

Gender Equity in Health Insurance - Evaluating Odisha's Health Insurance Scheme

April 2024

Dr Sudha Chandrashekar¹, Dr Abdul Aziz Kattakath¹, Dr Anushree Trikha¹, Dr Chetan Talekar²

¹Health System Transformation Platform, New Delhi

²Indian Institute of Public Health, Gandhinagar.



Contact

Sudha Chandrasekhar | Advisor, HSTP (supported by Tata Trusts) | schandrasekhar@hstp.org.in

This working paper, titled "*Gender Equity in Health Insurance – Evaluating Odisha's Health Insurance Scheme*," has been developed by the Health Systems Transformation Platform (HSTP).

Disclaimer

The Health Systems Transformation Platform is a not-for-profit organisation registered as the Forum for Health Systems Design and Transformation; a company licensed under Section 8 of the Indian Companies Act 2013.

Our mission is to enable Indian health systems respond to people's needs. We do this in collaboration with Indian & Global expertise through research for health systems design, enhancing stakeholders' capabilities and fostering policy dialogue.

HSTP is committed to the highest standards of ethics and professional integrity in all its endeavours and declares no conflict of interest on account of its funding arrangements. The funders have no role in the planning, design, development, and execution of any HSTP activities, including the organisation of meetings/ workshops/training/ research/ publications/ and any other dissemination material developed for the use of health systems stakeholders in India and elsewhere.

The contents of this report should not be attributed to, and do not represent the views of the funders. HSTP and its partners have taken all reasonable precautions to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall HSTP and its partners be liable for damages arising from its use.

Acknowledgement

We would like to express our sincere gratitude to Ms. Shalini Pandit, Health Secretary of the Government of Odisha, for her invaluable guidance and support throughout the development of this paper. Her strategic insights and leadership have been instrumental in shaping our understanding of gender equity within the Biju Swasthya Kalyan Yojana (BSKY).

We extend our heartfelt thanks to Dr. Rajeev Sadanandan, CEO of the Health Systems Transformation Platform (HSTP), for his unwavering support and encouragement. His expertise and vision have played a pivotal role in steering this research toward meaningful and impactful outcomes.

We are also deeply grateful to the State Health Assurance Society (SHAS) team for their collaboration and assistance. We wish to thank Ms. Brundha D, CEO of SHAS, for her valuable input and guidance. Our special thanks go to Mr. Shubhananda Mohapatra, Joint CEO of SHAS, and Mr. Bishnu Prasad Mohapatra, Additional Director of SHAS, for their insightful feedback and continued support, which have significantly enriched the depth of our analysis.

Finally, we acknowledge the entire SHA team for their collective efforts and for facilitating access to key data and resources, which have been essential for conducting this research. This work would not have been possible without the collective guidance and support of all the individuals and organisations mentioned above. Their contributions have been invaluable in ensuring the success of this study.

Table of Contents

1.	ABSTRACT	4
2.	INTRODUCTION	5
2.1	JOURNEY OF PUBLICLY FUNDED HEALTH INSURANCE SCHEMES IN INDIA	5
2.2	BIJU SWASTHYA KALYAN YOJANA (BSKY)	6
2.3	GENDER DISPARITIES IN HEALTHCARE ACCESS	7
2.4	GENDER EQUITY REFORM IN BIJU SWASTHYA KALYAN YOJANA	8
3.	METHODOLOGY	8
4.	RESULTS	9
5.	DISCUSSION	15
6.	CONCLUSION	16
7.	LIMITATIONS	17
8.	REFERENCES	17

1. ABSTRACT

The study focuses on gender disparity in Odisha's healthcare utilisation and the gap in the utilisation of Publicly Funded Health Insurance (PFHI) schemes among males and females. Gender disparities in healthcare can be attributed to factors like healthcare costs, resource allocation, and limitations in access. PFHI schemes primarily aim to reduce OOPe and achieve UHC, but without addressing the gender disparity in the healthcare system, attaining UHC becomes challenging. In 2018, the Government of Odisha launched the Biju Swasthya Kalyan Yojana (BSKY) scheme, followed by the introduction of gender-sensitive reform in 2019 to better serve women, who are often marginalised and face challenges in accessing healthcare coverage. The study examines gender disparity in healthcare and Odisha's journey in health coverage, particularly focusing on the BSKY scheme and its 2019 reform, which were designed to promote gender parity and enhance healthcare utilisation among women. It assesses its impact on the utilisation of healthcare services, especially regarding the increase in female participation in healthcare services, looking after claims for non-gender-specific services, and improved access to tertiary care services from FY 2018-19 to FY 2022-23 in Odisha. The study also evaluates the impact of policy reforms on healthcare utilisation among women and highlights the need for such reforms to achieve gender equity and to establish universal health coverage.

Keywords: Gender Equity, Health Insurance, Publicly Funded Health Insurance, Universal Health Coverage, Biju Swasthya Kalyan Yojana, Healthcare Utilisation

2. INTRODUCTION

Odisha, located on the eastern coast of India, is renowned for its rich cultural heritage and diverse geography. Administratively, the state is divided into 30 districts, grouped into three revenue divisions: Central, Southern, and Northern. In addition to Bhubaneswar, the state capital, major urban centres include Sambalpur, Cuttack, Rourkela, Brahmapur, and Puri. While agriculture remains the primary occupation for much of the population, Odisha's abundant mineral resources, including bauxite, iron ore, chromite, and manganese ore, contribute to a thriving mining industry.

According to the 2011 Census, Odisha accounts for 3.47% of India's population, with 96,61,085 households and a total population of 4,19,74,218, of which 49.46% are females. The state reports a sex ratio of 979 females per 1,000 males and a child sex ratio (ages 0-6) of 941, significantly exceeding the national average of 918. The literacy rates in Odisha reveal notable disparities across demographic groups. The male literacy rate is 81.59%, while the female literacy rate is 64%. However, literacy rates among marginalised communities, such as the Scheduled Castes (SC) and Scheduled Tribes (ST), remain considerably lower, at 69.02% and 52.24%, respectively¹. These disparities underscore the persistent gender inequities in the state, which extend to healthcare access and utilisation.

