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HEALTH INSURANCE ACCESSIBILITY AMONG PERSONS WITH DISABILITIES IN INDIA: A STRUCTURED NARRATIVE REVIEW OF THE “AYUSHMAN FOR ALL” EVIDENCE AND POLICY FRAMEWORK

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ABSTRACT

Background: Persons with disabilities (PwDs) experience health inequities arising from barriers in healthcare systems, social determinants, affordability, accessibility, and discrimination. In India, the policy framework includes the Rights of Persons with Disabilities Act, 2016 (RPwD Act), Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), and regulatory measures concerning health insurance products. Nevertheless, evidence indicates substantial gaps in financial protection and awareness.

Objective: To synthesize the evidence presented in the 2025 “Ayushman for All” campaign survey concerning health insurance coverage and AB-PMJAY awareness among PwDs in India, and to interpret those findings alongside national disability-survey evidence, Indian insurance regulation, and international disability-health standards.

Methods: A structured narrative review was undertaken using the uploaded manuscript as the primary source, supplemented by publicly available Government of India, WHO, United Nations, peer-reviewed, and reputable news/press reports identified during September 2026. The 2025 campaign figures were treated as campaign-reported estimates rather than as a nationally representative prevalence estimate because the technical survey report and sampling documentation were not available in the source material reviewed.

Results: The campaign survey, as reported by Press Trust of India, included more than 5,000 PwDs across 34 states and union territories; 82% reportedly lacked any form of insurance, 42% were unaware of AB-PMJAY, and 28% reported having applied for the scheme. These

findings coexist with substantial evidence of financial burden: analysis of the NSS 76th Round disability survey found that disability-related healthcare expenditure represented 20.32% of household monthly consumption expenditure on average, 57.1% of households experienced catastrophic health expenditure at a 10% threshold, and 19.1% of households above the poverty line before treatment were pushed below it after disability-related healthcare expenditure. Indian regulation has also evolved: IRDAI requires insurers to make products available across categories including PwDs and requires general and health insurers to offer a specific cover for PwDs, HIV/AIDS and mental illness.

Conclusion: The evidence points to a policy implementation gap rather than a simple absence of policy. A disability-inclusive health-financing strategy requires accessible enrolment, effective outreach, transparent underwriting, disability-disaggregated monitoring, grievance redressal, and meaningful participation of persons with disabilities and their representative organisations. Future research should independently validate the 2025 campaign estimates using transparent sampling and individual-level data.

KEYWORDS: persons with disabilities; health insurance; AB-PMJAY; universal health coverage; financial protection; accessibility; disability rights; India.

1. INTRODUCTION

Health insurance is one component of financial protection within universal health coverage (UHC), but insurance coverage alone does not guarantee equitable access. Persons with disabilities may require more frequent healthcare, rehabilitation, assistive products, transport, personal assistance, and long-term support. Consequently, the financial and access consequences of disability can extend beyond conventional hospital expenditure. The World Health Organization (WHO) identifies disability-related health inequities as a consequence of structural, socioeconomic and health-system barriers and emphasizes disability inclusion in UHC governance, financing, service delivery and monitoring.

The international legal framework is explicit. Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD) recognizes the right of persons with disabilities to the highest attainable standard of health without discrimination and calls for equal access to health services and protection against discriminatory denial of health insurance. India's RPwD Act, 2016, similarly establishes provisions concerning healthcare, insurance schemes, rehabilitation and accessibility. Section 25 addresses barrier-free access to government and private hospitals and healthcare institutions, while Section 26 concerns

insurance schemes for government employees with disabilities; Section 24 also provides a broader social-security framework.

Against this background, the 2025 “Ayushman for All” campaign brought renewed attention to insurance exclusion among PwDs. The uploaded manuscript reports that a nationwide campaign survey found 82% of respondents without health insurance, 42% unaware of AB-PMJAY, and 28% reporting an application for the scheme. The figures were also reported by Press Trust of India and reproduced by Business Standard and The Economic Times. The campaign discussion further highlighted barriers relating to awareness, accessibility, insurance practices, state-level variation and the financial burden of disability.

