

Comparative Assessment of Health Insurance Models and Policy Determinants: Lessons for India from International Practices

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Abstract: Conclusions are drawn from this study by investigating models, frameworks, and policy impacts on health insurance systems in India. This research looks at the public health insurance programs of the US, India, South Korea, Australia, Finland, Kenya, and the UK. Emphasis is placed on AB-PMJAY. A variety of research methods are employed in this study. The coverage, financial security, system governance, health equity, efficiency, and sustainability of health insurance are evaluated in this study using quantitative and qualitative metrics. Rates of maternal and infant mortality, healthcare expenditure per capita, health insurance penetration, and out-of-pocket expenses are all ways to quantify healthcare. By comparing these features across countries, we may learn how well those health insurance systems work. The qualitative part of the study looks at how laws and policies that target the coordination of socioeconomic institutions impact the availability and affordability of health insurance. Though AB-PMJAY improved access, it had the opposite effect on administrative efficiency, horizontal equity, and financial sustainability in India, according to the study. India can tweak a few processes by comparing tax-funded, social insurance, and mixed-models. Together, we can accomplish strong leadership, public-private partnerships, and protections for vulnerable communities. Universal health coverage, better health care accessibility and sustainability, and stronger health insurance are all things that the study suggests addressing.

Keywords: Health Insurance, Comparative Analysis, AB-PMJAY, Policy Determinants, Universal Health Coverage, India, Global Best Practices

INTRODUCTION

Insurance protects individuals financially against the dangers associated with bad health and helps cover the price of medical treatments. A variety of health insurance schemes have been put in place by various nations (Alobo, G. I. 2024). While some have instituted publicly financed universal health care, others have opted to mix public and private insurance (Azimi Nayebi, B. 2025). As a result of low government insurance coverage, high individual contributions, and socioeconomic inequalities, health care services in India are funded in an uneven manner (Daniel, D. A. 2021). It was the government's resolve to implement universal health care through financial assistance for the impoverished that led to the launch of the Ayushman Bharat– Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) (Iskandar, L. Y. 2025).

However, health and health care continue to be significant obstacles to systems that are economically self-sufficient, administratively successful, and promote socioeconomic justice (Selvamuthu, C. M. 2025). India should rationally look to existing health insurance system models for guidance on what works. To assess the coverage and its long-term viability, researchers in India might look to the country's current health insurance system for guidance (Vootukuri, K. 2024).

Background and Rationale

Any shifts in a nation's health insurance market are virtually always the result of factors unique to that country's economy, social goals, and public health system. Developed country governments use a "payroll tax" model of integrated taxes to pay for national health insurance programs (Toth, F. 2021). Every person has a right to health care under this paradigm, regardless of their tax contribution. This approach is founded on concerns about horizontal fairness. In systems with horizontal inequality, the out-of-pocket model is the most common (Prinja, S. 2025). As an example, consider the USA. This is an example of how the unequal distribution of health care services is caused by the use of private insurance to pay for medical treatment. A combination of public-controlled and privately-regulated health insurance is utilized to finance medical treatment in South Korea, Argentina, and Finland (Rice, T. 2021). This system is supported by private health insurance. Health care coverage and access are still aspirational in economically and socially disadvantaged areas like Kenya due to disjointed health care systems and inadequate funding for public health services (Shestakova, Y. 2025). The most economically disadvantaged people in India may now get health insurance thanks to recent changes like the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). Improving India's health insurance strategy may be achieved by studying other nations' governmental structures, finance choices, and equality centered policies (Ziegler, S. 2024).

Health Insurance Models: Global Perspectives

There are a few different kinds of health insurance systems in the globe. The most common ones include mixed systems, social insurance, and tax-funded systems. Social insurance systems like South Korea's and Finland's compel employers and workers to pay, which makes the funding of extensive coverage viable (Raghuvanshi, S. 2025). Tax-funded systems, like the ones in the UK and Australia, prioritize universal access and use taxes to pay for insurance (Elahi, R. 2024). When it comes to accessibility, efficiency, and cost, the United States is a mixed-system example because of the private insurance market and the fact that some

populations are covered by the government (Agustina, A. 2024). This diversity in social and economic variables is shown by the fact that different systems must strike a balance between benefits, regulatory control, depth of coverage, and the funding of protections (Furrer, C. 2025). While lowering out-of-pocket expenses for patients, these insurance models provide a variety of ways to increase coverage and fairness in health care access. The AB-PMJAY in India may take a page out of the worldwide models' books when it comes to public-private partnerships, efficient governance, and keeping costs down, even if it is a publicly-funded insurance system (Zinihi, A. 2025).

Objectives and Scope of the Study

In light of policies influencing the breadth of service, financial and governance safeguards, and equitable distribution of health resources, this research aims to analyze and contrast public health insurance systems in other nations with India's systems. Additional goals include studying the health insurance systems of the following countries: USA, South Korea, Argentina, Australia, Finland, Kenya, and South Korea to learn what works and what doesn't so that we can make evidence-based changes to AB-PMJAY and adapt it to India's system. In addition to attempting to quantify and qualitatively evaluate health system regulation and policy, this study use the frameworks of economic health service usage, health service outcomes, and health service coverage to assess health system socioeconomic indicators. In order to enhance India's insurance health care system and attain fair, sustainable, and inclusive health care, the research aims to assist health insurance policymakers in taking alternative actions based on lessons learned from other nations.

LITERATURE REVIEWS

Sahoo, P. M. (2023) Economic differences in health insurance financing, structure, and control are a result of differences in policy objectives and economic capacity. Studies comparing different health insurance models throughout the world have shown a variety of financing mechanisms, such as public health insurance, private health insurance that is voluntary, mixed multiple payer systems, and systems that are entirely supported by taxes. Varieties in payment methods, risk sharing, and governmental oversight characterize these approaches. A large population covered and better financial security are results of strong risk pooling and centralized financing. These cross-national analyses reveal the control and structural factors that influence the effectiveness and sustainability of health insurance programs across nations.