2.1 JOURNEY OF PUBLICLY FUNDED HEALTH INSURANCE SCHEMES IN INDIA

India's health sector is characterised by low public health spending and high out-of-pocket expenditure (OOPE)². This out-of-pocket expenditure on health (OOPE) pushes many into financial hardship, particularly during hospitalisation. Lower spending on public health, which causes high out-of-pocket expenditure on healthcare and impoverishment in India, highlights significant disparities across rural and urban areas, with rural communities facing a severe shortage of access to healthcare services³. According to the NSSO Household Social Consumption Health Survey 2018-18, the overall share of OOPE on health in India is 56.89%, with 24.07% in rural areas and 39.17% in urban areas. In Odisha, OOPE accounted for 80% of total health expenditure in 2011, significantly higher than the national average of 71%. The majority of OOPE was attributed to medications, outpatient care, inpatient stays, and childbirth⁴.

To address these challenges, India has implemented various national and state-level Publicly Funded Health Insurance (PFHI) schemes, aiming to achieve UHC and reduce OOPE. Studies indicate that these schemes have positively influenced healthcare utilisation and helped to reduce OOPE⁵.

¹ *Odisha Population Census 2011, Odisha Religion, Literacy, Sex Ratio - Census India*. (n.d.). www.censusindia.co.in. <https://www.censusindia.co.in/states/odisha>

² Dubey, S., Deshpande, S., Krishna, L., & Zadey, S. (2023). Evolution of Government-funded health insurance for universal health coverage in India. *The Lancet Regional Health. Southeast Asia*, 13, 100180. <https://doi.org/10.1016/j.lansea.2023.100180>

³ Rao, K. S. (2017). An Indian perspective on the challenges in global health financing. *Health Economics, Policy and Law*, 12(2), 113–116. <https://doi.org/10.1017/s1744133116000384>

⁴ National Health Mission Odisha. (n.d.). *Out of pocket spending on health in Odisha – current status and some recommendations*. National Health Mission Odisha. <https://nhmodisha.gov.in/wp-content/uploads/2014/07/OUT-of-POCKET-SPENDING-on-Health-in-ODISHA---CURRENT-STATUS-and-SOME-RECOMENDATIONS.pdf>

⁵ Prinja, S., Chauhan, A. S., Karan, A., Kaur, G., & Kumar, R. (2017). Impact of publicly financed health insurance schemes on healthcare utilisation and financial risk protection in India: A systematic review. *PLOS ONE*, 12(2), e0170996. <https://doi.org/10.1371/journal.pone.0170996>

India's journey of public health insurance began with the Employees' State Insurance Scheme (ESIS) in 1948, a landmark social security legislation aimed at protecting workers from the financial hardships caused by unforeseen health issues. However, its coverage was limited to the central government workers and their families, excluding a significant portion of the population. The Ex-Servicemen Contributory Health Scheme (ECHS), launched in 2003, extended medical coverage to ex-servicemen, pensioners, and their dependents⁶.

A major milestone was the launch of the Rashtriya Swasthya Bima Yojana (RSBY) in 2008 by the Ministry of Labour and Employment. RSBY aimed to provide health insurance coverage to below-poverty-line (BPL) families and other vulnerable groups, ensuring financial protection against hospitalisation expenses. However, challenges such as low awareness, high OOPe, inadequate post-hospital treatment, and poor service delivery limited its effectiveness⁷.

In September 2018, the Government of India launched the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), the world's largest health insurance scheme. AB PM-JAY provides coverage of up to ₹5 lakh per family per annum for secondary and tertiary care hospitalisations, targeting approximately 50 crore beneficiaries. As of now, 36,38,32,385 Ayushman cards have been issued, with near parity in hospitalisations: 49.93% females (2,12,11,458), 50.05% males (2,12,58,674), and 0.02% others (8,395)⁸. This scheme represents a significant step toward achieving UHC in India.

2.2 BIJU SWASTHYA KALYAN YOJANA (BSKY)

In Odisha, the Biju Swasthya Kalyan Yojana (BSKY) was launched in August 2018 by the Department of Health and Family Welfare to provide universal health coverage, with a special emphasis on vulnerable families and women. The scheme has two components. Through the first component, all citizens of the state are eligible for cashless healthcare services at public health facilities in the state. Any citizen can avail of free healthcare services at 8,530 public health facilities across Odisha.

The second component covers 83% of the state's population, equating to 99.09 lakh households and 4.79 crore individuals, with 49% female enrolment. The eligible population benefits from cashless health coverage of INR 5 lakhs per annum per family, with an additional INR 5 lakhs available for female family members after the initial limit is exhausted, at any empanelled private hospitals in and outside Odisha. A total of 979 private hospitals are empanelled under the scheme, comprising 787 hospitals within Odisha and 192 hospitals outside the state. Since its inception, ₹8,848.54 crore has been reimbursed to private hospitals⁹.

⁶ Ex-Servicemen Contributory Health Scheme (ECHS). (n.d.). *ECHS official website*. Government of India. <https://www.echs.gov.in>

⁷ Malhi, R., Goel, D., Gambhir, R. S., Brar, P., Behal, D., & Bhardwaj, A. (2020). Rashtriya Swasthya Bima Yojana (RSBY) and outpatient coverage. *Journal of Family Medicine and Primary Care*, 9(2), 459–464.

⁸ National Health Authority. (n.d.). *PM-JAY public dashboard*. Government of India. <https://dashboard.pmjay.gov.in/pmj/>

⁹ Government of Odisha. (n.d.). *Biju Swasthya Kalyan Yojana (BSKY) dashboard*. Government of Odisha. <https://bskydashboard.odisha.gov.in>

2.3 GENDER DISPARITIES IN HEALTHCARE ACCESS

While PFHI schemes aim to reduce OOPE, achieving UHC requires addressing broader socio-demographic factors, including gender disparities. Gender disparities in healthcare access remain a persistent challenge in India. These disparities are reflected in healthcare utilisation, financial protection, and access to services. Women often face unique challenges, including mobility restrictions, unpaid care responsibilities, and financial dependence, which hinder their full utilisation of health insurance benefits¹⁰. Female patients face greater challenges in healthcare access, particularly among younger and older age groups and those living farther from the hospital¹¹.

