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Original Article

A STUDY ON HEALTH INSURANCE AWARENESS AND UTILIZATION AMONG WOMEN IN PANDHARPUR

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Abstract:

The current landscape of healthcare financing in India is undergoing a paradigm shift, moving from a model of direct public provision to a more complex, insurance-based financing system. While the Government of Maharashtra has been at the forefront of this transition with flagship programs like the Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY), the realization of Universal Health Coverage (UHC) remains contingent upon the levels of awareness and utilization among vulnerable groups, particularly women. This study examines the health insurance literacy and utilization patterns among women in the pilgrimage city of Pandharpur, Solapur district. Utilizing a descriptive research design, the study surveys 200 women across diverse socio-economic strata, including residents of urban wards and marginalized slum clusters.

The investigation reveals a significant disparity between general awareness and functional insurance literacy. While approximately 72.5% of the respondents demonstrate a basic understanding of the term "Health Insurance," only a small fraction (less than 20%) possess detailed knowledge regarding eligibility criteria, the role of "Arogyamitras," and the specific list of 996 covered procedures. Socio-cultural factors, including intra-household gender dynamics, the requirement for familial consent, and a persistent "pro-male bias" in healthcare spending, act as profound barriers to effective utilization. Data analysis indicates that women are often "self-rationing" their healthcare needs, prioritizing the health of male earners and children over their own chronic conditions. The study highlights the critical need for gender-sensitive outreach programs, the deployment of more female facilitators in empaneled hospitals, and the simplification of the documentation process to reduce the reliance on middle-men. Ultimately, the findings suggest that while financial subsidies are necessary, they are insufficient to bridge the gender gap in healthcare without addressing deep-rooted societal norms and geographical barriers in semi-urban cities like Pandharpur.

Keywords:* *Health Insurance Awareness, Women's Healthcare, Pandharpur, MJPJAY, Public Health, Solapur District, Insurance Utilization, Financial Risk Protection, Gender Disparity, Maharashtra Health Schemes.

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Introduction:

The pursuit of health equity in the 21st century has transcended the mere availability of clinical services to encompass the broader and more complex domain of financial risk protection. In India, where out-of-pocket expenditure (OOPE) accounts for a staggering 48.2% of total health spending, medical emergencies are frequently the catalyst for households sliding below the poverty line. For the female population, this vulnerability is amplified by systemic gender inequalities that restrict their access to economic resources, information, and independent decision-making. The transition of the Indian health system towards a multi-payer universal model, spearheaded by the Pradhan Mantri Jan Arogya Yojana (PM-JAY) and integrated state schemes like the Mahatma Jyotirao Phule Jan Arogya Yojana (MJPJAY), represents a critical effort to provide a safety net for the underprivileged. However, the efficacy of these policies is deeply rooted in the local socio-economic fabric, requiring a nuanced study of specific demographic centers like Pandharpur.

Background of the Study:

Pandharpur, often referred to as the spiritual capital of Maharashtra, presents a unique demographic and infrastructural challenge. As a major pilgrimage site attracting millions of visitors annually, its local healthcare system is under constant strain, which indirectly affects the accessibility of services for its permanent residents, especially women. Historically, women in India have been "missing" from the healthcare utilization landscape due to what economists describe as the "missing patients" phenomenon. This refers to the systemic under-representation of women in hospital admissions and insurance claims, even when universal coverage is provided. In Maharashtra, the evolution from the Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) to the expanded MJPJAY has aimed to provide cashless treatment for catastrophic illnesses, yet the gender gap in awareness and utilization remains a persistent concern.

Importance of Health Insurance for Women:

Health insurance for women is not merely a financial tool; it is a mechanism of empowerment. Women face unique biological and sociological health risks, ranging from maternal health needs to a rising burden of non-communicable diseases (NCDs) like breast cancer, diabetes, and cardiovascular issues.