The purpose of this redrafted paper is therefore not to present the campaign survey as a primary epidemiological study, but to place its findings within a broader evidence and policy framework. This distinction is important for peer review because the strength of inference depends on the transparency of sampling, questionnaire design, response rates, weighting, and statistical analysis. Where these details are unavailable, the manuscript uses cautious language and explicitly identifies the limitation.

1.1 Review objectives

1. To describe the reported 2025 evidence on health-insurance coverage and AB-PMJAY awareness among PwDs in India.
2. To contextualize the campaign findings using nationally representative evidence on disability-related healthcare expenditure and financial hardship.
3. To examine the alignment between Indian disability and insurance policy frameworks and the barriers identified in the campaign evidence.
4. To identify evidence gaps and propose research, implementation and monitoring priorities for disability-inclusive health financing.

2. Conceptual Framework

The review adopts a disability-inclusive UHC framework in which insurance coverage is treated as one determinant of financial protection rather than a sufficient condition for healthcare access. The pathway can be represented as: disability-related needs → healthcare demand and additional costs → financial risk → insurance eligibility/enrolment → accessibility of enrolment and service delivery → effective use of covered services → financial protection and health outcomes. Cross-cutting determinants include poverty, gender,

rural residence, literacy, digital accessibility, transportation, caregiver dependence, and discrimination.

Level	Key issue	Potential consequence	Measurement priority
Structural	Eligibility, policy design, fragmented schemes	Unequal coverage	Coverage by disability status and scheme
Information	Low awareness; inaccessible communication	Non-enrolment or delayed care	Awareness, comprehension and uptake
Administrative	Documentation, digital and physical barriers	Application failure / delayed access	Application completion and rejection reasons
Insurance market	Underwriting, product design, exclusions	Inadequate or unaffordable protection	Approval, pricing, exclusions, claims
Service delivery	Physical, communication and procedural inaccessibility	Covered but unused benefits	Utilisation, denial, complaints
Financial	OOPE, transport, rehabilitation and caregiving costs	Catastrophic expenditure / impoverishment	OOPE, CHE and impoverishment
Governance	Weak disability-disaggregated monitoring	Invisible implementation gaps	Routine equity indicators

3. METHODS

3.1 Design

This manuscript is a structured narrative review and policy analysis. It is not presented as a systematic review or meta-analysis because the available campaign material does not provide sufficient information to reproduce a systematic evidence-synthesis protocol. The review follows a transparent narrative approach: the uploaded five-page manuscript was treated as the starting source; key claims were then checked against official Government of India and international sources and supplemented with peer-reviewed studies relevant to disability-related financial burden and healthcare access in India.

3.2 Sources and search approach

Supplementary sources were identified through targeted searches of official Indian government sources (National Health Authority, Ministry of Statistics and Programme Implementation, India Code and Insurance Regulatory and Development Authority of India), international organisations (WHO and United Nations), PubMed-indexed literature, and reputable reporting of the 2025 campaign findings. Search concepts included combinations of “persons with disabilities”, “health insurance”, “AB-PMJAY”, “Ayushman for All”, “out-of-pocket expenditure”, “catastrophic health expenditure”, “India”, “disability-inclusive health financing”, and “insurance regulation”. The search and verification were undertaken in September 2026.

The 2025 campaign survey is treated as a secondary reported evidence source because the technical survey instrument, sampling frame, response rate, weighting procedure and full statistical tables were not included in the material supplied with the original manuscript. Accordingly, percentages from that survey are reported as campaign findings and are not generalized beyond the surveyed respondents.

3.3 Evidence synthesis

Evidence was synthesized under four domains: (1) insurance coverage and awareness; (2) financial burden; (3) legal and regulatory protections; and (4) implementation and accessibility barriers. Particular attention was given to differences between policy entitlement and effective access, and to the distinction between evidence directly measured by a study and interpretations advanced by advocacy groups or media reports.

4. RESULTS

4.1 Reported findings from the 2025 “Ayushman for All” campaign

The source manuscript reports that the campaign survey covered more than 5,000 PwDs across 34 states and union territories. The figures reported in contemporary PTI coverage are 82% without any form of insurance, 42% unaware of AB-PMJAY, and 28% reporting that they had applied for the scheme. These figures were presented at a National Disability Network meeting in March 2025.