Studies have shown that an increase in OOPE adversely affects healthcare utilisation among women. Additionally, the distance from households to hospitals significantly impacts women's care-seeking behaviour. Public health insurance schemes among women in urban slums and marginalised lower caste women in rural regions remain suboptimal due to barriers such as limited awareness of the schemes, financial constraints, and cultural factors¹². Women, particularly from lower socio-economic groups, face higher OOPE despite more frequent healthcare utilisation¹³. Studies highlight significant gender gaps in health insurance coverage, with men exhibiting higher coverage than women. For instance, the National Family Health Survey (NFHS) 2015–16 revealed that only 17.9% of urban women and 40.4% of rural women in Odisha had health insurance coverage, compared to higher rates among men.

Studies have also highlighted gender disparities in the utilisation of health insurance schemes. The Bhamashah Swasthya Bima Yojana in Rajasthan recorded over 200,000 missing female hospital visits for nephrology, cardiology, and oncology services between 2017 and 2019¹⁴. Similarly, research on the Chief Minister's Comprehensive Health Insurance Scheme in a southern Indian state revealed significant gender disparities in claim status, claim value, and types of procedures availed. Women in Tamil Nadu believed that all home resources, including income and assets, as well as health insurance benefits, were intended to meet the requirements of men (and children) and that their personal needs couldn't be prioritised¹⁵.

The 2030 Agenda for Sustainable Development underscores the importance of achieving gender equality and empowering women as critical components of sustainable development. SDG 3.8, which focuses on UHC, emphasises the need for financial risk protection and access to quality healthcare

¹⁰ RamPrakash, R., & Lingam, L. (2021). Why is women's utilisation of a publicly funded health insurance low?: A qualitative study in Tamil Nadu, India. *BMC Public Health*, 21, 350. <https://doi.org/10.1186/s12889-021-10352-4>

¹¹ Kapoor, M., Agrawal, D., Ravi, S., Roy, A., Subramanian, S. V., & Guleria, R. (2019). Missing female patients: An observational analysis of sex ratio among outpatients in a referral tertiary care public hospital in India. *BMJ Open*, 9(8), e026850. <https://doi.org/10.1136/bmjopen-2018-026850>

¹² Mendhe, H. G., David, R., Singh, D., & Makade, K. G. (2021). Universal Health Insurance coverage and utilisation among women in urban slum of Rajnandgaon, Chhattisgarh. *Journal of Family Medicine and Primary Care*, 10(3), 1313–1319. <https://doi.org/10.4103/jfmpe.jfmpe.2226.20>

¹³ Moradhvaj, & Saikia, N. (2019). Gender disparities in health care expenditures and financing strategies (HCFS) for inpatient care in India. *SSM - Population Health*, 9, 100372. <https://doi.org/10.1016/j.ssmph.2019.100372>

¹⁴ Dupas, P., & Jain, R. (2021). Women left behind: Gender disparities in utilisation of government health insurance in India (NBER Working Paper No. 28972). National Bureau of Economic Research. <https://www.nber.org/papers/w28972>

¹⁵ RamPrakash, R., & Arun, C. J. (2021). Gender inequity in utilisation of publicly funded health insurance schemes—Findings based on insurance data from a Southern Indian state: Is there a difference in utilisation of state-sponsored health insurance between men and women? *Asia Pacific Journal of Health Management*, 16(3), 75–86. <https://doi.org/10.24083/apjhm.v16i3.973>

services for all. However, achieving gender equity in healthcare requires addressing systemic barriers, including poverty, social norms, and gender-blind policies.

2.4 GENDER EQUITY REFORM IN BIJU SWASTHYA KALYAN YOJANA

To address these challenges and safeguard the interests of women, BSKY introduced a transformative policy reform in 2019 aimed at promoting gender equity and improving healthcare access and utilisation among women. The reform introduced an additional INR 5 lakh benefit coverage for female family members upon the exhaustion of the initial limit.

The Biju Swasthya Kalyan Yojana (BSKY) 2019 women's reform was part of the Odisha government's broader strategy to enhance women-centric services, as outlined in its proposed 2019 election manifesto. The reform, which introduced an additional ₹5 lakh health coverage exclusively for women beneficiaries, aligned with the government's commitment to strengthening healthcare access, promoting gender equity, and empowering women through targeted welfare initiatives. This initiative was one of the key components of the manifesto's focus on inclusive healthcare, social welfare, and economic empowerment, reinforcing the state's efforts to prioritise women's well-being across various sectors.

This study examines gender disparities in healthcare utilisation in the Biju Swasthya Kalyan Yojana (BSKY) and the impact of the 2019 reform aimed at promoting gender equity and improving healthcare utilisation among women and the need for further policy interventions to achieve gender equity and realise UHC, ensuring that all individuals have access to a comprehensive range of quality health services, from health promotion, prevention, treatment, rehabilitation, and palliative care, without financial hardship.

3. METHODOLOGY

This quantitative study aimed to investigate gender disparities in healthcare utilisation under the BSKY scheme in Odisha, India. The analysis utilised BSKY claims data from fiscal years (FY) 2018-19 to 2022-23, provided by the State Health Assurance Society (SHAS). Data cleaning, sorting and analysis were performed using Microsoft Excel.

Non-gender-specific claims were filtered to exclude treatments related to gender-specific healthcare packages, ensuring a more accurate comparison of healthcare utilisation between males and females. This approach was essential to isolate and analyse the utilisation of non-gender-specific services by females, independent of gender-related healthcare needs.

UNIVARIATE ANALYSIS:

A univariate analysis was conducted to examine the following key variables:

- **Female-Specific Claims:** Claims related to maternal health, reproductive health services, and other female-related healthcare services.

- **Non-Gender-Specific Claims:** Claims for general hospitalisations, surgeries, and other treatments not specific to any gender.
- **Tertiary Care Claims:** Claims for tertiary care services.

Descriptive statistical measures were used to summarise the data and identify patterns in healthcare utilisation.