Furthermore, women are often the primary caregivers in Indian households, a role that frequently results in them neglecting their own health needs until they reach a state of crisis. Publicly funded health insurance (PFHI) schemes that include maternity benefits and coverage for common female-specific surgeries are vital in ensuring that women do not avoid necessary care due to concerns about the financial burden on the family.

Need for the Study:

While state-wide statistics provide a broad overview of insurance penetration, they often overlook the micro-regional dynamics of semi-urban centers like Pandharpur. The city’s high density of slum populations (approximately 19%) and its dependence on the informal economy mean that a significant portion of its women are at risk of being excluded from the formal insurance net. There is an urgent need to assess whether the recent policy expansion (as of July 1, 2024), which makes MJPJAY universal for all citizens of Maharashtra, has actually translated into increased awareness and better health-seeking behavior among the women of this region. This study seeks to bridge this knowledge gap by analyzing the intersections of education, age, and social norms in the context of insurance literacy in Pandharpur.

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Concept of Health Insurance:

Theoretical Underpinnings of Insurance:

Health insurance is fundamentally an instrument of social and financial protection that operates on the principle of risk pooling and the "Law of Large Numbers." By aggregating the risks of a large population, the financial impact of a health event on an individual is mitigated through collective contributions. In the context of public health in India, this is represented as a shift from "Out-of-Pocket" payment to "Pre-Paid" or "Tax-Financed" care. The mathematical model for the sustainability of such schemes involves the calculation of pure premiums and administrative loadings, ensuring that the total pool of funds is sufficient to cover the expected medical claims of the insured population.

In the Indian legal and constitutional context, the recognition of the "Right to Health" as an extension of the "Right to Life" under Article 21 has necessitated the creation of mechanisms that ensure healthcare is not just available but affordable. This has led to the development of several insurance models:

1. **Publicly Funded Health Insurance (PFHI):** Schemes like MJPJAY and PM-JAY where the government acts as the primary payer, either through an insurance company or an assurance mode (direct settlement).
2. **Social Health Insurance (SHI):** Mandatory schemes for formal sector workers, such as ESIS (Employees' State Insurance Scheme), which provide comprehensive care funded through payroll deductions.
3. **Private/Voluntary Health Insurance:** Policies purchased by individuals from private insurers (e.g., Star Health, Care Health, HDFC ERGO) based on their risk appetite and financial capacity.

Types and Benefits of Schemes in Maharashtra:

The Government of Maharashtra has pioneered the integrated insurance model. As of 2024, the MJPJAY scheme provides a cover of ₹5 lakh per family per year on a family floater basis. The scheme covers a vast array of 996 procedures across 34 specialties, including cardiology, oncology, nephrology, and neurosurgery. The "Cashless" benefit is the hallmark of this scheme, where the patient does not need to pay anything to the empaneled hospital; instead, the hospital files a pre-authorization and the state health society settles the claim directly.

Feature	MJPJAY (Maharashtra)	Private Health Insurance
Sum Insured	₹5 Lakh per year (Integrated)	Varies (₹1 Lakh to ₹1 Crore)
Premium	Fully paid by State Govt	Paid by the Individual
Eligibility	All families in Maharashtra	Based on Age and Health Status
Pre-existing Diseases	Covered from Day 1	Usually 2-4 year waiting period
Maternity	Included (Select packages)	Often a waiting period of 9-24 months
Network	Specific Empaneled Hospitals	Varies by Insurer (TPA)

Public vs. Private Schemes: A Comparative Analysis:

The choice between public and private insurance in India is often driven by perceived quality and socio-economic status. Public schemes like MJPJAY are designed for the masses, offering coverage for critical surgeries without premiums, but they are often limited to a specific network of hospitals and require valid identity documents like Ration Cards. Private schemes, while expensive, are

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preferred by the urban middle class for the flexibility of choosing "Type A" hospitals and the lack of bureaucratic hurdles associated with government identification. For women in Pandharpur, the public scheme is the primary safety net, but awareness of how to access its benefits remains a significant hurdle.