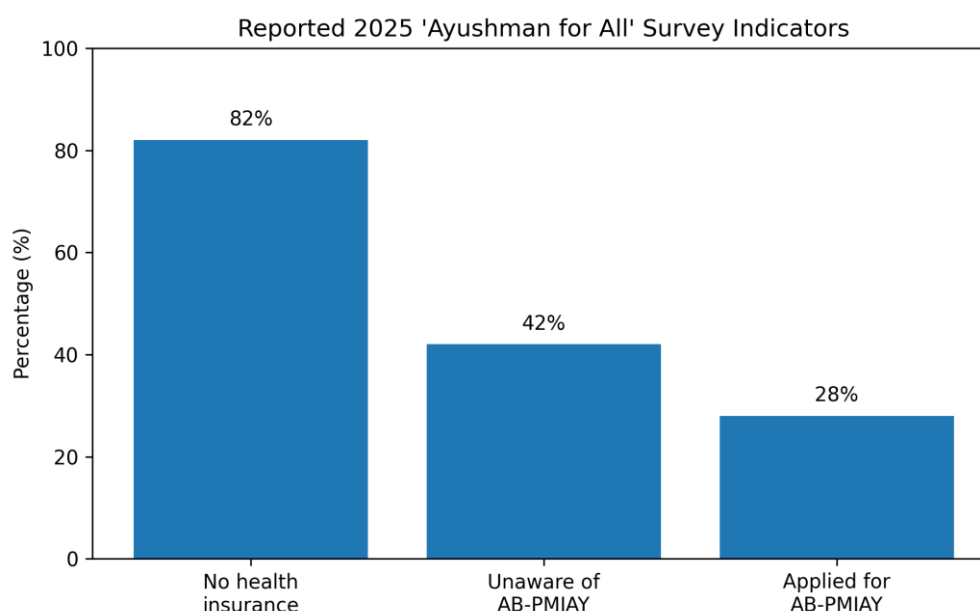


Figure 1. Reported indicators from the 2025 “Ayushman for All” campaign survey. The categories are not mutually exclusive; therefore, the bars should not be interpreted as a single distribution.

Indicator	Reported value	Interpretation for this review
No form of health insurance	82%	Indicates a large reported protection gap among respondents.
Unaware of AB-PMJAY	42%	Indicates an information and outreach gap.
Applied for AB-PMJAY	28%	Indicates limited reported application/uptake; it is not equivalent to enrolment or successful coverage.
Insurance rejection	Not quantified in the supplied survey report	The original manuscript described rejection as anecdotal; a quantitative rejection rate should not be asserted without the underlying survey table.

4.2 Financial burden of disability-related healthcare

The campaign findings are consistent with a broader Indian evidence base showing that disability can generate substantial household financial burden. Yadav et al. (2023), using the nationally representative NSS 76th Round Survey of Persons with Disabilities, analysed 1,18,152 households and 5,76,569 individuals, including 1,06,894 persons with disability. The study estimated that disability-related out-of-pocket expenditure represented 20.32% of monthly household consumption expenditure. At a 10% threshold, 57.1% of households experienced catastrophic health expenditure associated with disability-related care; at a 20% threshold, the corresponding figure was 34.1%. The study also estimated that 19.1% of households that were above the poverty line before disability-related treatment were pushed below it after such expenditure.