BSKY Claims Analysis:

The analysis involved the following steps:

1. **Data Preparation:** Duplicate claims (multiple claims raised during the same hospitalisations) and inconsistent claims (claims with incomplete and inconsistent data capture) were removed to ensure data accuracy.
2. **Categorisation of Claims:**
 - a. **Non-gender-specific Claims:** The Health Benefit Packages (HBPs) related to maternal health, reproductive health, and gender-related health services were categorised, and all claims under these packages were classified as gender-specific. Claims under all other packages were classified as non-gender-specific.
 - b. **Female-specific Claims:** All packages related to female-specific healthcare services were categorised, and all claims booked under these packages were classified as female-specific.
 - c. **Tertiary care claims:** Claims under tertiary care specialities were examined separately to assess utilisation patterns.

Analytical Framework:

1. **Volume and Value:** The absolute and relative volume and value of total claims, non-gender-specific claims, female-specific claims, and tertiary care services were calculated.
2. **Utilisation Trends:** Changes in utilisation of the healthcare services over the study period (FY 2018-19 to FY 2022-23) were analysed to identify any trends and patterns.
3. **Gender Disparities:** Differences in utilising the healthcare services by females compared to males were examined to assess gender-based disparities in healthcare access.

4. RESULTS

The analysis of BSKY claims data from FY 2018-19 to FY 2022-23 reveals exponential growth in both the volume and value of claims. It also highlights significant trends in healthcare utilisation, particularly in terms of gender disparities and the impact of policy reforms.

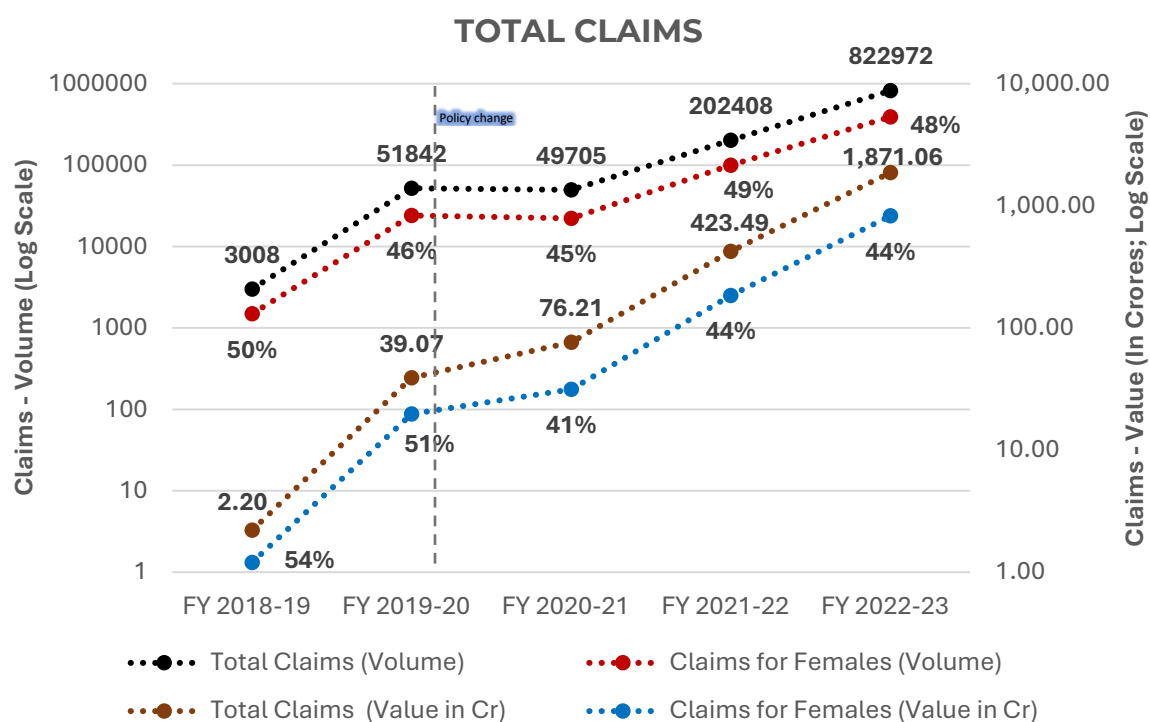


Figure 1: Total Claims - Utilisation in Volume and Value

The total number of claims increased from 3,008 in FY 2018-19 to over 8,22,972 in FY 2022-23, while the total claim value rose from INR 2.2 crores to INR 1,871.06 crores during the same period. In FY 2018-19, females accounted for 50% of the total claims but declined to 46% in FY 2019-20 and 45% in FY 2020-21, likely due to the disruptive impact of the COVID-19 pandemic. However, female utilisation recovered to 49% in FY 2021-22 and 48% in FY 2022-23, respectively, indicating post-pandemic recovery. In terms of claims value, female beneficiaries initially accounted for over 50% of the total claimed amount, but this figure declined to 44% in FY 2022-23. (Figure 1).