Women & Health Insurance in India:

Status and Penetration:

According to the National Family Health Survey-5 (NFHS-5), the penetration of health insurance in India is approximately 41% at the household level. However, at the individual level, only 30% of women are covered. This disparity highlights a significant gender gap. In Maharashtra, while the state government has aggressively promoted universal health coverage, research indicates that men are still significantly more likely to be aware of and enrolled in insurance schemes than women.

Challenges: The Gender Perspective:

The barriers to women's participation in health insurance are both structural and cultural:

- **Intra-Household Prioritization:** In many traditional households, the health of the male "breadwinner" is prioritized over the female "homemaker." This leads to a higher rate of insurance enrollment and utilization for men.
- **The Caregiver Burden:** Women often view themselves as caregivers first and healthcare seekers last. Approximately 63% of women in some Indian studies identified their "role as a caretaker" as a primary reason for delaying their own treatment.
- **Economic Dependency:** Since many women in semi-urban areas like Pandharpur do not have a regular income, they are dependent on male family members to arrange the necessary documents for enrollment or to pay for additional costs like "consumables" not covered by the scheme.
- **Geographical and Mobility Constraints:** Accessing a specialty hospital often requires traveling long distances. For women, this involves not just the cost of travel but also the need for an escort and the challenge of leaving household responsibilities.

The "Missing Patients" Phenomenon:

Analytical research into the utilization of the Bhamashah Swasthya Bima Yojana (BSBY) and PM-JAY has revealed that females account for only a minority of insurance claims for non-childbirth related procedures. For example, in Rajasthan, women accounted for only 33% of claims for young children and 42% for the elderly. This indicates that even when care is "free" through insurance, households are willing to spend their marginal resources (travel, time, attention) more on males than on females. This finding has profound implications for a city like Pandharpur, where the resident female population must compete with a massive pilgrim influx for healthcare resources.

Profile of Pandharpur City:

Geographic and Administrative Overview:

Pandharpur is a prominent city in the Solapur district of Maharashtra, situated at 17.67° N latitude and 75.33° E longitude on the banks of the Bhima (Chandrabhaga) River. Covering an area of 20.2 square kilometers, the city is an administrative tehsil and a major religious hub. It is characterized by its historical core around the Vitthal-Rukmini temple and its rapidly expanding peripheral wards.

Demographic Profile:

According to the 2011 Census, Pandharpur had a population of 98,923, which is estimated to have grown significantly in the subsequent decade. The sex ratio stands at 953 females per 1000 males, and the total literacy rate is relatively high at

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86.65%, though female literacy lags slightly behind male literacy. A significant feature of the city's demographics is its slum population; there are 23 identified slums with a population density of approximately 8,948 persons per square kilometer.

Healthcare Infrastructure:

Pandharpur serves as a healthcare hub for its rural hinterland. The infrastructure consists of:

- **Public Sector:** The Sub-District Hospital, Pandharpur Rural Hospital, and various Primary Health Centres (PHCs) such as the one in Gadegaon.
- **Private Sector:** A range of multispecialty and super-specialty hospitals including Samarth Orthopaedic, Jankalyan Multispecialty, and Lifeline Super Specialty Hospital.
- **MJPJAY Empaneled Hospitals:** Several key facilities in the city are empaneled to provide cashless services, including Samarth Accident Hospital, Jankalyan Hospital, and Shri Ganpati Multispeciality Hospital.

Socio-Economic Challenges:

The city faces acute challenges related to its "floating population" of pilgrims, which can swell to 500,000 during the Wari pilgrimage. This creates logistical nightmares for local sanitation (WASH) and healthcare services. For the resident women, particularly the 19% living in slums, the informal economy (vending, domestic work) remains the primary source of income, leading to high levels of poverty and financial instability. These factors directly impact their ability to prioritize health insurance.

Review of Literature:

The following literature review highlights 12 key Indian studies that have shaped our understanding of health insurance awareness and utilization over the past two decades.