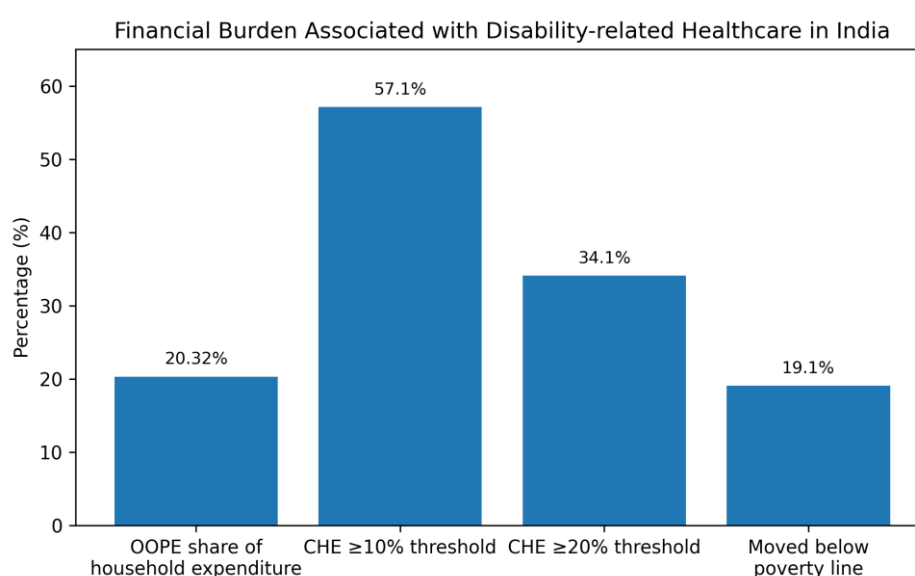


Figure 2. Selected financial-burden estimates from Yadav et al. (2023), based on NSS 76th Round disability data. The indicators use different analytical thresholds and should not be interpreted as mutually exclusive groups.

The national survey evidence also shows geographical and socioeconomic variation. For example, the published analysis reported a higher share of household expenditure devoted to disability-related healthcare among rural households and lower economic groups. These findings support the interpretation that health-financing gaps cannot be addressed through insurance enrolment alone; accessibility, affordability, transport and non-medical costs also require attention.

4.3 Access barriers beyond insurance coverage

The WHO global evidence base emphasizes that persons with disabilities face barriers across health systems, including inaccessible facilities, communication barriers, stigma and discrimination, transportation constraints and financial barriers. Importantly, a person may be formally insured but still experience unmet need if registration systems, information, hospitals, diagnostics, rehabilitation services or claims processes are inaccessible.

Evidence from an analysis of the NSS disability survey among people with visual disability provides a specific illustration: approximately 15% of people with visual disability reportedly did not have access to disability-related healthcare, with affordability identified as the leading reason. Access was also associated with age, sex, literacy, consumption expenditure and scheduled-tribe status. This reinforces the need for intersectional monitoring rather than treating “persons with disabilities” as a homogeneous population.

5. Legal and Policy Framework

5.1 UN Convention on the Rights of Persons with Disabilities

Article 25 of the CRPD requires States Parties to ensure access to health services without discrimination on the basis of disability and specifically calls for protection against discriminatory denial of health or life insurance where such insurance is permitted by national law. It also emphasizes the same range, quality and standard of affordable healthcare, disability-specific health services, community proximity and gender-sensitive care. These principles provide an international benchmark against which national health-financing systems can be assessed.

5.2 Rights of Persons with Disabilities Act, 2016

The RPwD Act, 2016 gives domestic legal effect to India’s obligations under the CRPD. Section 25 requires appropriate governments and local authorities to take measures relating to healthcare, including free healthcare in specified circumstances, barrier-free access to government and private hospitals and healthcare institutions, and priority in attendance and treatment. The Act also contains provisions on social security, insurance schemes and

rehabilitation. The legal framework therefore establishes a strong rights-based basis for disability-inclusive healthcare, although implementation depends on schemes, regulations, budgets, administrative procedures and service accessibility.

5.3 AB-PMJAY

AB-PMJAY is a publicly financed health assurance scheme providing cashless and paperless secondary and tertiary hospitalization benefits to eligible households. National Health Authority materials describe coverage of up to ₹5 lakh per family per year and emphasize portability and coverage of pre-existing conditions for eligible beneficiaries. The 2024 expansion for citizens aged 70 years and above is unconditional with respect to income, according to NHA's official FAQ. The policy significance for disability research is that eligibility architecture is not identical to disability status: disability does not, by itself, appear in the reviewed NHA materials as a universal automatic eligibility category. This distinction is important when interpreting advocacy demands for automatic or unconditional disability-based inclusion.