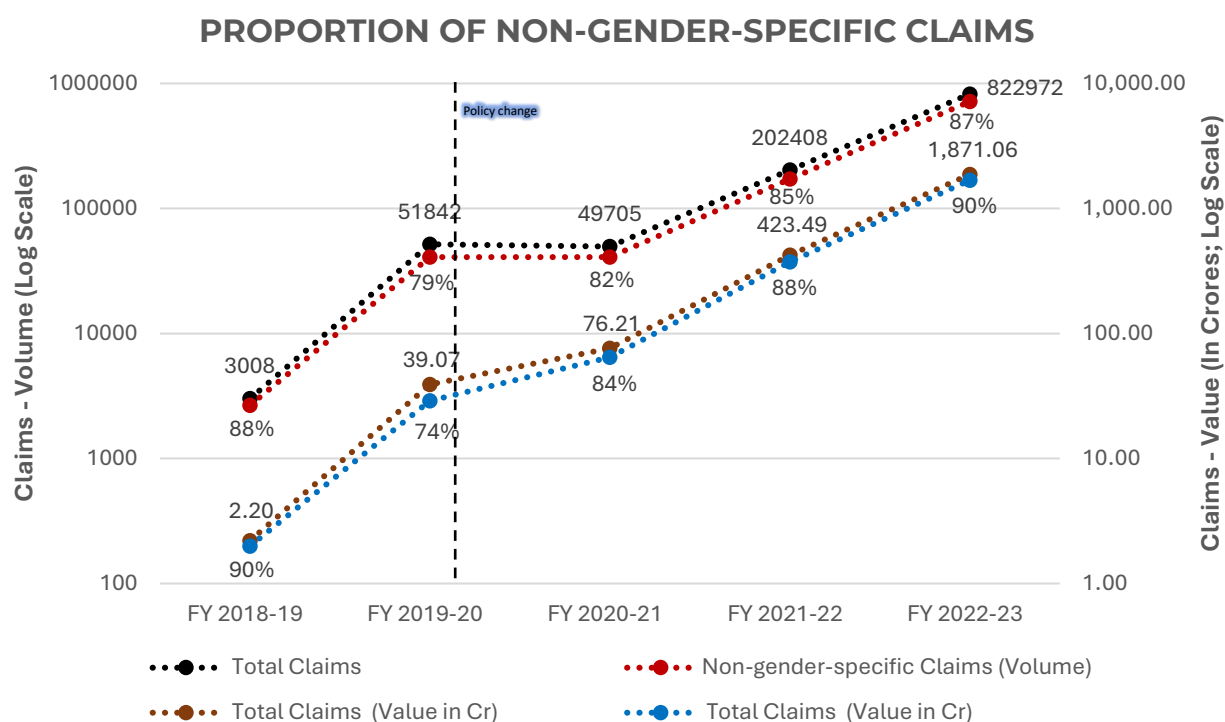


Figure 2: Proportion of Non-gender-specific Claims

Non-gender-specific claims constituted the majority of claims under BSKY, rising from 2,662 in FY 2018-19 to 7,16,548 in FY 2022-23. The proportion of non-gender-specific claims among total claims remained high, starting at 88% in FY 2018-19, dipping to 79% in FY 2019-20, and rising to 87% in FY 2022-23. Similarly, the claim value for non-gender-specific services grew exponentially, from INR 1.99 crores (90% of total claim value) in FY 2018-19 to INR 1682.77 crores (90% of total claim value) in FY 2022-23 (Figure 2).

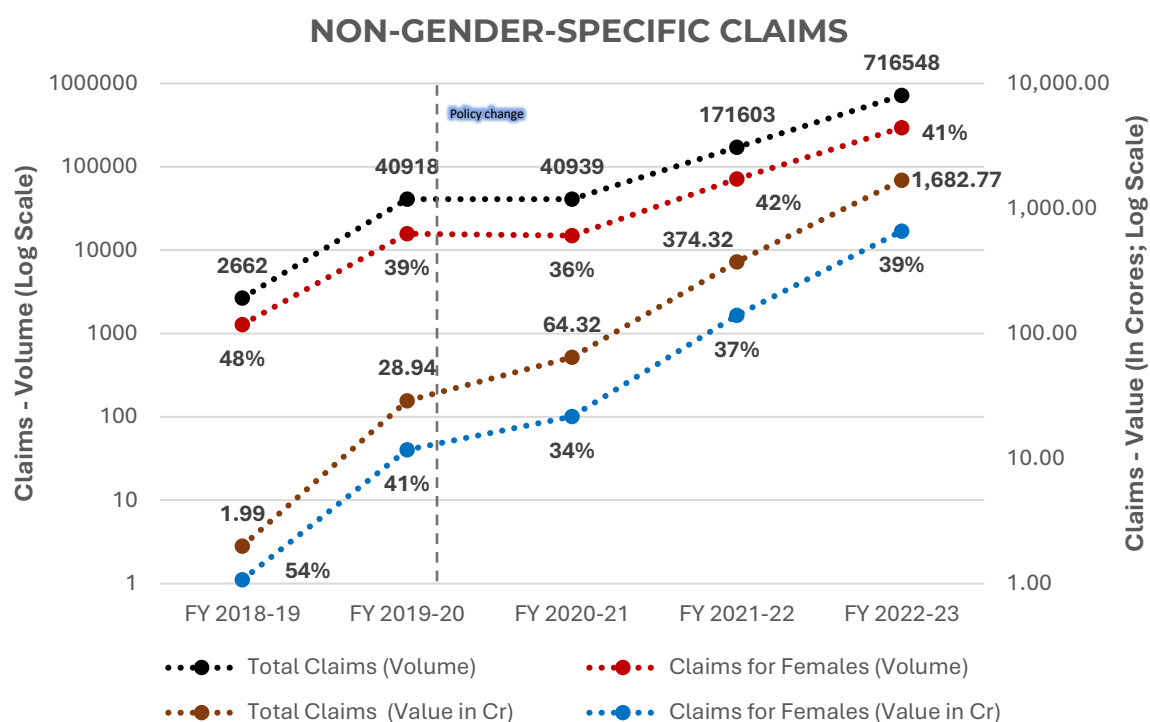


Figure 3: Non-gender-specific Claims - Utilisation in Volume and Value

The female utilisation of non-gender-specific services initially declined, dropping from 48% in FY 2018-19 to 39% in FY 2019-20 and further to 36% in FY 2020-21. However, it stabilised at 41% in FY 2021-22 and FY 2022-23. In terms of claim value, female beneficiaries accounted for 54% of the non-gender-specific claim amount in FY 2018-19, but this proportion declined to 41% in FY 2019-20 and 34% in FY 2020-21 before stabilising at around 39% in subsequent years (Figure 3).