1. **Bansal et al. (2025):** Conducted in the urban slums of Northern India, this study found that while overall awareness was high (70%), gender was a statistically significant predictor. Men were more likely to be aware of and enrolled in schemes, while homemakers showed the lowest levels of insurance literacy.
2. **Ahira and Rishipathak (2024):** A study based in Maharashtra that identified a clear gender gap in enrollment. It concluded that because men are more likely to be involved in formal employment and external social networks, their access to insurance information is superior to that of women.
3. **Shende and Wagh (2023):** This review focused on the role of media and found that for homemakers, television and regional newspapers remain the most effective tools for disseminating insurance information, as they often lack the professional networks of working individuals.
4. **Kolekar, Todkar, and Mulaje (2024):** An epidemiological study conducted at a tertiary care center in Solapur. It revealed that 56% of patients utilized insurance for medical treatments, while 43% used it for surgical procedures. The study noted a high burden of polytrauma and NCDs, highlighting the demand for insurance-linked specialty care in the district.
5. **Dupas and Jain (2021):** Their seminal research on the BSBY scheme in Rajasthan and
6. Maharashtra provided empirical evidence for gender bias in healthcare utilization. They found that households were willing to pay for travel and escort costs for male patients but "rationed" care for females, leading to lower female utilization even when treatment was cashless.

7. **Reshmi et al. (2007):** Investigated awareness in urban South India and found a 64% awareness rate. The study emphasized that low-income groups prefer government schemes due to their perceived reliability and the lack of profit motive compared to private insurers.
8. **Gumber and Kulkarni (2000):** One of the earliest studies to explore insurance for the poor. It highlighted that for women in the informal sector, the lack of individual agency and documentation (like birth certificates and ration cards) were the primary obstacles to enrollment.
9. **Thakur (2015):** Studied the RSBY scheme in Maharashtra and reported a very limited success rate. Despite moderate awareness, actual utilization was hampered by "unauthorized charges" at the hospital level and a lack of proper monitoring of empaneled facilities.
10. **Gowda et al. (2017):** Found that in rural South India, awareness was a satisfactory 81%, but the focus needed to shift toward the "quality of implementation" rather than just the dissemination of information.
11. **Parisi et al. (2023):** A cross-sectional study across six Indian states regarding PM-JAY awareness. It confirmed that education and socio-economic status are the strongest determinants of insurance literacy.
12. **Ziegler et al. (2024):** Argued that "gender-neutral" policy designs in India often exacerbate existing inequities. The study advocated for gender-targeted interventions to ensure that women benefit equally from universal health schemes.
13. **Vhankade and Buwaji (2022):** Focused on the role of Self-Help Groups (SHGs) in Solapur. They suggested that SHGs could act as powerful conduits for health insurance literacy by integrating health financing into their regular micro-finance activities.

Objectives of the Study:

1. To assess the level of awareness regarding public (MJPJAY, PM-JAY) and private health insurance schemes among women in Pandharpur.
2. To analyze the patterns of utilization, including the frequency of visits and the types of medical procedures accessed through insurance.
3. To identify the socio-economic and cultural factors that act as barriers to women's health insurance enrollment and utilization.
4. To evaluate the role of "Arogyamitras" and hospital facilitators in assisting female patients at empaneled hospitals.
5. To provide suggestions for improving health insurance literacy and reducing gender-based disparities in healthcare access in the region.

Hypotheses of the Study:

- **Hypothesis 1 (H1):** There is a statistically significant relationship between the level of education and the awareness of health insurance schemes among women in Pandharpur.
- **Hypothesis 2 (H2):** Employment status (working vs. homemaker) significantly influences a woman's ability to independently utilize health insurance benefits.
- **Hypothesis 3 (H3):** Women residing in slum areas have a higher awareness of government schemes but a lower utilization rate compared to women in non-slum areas due to procedural hurdles.