5.4 Insurance regulation and disability-specific products

The insurance regulatory environment has also changed. IRDAI's health-insurance guidance states that insurers are required to make products or add-ons/riders available across categories including persons with disabilities and other categories, while also complying with the RPwD Act and other applicable laws. IRDAI further states that general and health insurers should offer a specific cover for persons with disabilities, persons affected by HIV/AIDS and persons with mental illness, with a model product framework issued by the regulator. This is an important counterpoint to the original manuscript's broad statement that private insurers simply reject PwDs: the current regulatory framework contains explicit obligations, but implementation, product availability, underwriting practices and consumer experience still require empirical assessment.

Framework instrument /	Relevant principle	Peer-review interpretation
UN CRPD, Article 25	Non-discriminatory access to affordable health services and protection against discriminatory insurance denial	International rights benchmark.
RPwD Act, 2016	Healthcare, accessibility, social security, insurance and rehabilitation provisions	Domestic legal framework; implementation must be assessed.
AB-PMJAY	Financial protection for eligible beneficiaries; cashless/paperless hospitalization benefits	Major financing mechanism, but disability-specific automatic eligibility should not be assumed.
IRDAI health-insurance framework	Products for PwDs and compliance with disability law	Regulatory basis for inclusive private insurance; effectiveness needs outcome data.
WHO disability-health equity guidance	Disability inclusion in governance, financing, services and monitoring	Useful international implementation framework.

6. DISCUSSION

The central finding of this review is that the reported insurance gap among PwDs should be interpreted as part of a broader financial-protection and accessibility problem. The 2025 campaign survey provides a timely signal of low insurance coverage and limited AB-PMJAY awareness among its respondents. National survey-based research independently demonstrates that disability-related healthcare expenditure can consume a substantial share of household resources and can contribute to catastrophic expenditure and impoverishment. Taken together, these sources support further investigation of how insurance design and implementation can reduce—not merely re-label—financial risk.

At the same time, the evidence should not be overstated. The 82%, 42% and 28% figures derive from a campaign survey for which the original manuscript does not provide a sampling frame, response rate, instrument validation, weighting or confidence intervals. Consequently, they should not be presented as national prevalence estimates for all PwDs in India. A peer-reviewed article should instead identify them as reported survey findings and explain the evidentiary limitation.

A second issue concerns the difference between awareness, application, enrolment and effective coverage. The statement that 28% “applied” cannot establish how many were eligible, enrolled, received an Ayushman card, used benefits, experienced claim denial, or obtained effective financial protection. Future studies should therefore construct a sequential cascade: awareness → eligibility → application → approval/card generation → first use → successful treatment → claim settlement → financial protection.

Third, insurance is only one element of disability-inclusive health financing. Disability-related costs may include rehabilitation, assistive technology, transport, personal assistance, caregiver time, communication support and repeated outpatient services. A hospitalization-focused financing instrument may therefore leave important disability-related expenditure uncovered. This issue is particularly relevant to UHC because WHO defines UHC across the continuum from health promotion and prevention through treatment, rehabilitation and palliative care.

Fourth, gender and intersectionality deserve greater attention. The original manuscript correctly highlighted concerns about women with disabilities, but the evidence should be expressed analytically rather than rhetorically. Research using NSS data has found gender differences in disability-related healthcare expenditure. Future studies should examine whether disability, sex, rural residence, caste/tribal status, poverty, age and type of disability interact to produce different insurance and healthcare outcomes.

Finally, the review identifies a governance issue: disability-disaggregated indicators should be integrated into health-financing monitoring. WHO recommends disability-disaggregated data for tracking UHC coverage and outcomes. Without such data, schemes may appear universal while persistent exclusion remains invisible.