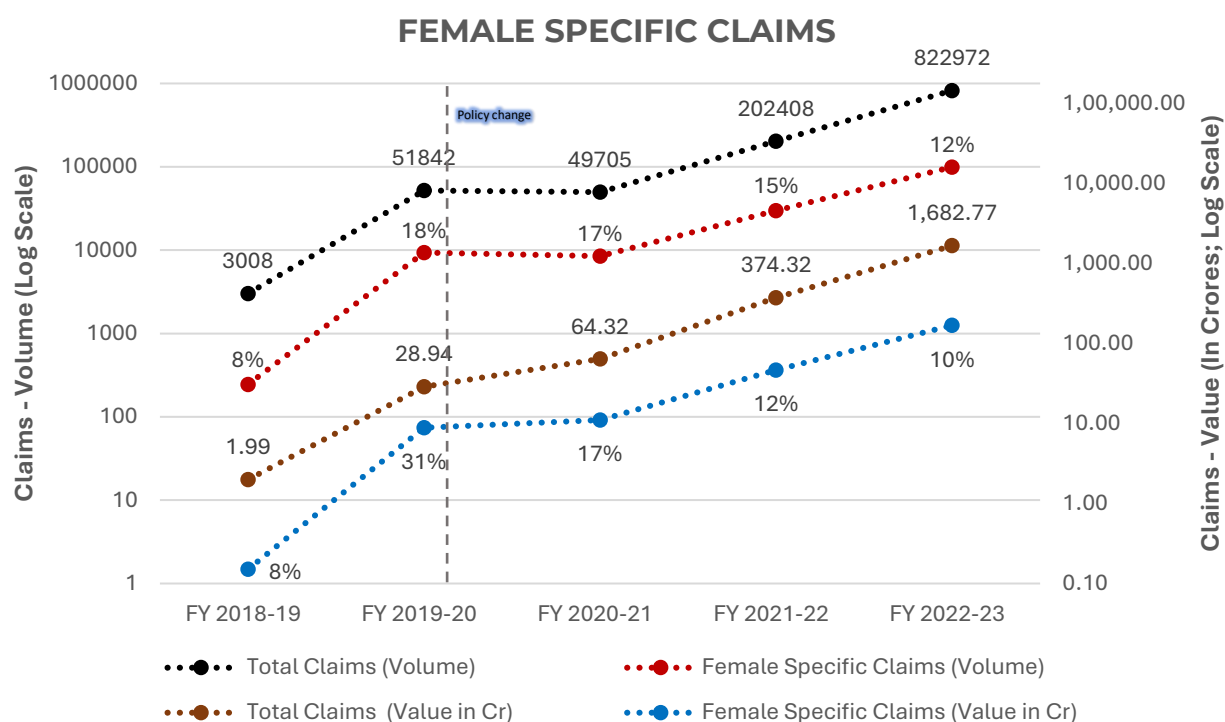


Figure 4: Female-specific Claims - Utilisation in Volume and Value

Female-specific claims, which include maternal health, reproductive health, and other female-related healthcare services, demonstrated exponential growth over the study period. Female-specific claims surged from 9,312 in FY 2019-20 to 99,329 in FY 2022-23, with an annual average growth factor of 7.83. However, the proportion of claim value for female-specific services fluctuated, starting at 8% in FY 2018-19, peaking at 31% in FY 2019-20 and stabilising at 10% in FY 2022-23 (Figure 4).

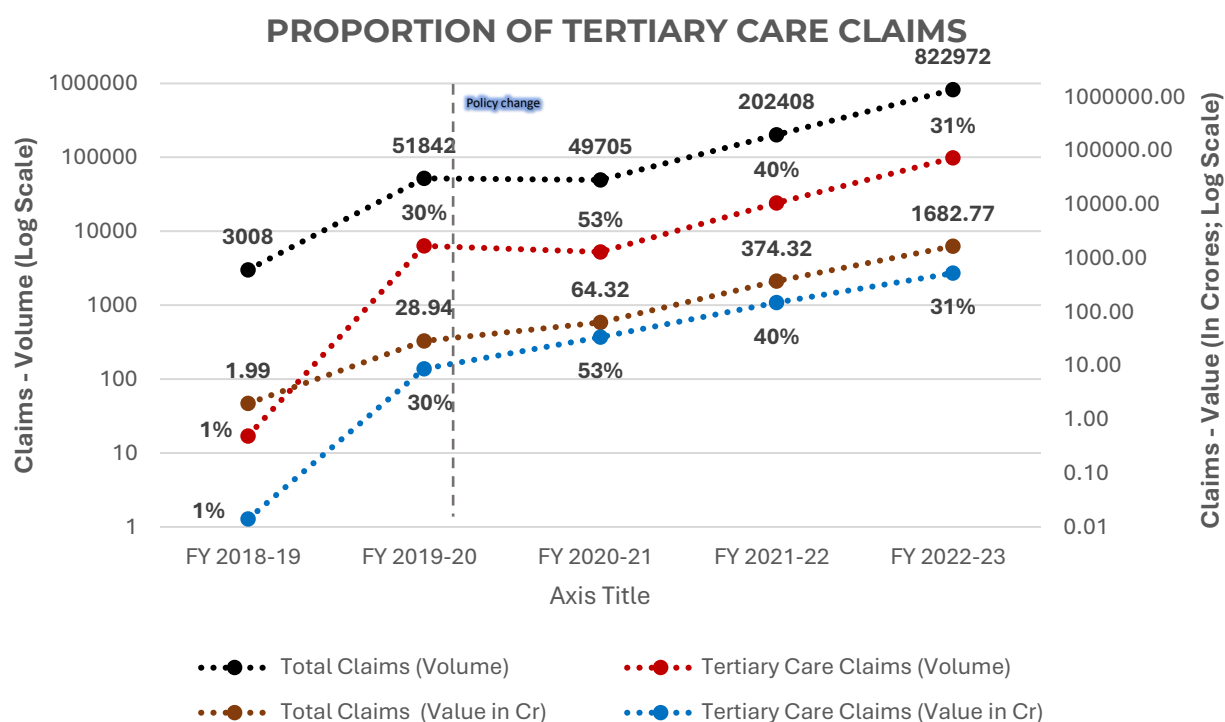


Figure 5: Tertiary Claims - Utilisation in Volume and Value

The utilisation of tertiary care services by females increased significantly over the study period. While the proportion of tertiary care claims remained constant at around 12% of total claims, the claim value for tertiary care services increased from 30% in FY 2019-20 to 53% in FY 2020-21 and then stabilised to 40% in 2021-22 and 31% in FY 2022-23. Female utilisation of tertiary care services accounted for around 18% in FY 2018-19 and 2019-20 but steadily increased to 33% in FY 2020-21, 38% in FY 2021-22 and 41% in FY 2022-23. Similarly, the claim value for tertiary care utilised by females rose from 19% in FY 2018-19 to 38% in FY 2022-23 (Figure 5,6).