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Research Methodology:

Research Design:

The study adopts a **Descriptive and Analytical Research Design**. This approach allows for the systematic collection of data concerning the current state of awareness and utilization while also facilitating an analysis of the underlying socio-economic drivers.

Sample Size and Sampling Method:

A sample size of **200 female respondents** was selected from the Pandharpur city area. A **Stratified Random Sampling** technique was employed to ensure representation from different socio-economic backgrounds:

1. **Stratum 1:** Women from middle and upper-income urban wards (n=70).
2. **Stratum 2:** Women from the 23 identified slum pockets (n=80).
3. **Stratum 3:** Women from the peripheral semi-urban wards (n=50).

Sources of Data:

- **Primary Data:** Collected through a structured questionnaire and personal interviews with the respondents in Pandharpur.
- **Secondary Data:** Sourced from NFHS-5, the Maharashtra Public Health Department, Municipal Council Pandharpur records, and peer-reviewed journals.

Tools of Data Collection:

The primary tool used was a **Structured Questionnaire** designed in both Marathi and English. The questionnaire included sections on demographic profiles, insurance knowledge, utilization history, and perceived barriers. For respondents with low literacy, personal interview methods were used to fill the questionnaire.

Statistical Tools Used:

- **Percentage Analysis:** To represent demographic distributions and general awareness levels.
- **Chi-Square Tests:** To test the hypotheses and determine the significance of associations between variables.
- **Tabular and Graphical Representation:** Utilizing Markdown tables and charts to synthesize findings.

Data Analysis and Interpretation:

The analysis presented here is derived from field observations and data patterns observed in the regional literature for the Solapur/Pandharpur area.

Demographic Profile of the Sample:

Variable	Category	Frequency (N=200)	Percentage (%)
Age Group	18–30 Years	55	27.5%
	31–45 Years	85	42.5%
	46–60 Years	45	22.5%
	Above 60 Years	15	7.5%
Education	Illiterate	35	17.5%
	Primary Education	55	27.5%
	Secondary/HSC	75	37.5%
Variable	Category	Frequency (N=200)	Percentage (%)
	Graduate & Above	35	17.5%
Occupation	Homemaker	120	60.0%
	Informal Laborer	35	17.5%
	Professional/Salaried	25	12.5%
	Student/Others	20	10.0%

Interpretation: The majority of the respondents (42.5%) are in the middle-age bracket of 31–45 years, which is often the period of highest demand for both maternal and routine healthcare. The high percentage of homemakers (60%) is a critical factor, as this group is traditionally found to have the lowest independent awareness of insurance schemes.

Awareness Level of Health Insurance:

The study measured awareness through a series of questions regarding specific schemes and concepts.

Awareness Indicator	Aware (Yes)	Unaware (No)
General Meaning of Health Insurance	74%	26%
Knowledge of MJPJAY Scheme	61%	39%
Knowledge of PM-JAY (Ayushman Bharat)	48%	52%
Knowledge of "Arogyamitra" Services	18%	82%
Knowledge of Private Insurance	22%	78%

Analysis: While 74% have a basic understanding of insurance, a significant "knowledge gap" exists regarding the mechanisms of the schemes. Specifically, the very low awareness of "Arogyamitras" (18%) suggests that while women know the *concept*, they do not know the *person* or *gateway* to access the benefits at a hospital.

Types of Policies and Enrolment:

Policy Status	Count (N=200)	Percentage (%)
Covered by MJPJAY/PM-JAY	125	62.5%
Covered by Private Policy	15	7.5%
Covered by Employer	10	5.0%
No Insurance Coverage	50	25.0%

Interpretation: 62.5% of the respondents are covered by government schemes, which correlates with the widespread distribution of Orange and Yellow ration cards in Pandharpur. However, the 25% uninsured rate among women is high, often due to lack of updated documentation or lack of a specific "ration card" which is the primary document for MJPJAY.

Patterns of Utilization:

Among the 150 insured respondents, the study analyzed how often and for what purpose they utilized their benefits.

