₹) (Rural)	No. of Ayushman Cards Issued (Urban)	No. of Persons Benefitted (Urban)	Amount Released to Hospitals (₹) (Urban)	Total Ayushman Cards Issued	Total Persons Benefitted	Total Amount Released to Hospitals (₹)
2018-19	563546	4756	66879623	328769	2244	29869753	892315	7000	96749376
2019-20	1009174	48287	600716327	289393	24409	282670326	1298567	72696	883386653
2020-21	241244	69691	801399161	96159	38867	36107178	337403	108558	1162476339
2021-22	200467	57315	1118094576	101444	23393	539464743	301911	80708	1657559319
2022-23	4066380	84417	1725442072	1303360	33713	799079209	5369740	118130	2524521281
2023-24 (P)	2445801	41934	1003117934	844697	14487	321540984	3290498	56421	1324658918

Source: Compiled from Ayushman Bharat - Haryana Health Protection Authority Note : The Scheme has been modified and renamed as Chirayu Haryana Pardhan Mantri Jan Arogya Yojana during the year 2022-23

6.3. Discussion of Findings:

Haryana reflects India's mixed experience with health privatization. Higher public financing is strongly associated with improved outcomes: rising health expenditure (Tables 2-3) coincided with lower IMR and MMR and wider service coverage (Table 4). The decline in out-of-pocket spending and PM-JAY coverage show that public financing whether through public or private delivery reduces financial barriers, supporting equity theory and prior evidence (Prinja et al., 2017). Privatized delivery under PM-JAY enabled rapid scale-up using private capacity (>5 million cards; 90% care by private hospitals, Table 5), improving tertiary access in the short term (Cutler, 2002; Day, 1994). However, governance risks are clear: payment delays (₹500+ crore arrears; 650 hospitals threatening withdrawal in 2025) exposed equity vulnerabilities, as poor beneficiaries face service denial when private providers exit.

Urban-rural disparities in healthcare access continue to persist in Haryana. Private health facilities are heavily concentrated in the Gurugram-Faridabad belt, whereas districts such as Nuh, Mahendragarh and Sirsa remain poorly served. Shortages of medical personnel—reflected in vacancy levels of around 27 percent and the absence of full-time doctors in nearly one-third of Primary Health Centres—compel rural populations to rely on expensive private services, indicating market failure in the provision of essential care (Hooda, 2020). Although public-private partnerships have generated efficiency gains in areas such as diagnostics and insurance-based service purchasing, these benefits are offset by equity concerns when regulatory enforcement is weak. Inadequate implementation of the Clinical Establishments Act has allowed price irregularities and uneven service quality, with disproportionate adverse effects on low-income groups. Evidence suggests that outcomes are closely tied to the strength of public stewardship: effective oversight has improved access, while regulatory lapses have deepened inequities (Braithwaite et al., 2011). In comparison, states with stronger public health systems and stricter regulation, such as Kerala and Tamil Nadu, demonstrate better equity outcomes through higher public spending and tighter

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governance. The Haryana experience underscores the need for a rebalanced approach that sustains public financing, strengthens rural public health infrastructure, enforces regulation rigorously and engages private providers selectively under robust contractual controls to safeguard equity.

VII. POLICY RECOMMENDATIONS

Haryana's experience indicates that expanded public financing alongside private service delivery can improve coverage and health outcomes but equity benefits remain uneven. Higher spending, insurance expansion and private participation have strengthened financial protection and key indicators, yet persistent urban-rural disparities, staff shortages, governance weaknesses and limited regulatory enforcement continue to restrict equitable access. While privatization enhances service availability, inadequate public stewardship risks deepening existing inequalities.

7.1. Policy Directions:

- Increase public health expenditure beyond the present 5 percent of the state budget and 0.7 percent of GSDP, with priority to primary healthcare and rural infrastructure.
- Upgrade public facilities in underserved districts by addressing staff shortages, expanding diagnostic capacity and offering incentives for rural postings.
- Strengthen regulation of private providers through effective enforcement of the Clinical Establishments Act, price transparency and regular quality audits.
- Improve the functioning of PM-JAY/Chirayu Haryana by ensuring timely reimbursements, controlling costs and increasing the role of public hospitals.
- Structure public-private partnerships with clear equity requirements, including mandatory service provision in rural areas.
- Enhance health information systems through district-level and rural-urban data tracking to support targeted policy action.