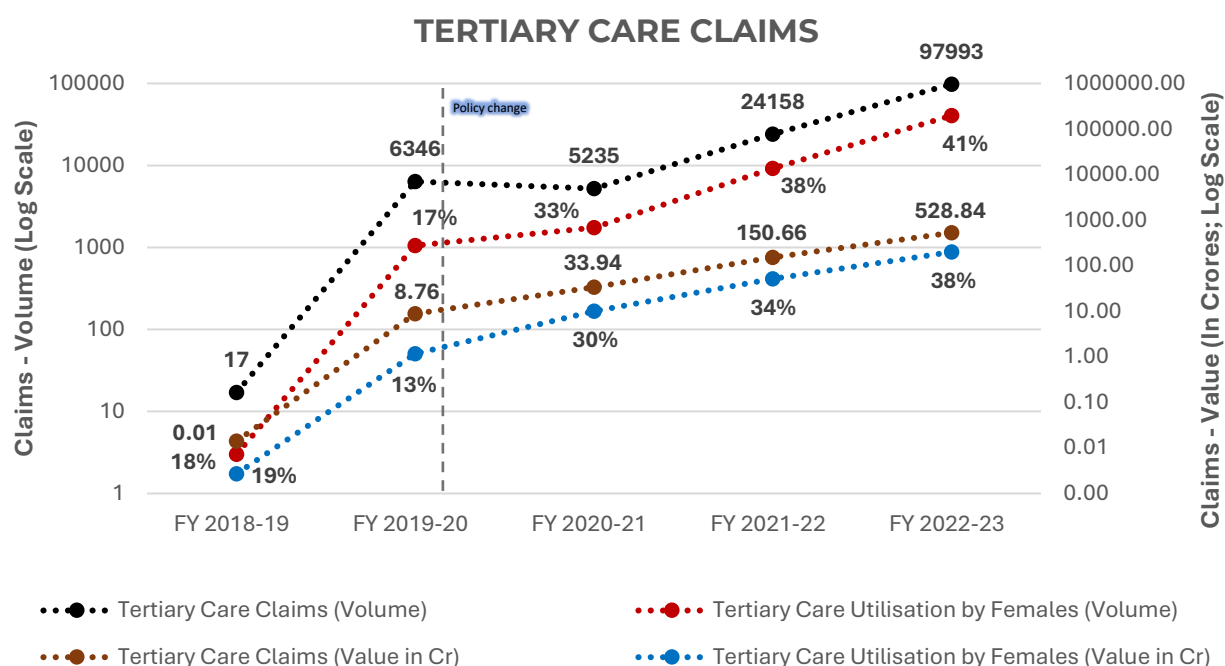


Figure 6: Tertiary Care Claims - Utilisation in Volume and Value

5. DISCUSSION

The analysis reveals significant trends in healthcare utilisation under BSKY, particularly in terms of gender disparities and the impact of policy reforms. The exponential growth in both the volume and value of claims underscores the scheme's expanding reach and the role of awareness generation in improving access to healthcare services in Odisha. The analysis also highlights persistent gender disparities, particularly in the utilisation of non-gender-specific and tertiary healthcare services.

The initial gender parity in healthcare utilisation, with females accounting for 50% of the total claims in FY 2018-19, reflects the inclusive design of the BSKY scheme. The decline in female utilisation during FY 2019-20 and FY 2020-21 could be attributed to the disruptive impact of the COVID-19 pandemic, aligning with global evidence suggesting that women disproportionately faced barriers to healthcare access during the COVID-19 pandemic¹⁶. The subsequent recovery in female utilisation to around 48% in the following years indicates the effectiveness of the 2019 policy reform, which introduced additional coverage benefits for female family members, thereby encouraging the utilisation of healthcare services by females.

¹⁶ Turner, K., Brownstein, N. C., Whiting, J., Arevalo, M., Islam, J. Y., Vadaparampil, S. T., Meade, C. D., Gwede, C. K., Kasting, M. L., Head, K. J., & Christy, S. M. (2022). Impact of the COVID-19 pandemic on women's health care access: A cross-sectional study. *Journal of Women's Health, 31*(12), 1690. <https://doi.org/10.1089/jwh.2022.0128>

Most BSKY claims were non-gender-specific healthcare services, constituting 87% of the total claims in FY 2022-23. The decline in female utilisation of non-gender-specific services from 48% in FY 2018-19 to 36% in FY 2020-21, stabilising at 41% in the post-pandemic years, suggests that gender disparities in accessing these services persist and women accessed smaller proportions of non-gender-specific healthcare services than men. The analysis aligns with studies indicating that sociocultural barriers, such as limited decision-making ability and mobility constraints, often hinder access to healthcare for women¹⁷.

The exponential growth of female-specific claims during the study period, however, reflects the impact of the scheme in addressing gender-specific healthcare needs. The increase in the proportion of claims value and the volume during the pandemic also suggests the resilience of the health system, ensuring essential maternal services, which form the majority of the claims of female-specific years during the pandemic.

The significant increase in female utilisation of tertiary care services, from 18% in FY 2018-19 to 41% in FY 2022-23, also indicates improved parity in access to specialised healthcare. However, the disparity in the value of tertiary claims for females could suggest the limitations in access to specific specialised care, which requires more exploration of the claims data. The provision of coverage for hospital care alone is insufficient to guarantee gender equity in access to healthcare.

Comparative studies show that gender-targeted reforms in health financing can significantly enhance service utilisation but require sustained, context-specific strategies to address structural barriers¹⁸¹⁹.

6. CONCLUSION

The study highlights the growing need for gender-sensitive, publicly funded health insurance schemes to ensure equitable and universal access to healthcare services. The 2019 policy reform under BSKY had a protective, shock-absorbing effect, ensuring that healthcare services remained accessible to women during the pandemic. Despite initial disruptions, the reform appears effective in increasing female utilisation across the spectrum of healthcare services in subsequent years. However, persistent gender disparities in non-gender-specific and tertiary care utilisation underscore the need for sustained, context-specific strategies to address structural barriers and achieve gender equity in healthcare access.