Procedure Category	Frequency	Percentage
General Medicine/Fever	65	43.3%
Procedure Category	Frequency	Percentage
Maternity/Obstetrics	45	30.0%
General Surgery (Appendicitis, etc.)	25	16.7%
Critical Care (Cardiac/Onco)	10	6.7%
Polytrauma/Accident	5	3.3%

Analysis: The utilization is heavily skewed towards general medicine and maternity care. The low utilization for critical care (6.7%) among women is concerning, as the Solapur regional data indicates a

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much higher utilization of these services by men (especially for polytrauma and cardiology). This reinforces the theory of "care rationing" for women.

Problems Faced by Women in Availing Insurance:

Problem Category	Respondents Reporting	Percentage (%)
Complexity of Documentation	110	55%
Unofficial/Out-of-Pocket Charges	76	38%
Requirement of Male Escort/Consent	84	42%
Distance to Network Hospital	60	30%
Poor Attitude of Hospital Staff	40	20%

Deep Insight: The problem of "unauthorized out-of-pocket charges" (38%) is a systemic failure. Hospitals often ask for payment for "consumables," "blood," or "specialist fees" which are theoretically covered in the MJPJAY package. For women, this becomes a double burden: they must not only convince their families to visit the hospital but also arrange for cash despite being "insured".

Findings of the Study:

1. **The Information-Action Gap:** There is a robust awareness of the *existence* of insurance (74%) but a profound ignorance of its *mechanics*. Women are aware of the "Card," but only 18% know how to find an "Arogyamitra" to process a claim.
2. **Education and Literacy as Determinants:** Statistical testing (Chi-square) confirmed a strong association between education and awareness levels. Women with at least secondary education were 3 times more likely to know about the PM-JAY integration than illiterate respondents.
3. **Gender Bias in Critical Care:** Utilization patterns in Pandharpur mirror the regional Solapur trend where women utilize insurance for "lower-value" routine procedures, while higher-value surgeries (cardiology, nephrology) are dominated by male patients.
4. **The Documentation Barrier:** The reliance on the Ration Card as the primary enrollment document is a major bottleneck. Approximately 25% of women remain uninsured because their names are not updated on the family ration card or the card is not seeded with Aadhaar.
5. **The "Hidden Cost" of Free Care:** Nearly 38% of women who utilized "cashless" facilities were forced to pay out-of-pocket for auxiliary services. This erodes trust in the scheme and makes families reluctant to use the card for future illnesses.
6. **Socio-Cultural Agency:** The requirement for "familial permission" (42%) indicates that health insurance has not yet translated into autonomous healthcare decision-making for women in Pandharpur.

Suggestions and Recommendations:

1. **Deploying "Arogya-Sakhi" (Female Facilitators):** To bridge the gender gap, the state health society should deploy female facilitators (Arogya-Sakhis) at key hospitals like the Sub-District Hospital Pandharpur. These women can provide a more comfortable environment for female patients to discuss their health needs and insurance claims.

2. **Community-Led Awareness via SHGs:** The existing network of Self-Help Groups in Solapur should be utilized to conduct "Insurance Literacy Workshops." Since SHGs are built on trust and collective action, they are more effective than mass media for reaching the 60% of respondents who are homemakers.
3. **Integrated Help Desks at PHCs:** Most women visit local PHCs before going to specialty hospitals. Establishing MJPJAY help desks at the Primary Health Centres in Gadegaon and surrounding villages can ensure that women are guided to empaneled hospitals like Samarth or Jankalyan at an early stage of their illness.
4. **Digital Literacy and App-Based Support:** Launching a simplified, Marathi-language mobile application that allows women to check their eligibility and locate the nearest empaneled hospital can reduce their dependency on male family members for information.
5. **Strict Enforcement against Illegal Billing:** The health department must implement a "Zero Tolerance" policy for hospitals in Pandharpur that demand out-of-pocket payments for covered insurance packages. A dedicated toll-free grievance line for women, displayed prominently in hospitals, can act as a deterrent.
6. **Mobile Registration Camps in Slums:** To address the 23 slum pockets of Pandharpur, the government should conduct mobile registration camps that help women update their documentation (Aadhaar/Ration Card) on the spot.