7. Policy and Practice Implications

Priority	Recommended action	Suggested indicator
Accessible information	Provide AB-PMJAY and insurance information in plain language, accessible digital formats, Braille/large print, sign-language/video and community outreach formats.	Awareness and comprehension by disability type and geography
Enrolment accessibility	Enable assisted enrolment, accessible kiosks, simplified documentation and support through trained frontline workers.	Application completion rate; time to enrolment
Coverage cascade	Track eligibility, application, approval, card issuance, utilisation and claims separately.	Coverage cascade at district/state level
Private insurance	Monitor availability, underwriting decisions, exclusions, pricing and complaints for PwDs under applicable IRDAI requirements.	Acceptance/rejection reasons; complaint resolution time
Financial protection	Measure OOPE including medical and non-medical disability-related costs, not only inpatient expenditure.	OOPE, CHE and impoverishment by disability subgroup
Service accessibility	Audit hospitals and digital systems for physical, communication and procedural accessibility.	Accessibility compliance and user-reported barriers
Disability-disaggregated data	Integrate disability status and functional indicators into UHC monitoring while protecting privacy.	Coverage and outcomes by disability status
Participation	Include organisations of persons with disabilities in scheme design, monitoring and grievance mechanisms.	Number and quality of participatory mechanisms
Research	Conduct a transparent, independently designed national study of insurance coverage and AB-PMJAY utilisation among PwDs.	Representative prevalence estimates with CIs

8. Research Agenda

1. Validate the 2025 campaign estimates using a transparent probability-based national sample or a well-described multi-stage design.
2. Publish the questionnaire, sampling frame, response rate, missing-data procedures, weighting strategy and confidence intervals.
3. Measure the full insurance cascade from awareness to effective financial protection.

4. Compare outcomes across disability types, age groups, gender, rural/urban residence, socioeconomic status and social-group categories.
5. Examine the relationship between insurance status and disability-related outpatient care, rehabilitation, assistive technology and caregiver costs.
6. Study private-insurance underwriting and claims experiences quantitatively using administrative and consumer-complaint data.
7. Evaluate whether accessible enrolment interventions increase uptake and reduce delays.
8. Develop a disability-inclusive UHC monitoring framework aligned with WHO guidance and India's legal obligations.

9. Strengths and Limitations

9.1 Strengths

- Integrates campaign-reported evidence with nationally representative Indian disability-survey research.
- Separates legal entitlements and regulatory requirements from empirical evidence about implementation.
- Uses international disability-health standards to frame the analysis within UHC and human-rights principles.
- Explicitly identifies uncertainty around the methodology of the 2025 campaign survey rather than treating it as a nationally representative epidemiological estimate.

9.2 Limitations

- The technical report for the 2025 NCPEDP campaign survey was not available in the material supplied; therefore its sampling, response rate, questionnaire validity and weighting could not be independently assessed.
- The review is structured and narrative rather than a registered systematic review; no meta-analysis was attempted.
- Most Indian disability expenditure evidence is based on the NSS 76th Round conducted in 2018, so it should not be interpreted as a direct estimate of 2026 conditions.
- Media reports are used only to document the reported 2025 campaign findings; they are not treated as substitutes for the underlying survey dataset.
- The review does not include individual-level claims or enrolment data from AB-PMJAY, so it cannot estimate actual disability-specific utilisation or claim-denial rates.

10. CONCLUSION

Evidence reviewed in this manuscript indicates a substantial challenge in achieving disability-inclusive financial protection for healthcare in India. The 2025 “Ayushman for All” campaign reported high levels of uninsured status and limited awareness of AB-PMJAY among its respondents, while nationally representative research demonstrates that disability-related healthcare can impose catastrophic expenditure and impoverishment on households. India has an established legal and regulatory architecture supporting disability-inclusive healthcare and insurance, including the RPwD Act, IRDAI requirements and the broader UHC orientation of Ayushman Bharat.

The key research question is therefore increasingly one of implementation: whether eligible persons with disabilities can understand, access, enrol in and effectively use health-financing mechanisms without discrimination or additional administrative burden. A rigorous disability-inclusive approach should combine accessible information, assisted enrolment, transparent insurance practices, accessible health facilities, disability-disaggregated monitoring, effective grievance redressal and meaningful participation of persons with disabilities. Future peer-reviewed research should independently validate the 2025 campaign estimates and move from headline coverage figures toward evidence on actual utilisation and financial protection.

11. Declarations

Ethics approval: Not applicable. This manuscript is a secondary narrative review and does not involve collection of new human-participant data.

Consent to participate: Not applicable.

Data availability: No new dataset was generated. The manuscript uses publicly available sources and the campaign findings reported in the supplied manuscript and public reporting.

Conflict of interest: The author should disclose any relevant financial, professional or institutional conflicts before journal submission.

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Author contribution: The author conceptualized the manuscript and is responsible for the interpretation and final version.

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