¹⁷ Sen, G., & Östlin, P. (2008). Gender inequity in health: Why it exists and how we can change it. *Global Public Health*, 3(sup1), 1–12. <https://doi.org/10.1080/17441690801900795>

¹⁸ Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., Kharel, C., ... Gender Equality, Norms, and Health Steering Committee. (2019). Disrupting gender norms in health systems: Making the case for change. *The Lancet*, 393(10190), 2535–2549. [https://doi.org/10.1016/S0140-6736\(19\)30648-8](https://doi.org/10.1016/S0140-6736(19)30648-8)

¹⁹ Ranjan, A., Suresh, A., & Parmar, D. (2018). Gender equity as a dimension of progress towards universal health coverage: Evidence from India's 71st round National Sample Survey. *Journal of Health Policy and Administration*, 1, 41-58.

7. LIMITATIONS

While the reliance on secondary data limits the ability to fully capture contextual factors such as socioeconomic disparities, cultural influences, and regional variations in healthcare access, the initial trends indicate promising progress. Policy interventions often take time to yield sustained impact, and while short-term improvements are encouraging, a long-term assessment is essential to understand their full effectiveness. Future research can build on these findings by incorporating qualitative methods, such as in-depth interviews and focus group discussions, to provide deeper insights into beneficiaries' experiences and further strengthen the understanding of policy outcomes.

8. References

1. *Odisha Population Census 2011, Odisha Religion, Literacy, Sex Ratio - Census India*. (n.d.). www.censusindia.co.in. <https://www.censusindia.co.in/states/odisha>
2. Dubey, S., Deshpande, S., Krishna, L., & Zadey, S. (2023). Evolution of Government-funded health insurance for universal health coverage in India. *The Lancet Regional Health*. Southeast Asia, 13, 100180. <https://doi.org/10.1016/j.lansea.2023.100180>
3. Rao, K. S. (2017). An Indian perspective on the challenges in global health financing. *Health Economics, Policy and Law*, 12(2), 113–116. <https://doi.org/10.1017/s1744133116000384>
4. National Health Mission Odisha. (n.d.). *Out of pocket spending on health in Odisha – current status and some recommendations*. National Health Mission Odisha. <https://nhmodisha.gov.in/wp-content/uploads/2014/07/OUT-of-POCKET-SPENDING-on-Health-in-ODISHA—CURRENT-STATUS-and-SOME-RECOMENDATIONS.pdf>
5. Prinja, S., Chauhan, A. S., Karan, A., Kaur, G., & Kumar, R. (2017). Impact of publicly financed health insurance schemes on healthcare utilisation and financial risk protection in India: A systematic review. *PLOS ONE*, 12(2), e0170996. <https://doi.org/10.1371/journal.pone.0170996>
6. **Ex-Servicemen Contributory Health Scheme (ECHS)**. (n.d.). *ECHS official website*. Government of India. <https://www.echs.gov.in>
7. Malhi, R., Goel, D., Gambhir, R. S., Brar, P., Behal, D., & Bhardwaj, A. (2020). Rashtriya Swasthya Bima Yojana (RSBY) and outpatient coverage. *Journal of Family Medicine and Primary Care*, 9(2), 459–464.
8. **National Health Authority**. (n.d.). *PM-JAY public dashboard*. Government of India. <https://dashboard.pmjay.gov.in/pmi/>
9. **Government of Odisha**. (n.d.). *Biju Swasthya Kalyan Yojana (BSKY) dashboard*. Government of Odisha. <https://bskydashboard.odisha.gov.in>
10. RamPrakash, R., & Lingam, L. (2021). Why is women's utilisation of a publicly funded health insurance low?: A qualitative study in Tamil Nadu, India. *BMC Public Health*, 21, 350. <https://doi.org/10.1186/s12889-021-10352-4>
11. Kapoor, M., Agrawal, D., Ravi, S., Roy, A., Subramanian, S. V., & Guleria, R. (2019). Missing female patients: An observational analysis of sex ratio among outpatients in a referral tertiary care public hospital in India. *BMJ Open*, 9(8), e026850. <https://doi.org/10.1136/bmjopen-2018-026850>
12. Mendhe, H. G., David, R., Singh, D., & Makade, K. G. (2021). Universal Health Insurance coverage and utilisation among women in urban slum of Rajnandgaon, Chhattisgarh. *Journal of*

- Family Medicine and Primary Care*, 10(3), 1313–1319. https://doi.org/10.4103/jfmpc.jfmpc_2226_20
13. Moradhvaj, & Saikia, N. (2019). Gender disparities in health care expenditures and financing strategies (HCFS) for inpatient care in India. *SSM - Population Health*, 9, 100372. <https://doi.org/10.1016/j.ssmph.2019.100372>
 14. Dupas, P., & Jain, R. (2021). Women left behind: Gender disparities in utilisation of government health insurance in India (*NBER Working Paper No. 28972*). National Bureau of Economic Research. <https://www.nber.org/papers/w28972>
 15. RamPrakash, R., & Arun, C. J. (2021). Gender inequity in utilisation of publicly funded health insurance schemes—Findings based on insurance data from a Southern Indian state: Is there a difference in utilisation of state-sponsored health insurance between men and women? *Asia Pacific Journal of Health Management*, 16(3), 75–86. <https://doi.org/10.24083/apjhm.v16i3.973>
 16. Turner, K., Brownstein, N. C., Whiting, J., Arevalo, M., Islam, J. Y., Vadaparampil, S. T., Meade, C. D., Gwede, C. K., Kasting, M. L., Head, K. J., & Christy, S. M. (2022). Impact of the COVID-19 pandemic on women's health care access: A cross-sectional study. *Journal of Women's Health*, 31(12), 1690. <https://doi.org/10.1089/jwh.2022.0128>
 17. Sen, G., & Östlin, P. (2008). Gender inequity in health: Why it exists and how we can change it. *Global Public Health*, 3(sup1), 1–12. <https://doi.org/10.1080/17441690801900795>
 18. Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., Kharel, C., ... Gender Equality, Norms, and Health Steering Committee. (2019). Disrupting gender norms in health systems: Making the case for change. *The Lancet*, 393(10190), 2535–2549. [https://doi.org/10.1016/S0140-6736\(19\)30648-8](https://doi.org/10.1016/S0140-6736(19)30648-8)
 19. Ranjan, A., Suresh, A., & Parmar, D. (2018). Gender equity as a dimension of progress towards universal health coverage: Evidence from India's 71st round National Sample Survey. *Journal of Health Policy and Administration*, 1, 41–58.