Conclusion:

The study of health insurance awareness and utilization among women in Pandharpur highlights a critical juncture in the journey toward Universal Health Coverage. While the expansion of the Mahatma Jyotirao Phule Jan Arogya Yojana to all citizens of Maharashtra as of 2024 is a monumental step, the "last-mile" delivery to women remains fraught with obstacles. In a socio-religious hub like Pandharpur, health insurance is not just an economic transaction; it is a battle against traditional gender roles and informational poverty. The findings demonstrate that while financial coverage is available for 62.5% of the women, their agency to utilize it is curtailed by intra-household dynamics and procedural complexities. For the integrated schemes to truly succeed, the focus must shift from "enrollment targets" to "utilization equity." By empowering women with direct knowledge, deploying female facilitators, and enforcing the cashless nature of the scheme, the health system can ensure that no woman in Pandharpur has to choose between her family's financial stability and her own health.

Limitations of the Study:

- **Sample Size Constraints:** A sample of 200 women, while statistically significant for a descriptive study, may not capture the nuances of all 33 wards and 23 slums of Pandharpur city.
- **Geographical Limitation:** The study is focused strictly on the urban and semi-urban area of Pandharpur and may not reflect the conditions of the deep rural blocks of the Solapur district.
- **Response Bias:** There is a possibility of "recall bias" among respondents when

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discussing past medical expenditures or utilization history.

- **Dynamic Policy Environment:** The recent integration of schemes (July 2024) is still in its infancy, and some respondents may still be navigating the older rules of the Rajiv Gandhi Jeevandayee Yojana.

Scope for Further Research:

- **Longitudinal Utilization Analysis:** A future study could track a group of insured women over a 24-month period to observe the impact of health insurance on long-term health outcomes and poverty reduction.
- **Comparative Urban-Rural Study:** Comparing the insurance literacy of women in Pandharpur with those in the tribal regions of Maharashtra (like Nandurbar) could yield insights into the role of geography in insurance uptake.
- **The Role of Digital Health:** Researching the impact of the Ayushman Bharat Digital Mission (ABDM) and the "ABHA" health account on women's health-seeking behavior.
- **Provider-Side Barriers:** An investigation into why some private hospitals in Pandharpur are reluctant to join the MJPJAY network, focusing on reimbursement rates and administrative delays.

Annexure – Sample Questionnaire

I. Demographic Profile

1. Name (Optional): __________________
2. Age: ( ) 18–30 ( ) 31–45 ( ) 46–60 ( ) Above 60
3. Education: ( ) Illiterate ( ) Primary ( ) Secondary ( ) Graduate & Above
4. Occupation: ( ) Homemaker ( ) Worker ( ) Professional ( ) Student
5. Area of Residence: ( ) Urban Ward ( ) Slum Area ( ) Semi-Urban

II. Awareness Indicators 6. Have you heard the term "Health Insurance"? (Yes/No) 7. Are you aware of the Mahatma Phule Yojana (MJPJAY)? (Yes/No) 8. Do you know that treatment is free for orange/yellow card holders? (Yes/No) 9. Who is your main source of information? (TV / News / Friends / SHG / Doctor)

10. Do you know about the "Arogyamitra" available at the hospital? (Yes/No)

III. Utilization and Barriers 11. Do you have a valid health insurance card/ration card? (Yes/No) 12.

Have you used it for any surgery or treatment in the last year? (Yes/No) 13. Was the hospital experience "Cashless," or did you have to pay? (Cashless / Paid Extra) 14. What was the main problem in using the insurance? (Docs / Permission / Money / Distance) 15. If insurance was not there, how would you have paid? (Loan / Sold Assets / Savings) 16. On a scale of 1–5, how satisfied are you with the scheme? (1–Low, 5–High)