VIII. CONCLUSION

Haryana's experience confirms that public financing is the primary force behind improvements in health outcomes, even within a system where service delivery is largely privatized. Increased public spending, expansion of insurance coverage under PM-JAY/Chirayu Haryana and continued NHM support have contributed to lower infant and maternal mortality, higher institutional deliveries and wider service reach. Publicly funded insurance has reduced financial barriers for insured households and limited exposure to catastrophic health expenditure. At the same time, equity outcomes remain uneven. Heavy reliance on private providers has created governance challenges, including reimbursement delays, inconsistent quality oversight and concentration of services in urban areas. Persistent shortages of health personnel in rural areas, gaps in public facilities and weak enforcement of regulatory standards continue to disadvantage poorer and rural populations. The evidence makes clear that privatization alone does not guarantee equitable access. Its impact depends on the strength of public stewardship. In Haryana, achieving equity requires sustained public investment, stronger rural public health capacity, effective regulation of private providers and reliable financing of insurance schemes. Without these conditions, efficiency gains from privatization risk coexisting with widening health disparities.

REFERENCES

[1] Alayed, T. M., Alrumeh, A. S., Alkanhal, I. A., & Alhuthil, R. T. (2024). *Impact of Privatization on Healthcare System: A Systematic Review*. Saudi Journal of Medicine & Medical Sciences, 12(2), 125-133.

[2] Braithwaite, J., Travaglia, J., & Corbett, A. (2011). *Can questions of privatization and corporatization be addressed through legislation? An Australian perspective on health reforms*. Health Sociology Review, 20(3), 306-319.

[3] Duggan, M., Gupta, A., Jackson, E. J., & Templeton, Z. S. (2023). *The Impact of Privatization: Evidence from the Hospital Sector*. NBER Working Paper No. 30824.

[4] Goodair, B. (2024). *The effect of health-care privatisation on the quality of care*. The Lancet Public Health, 9(1), e6-e7.

[5] Government of Haryana. (2001-2025). *Budget at a Glance* (Annual Budget Documents). Chandigarh: Department of Finance.

[6] Hooda, S. (2020). *Determinants of Public Expenditure on Health in India: A Panel Data Analysis*. Journal of Health Management, 22(2), 151-169.

[7] Khetrapal, S. (2019). *Private sector engagement for public*

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health objectives: The case of Ayushman Bharat in India. WHO South-East Asia Journal of Public Health, 8(2), 67-72.

[8] Koli, K. (2024). *The rise of privatization in the health sector: Exploring the relationship between private health care and the upper class*. *EPRA International Journal of Research and Development, 9*(7), 191-205. https://doi.org/10.36713/epra2016

[9] Ministry of Health and Family Welfare [MoHFW]. (2017). *National Health Policy 2017*. New Delhi: Government of India.

[10] Ministry of Health and Family Welfare [MoHFW]. (2019-2024). *National Health Accounts Estimates for India (2010-11 to 2020-21)*. New Delhi: Government of India.

[11] Ministry of Statistics and Programme Implementation [MoSPI]. (2019). *Key Indicators of Social Consumption in India: Health* (NSS 75th Round). New Delhi: Government of India.

[12] National Health Authority [NHA]. (2024). *Annual Report on Ayushman Bharat - PM-JAY Implementation 2023-24*. New Delhi: Government of India.

[13] NITI Aayog. (2022). *Public-Private Partnerships for Health Sector Reform in India*. New Delhi: NITI Aayog.

[14] Press Information Bureau [PIB]. (2019, July 23). *Comparative Study on Healthcare Spending* (Press Release ID: 1579861).

[15] Press Information Bureau [PIB]. (2024, April 25). *Out-of-Pocket Expenditure on Health Declines to 39.4 Percent of Total Health Expenditure in 2021-22*. Press Release.

[16] Prinja, S., Bahuguna, P., Tripathy, J. P., Kumar, R., & Kaur, M. (2017). *Availability of health insurance and its implications for out-of-pocket expenditures in India*. PLOS ONE, 12(2), e0170996.

[17] Venkatraman, A., & Lahariya, C. (2024). *Governance Framework and Public-Private Partnership for Universal Health Coverage: Findings from India's Federal Health Structure*. Journal of Medical Evidence, 5(3), 205-214.

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