Mossialos, E. (2020) The distinctions between single-payer and multi-payer healthcare finance models have been extensively studied. One unified risk pool is created by government financing through taxes in single-payer systems, which allows for better control over healthcare spending and more fair access. However, administrative overhead and uneven access are regular outcomes of multi-payer systems, despite the fact that they offer greater flexibility and customer choice. by what we can tell by comparing policies, there isn't a silver bullet when it comes to healthcare funding; rather, by combining several models, we can find the optimal balance between efficiency, equality, and sustainability.

Paramarthalingam, K. (2022) health insurance frameworks reveals that policies shield families from the potentially disastrous financial effects of medical treatment while simultaneously expanding their access to quality medical treatment. The foundation of insurance is the idea of dividing up the financial burden of a disease and other risks. Health insurance expansion is critical for developing nations to lower healthcare costs and increase access, according to research. Nevertheless, regulatory constraints, policy benefit designs, reimbursement rules, and health provider coordination impact insurance programs' efficacy. With this knowledge in hand, insurance companies may craft plans to better safeguard their clients' health and finances.

Dixit, P. (2020) Health insurance models differ in their success depending on factors other than financial ones, according to comparisons of healthcare systems throughout the world. Government policy, institutional coordination, and healthcare system ability to provide services are other considerations. Patients report higher levels of satisfaction, easier access to treatments, and more efficient use of healthcare resources when their country's healthcare legislation and system are more coherent, according to research from other nations. On the other hand, health care is commonly cited as expensive and unequal in systems that are disjointed and lack proper regulation. Developing nations may strengthen their healthcare systems, according to policy analysis, by instituting computerized claims processing, centralized rules, and integrated public-private partnerships. This has the potential to improve the effectiveness and sustainability of their national health insurance systems.

METHODOLOGY

Research Design

The research used a comparative case study approach to examine the selected nations' public health insurance systems, policies, and outcomes. This method permits an in-depth understanding of the various healthcare funding models and the governing structures that regulate them. Research comparing India's healthcare system to that of other nations sheds light on shared objectives (such as universal coverage) and varying levels of focus on financing, fairness, and regulation. To better understand the factors (such as socioeconomic status, demographics, and institutional frameworks) that impact policymaking and implementation, qualitative researchers often turn to case studies. Examining the AB-PMJAY in India through the lenses of institutional flexibility, financial sustainability, and coverage adequacy, the author draws comparisons to other nations to highlight what may work for India and be easily replicated.

Study Type and Sample Selection

This study takes a descriptive and comparative approach to its research, focusing on eight nations chosen at random to represent different types of health insurance (e.g., tax-based, social insurance, and hybrid models). There is no need to compute a sample size in the conventional sense because this study relies solely on secondary data. To maintain a fair representation of the world's nations, we choose our sample based on the variety of their financial systems, policy reactions, and socioeconomic situations. This statistically-based comparison sample provides a chance to compare and contrast the public and private health insurance systems in terms of efficiency, financial security, oversight, and coverage. In order to improve the health insurance policies and program implementations in India, this evaluation sample will help provide findings.

Data Sources

All aspects of health financing, insurance, population health, and policy frameworks are covered by the data used in this study, which comes from a wide range of international and domestic sources such as the World Health Organization (WHO), the World Bank, the OECD, the United Nations Development Program (UNDP), reputable national policy journals, peer-reviewed publications, and official government reports. Secondary data allows for quantitative cross-national comparisons of health systems, insurance coverage, out-of-pocket expenses,

total health expenditures per capita, and overall health expenditures. This is useful in health funding analysis. Analysis, governance, and policy frameworks are covered in secondary data found in health-related publications and policy research. Health insurance research that draw from a variety of disciplines have improved the validity, dependability, and breadth of coverage for every country's health insurance market.

Data Analysis Techniques

The research makes use of contextual interpretation, comparative matrices, and thematic analysis. Policy tendencies and governmental structures can be discovered via theme analysis of qualitative data. A comparison matrix examines equality, efficiency, coverage, and financing. Using data on life expectancy, out-of-pocket spending, newborn and maternal mortality, we can identify and quantify the components. Practices' transferability to India's healthcare system may be ascertained by contextual interpretation, which examines demographic, socioeconomic, regulatory, and institutional factors. To get to the study's conclusion, the composite method strategically investigates both the policy processes and the outcomes.

SWOT Analysis for India

In order to comprehend the public health insurance system in India and provide concrete policy suggestions for improvement, the study used a SWOT analysis approach. Population coverage and assistance for certain disadvantaged groups are two of AB-PMJAY's strongest points. Funding, administrative inefficiencies, and unfairness are all areas of concern. The Indian system may learn a lot from successful overseas models that have been found through public-private partnerships, cost containment criteria, and strong governance. Dangers include financial difficulties, disjointed service delivery, and the preponderance of the private sector. In order to improve the health insurance system's efficacy, efficiency, and sustainability, the SWOT analysis incorporates global lessons with the Indian policy environment.

RESULTS

Coverage and Accessibility

Comparing public and private insurance systems, as well as analyzing the various benefit packages, reveals that tax-funded systems in the European Union and Australia provide nearly universal coverage, while the mixed-model system in the United States reveals large coverage

gaps. Although 40% of Indians are covered by the AB-PMJAY system, there is still a coverage gap, particularly among rural residents and the vulnerable. When there is sufficient enrollment, healthcare infrastructure, and geographic coverage, accessibility becomes successful.

Table 1: Health Insurance Coverage Across Selected Countries (2025 Estimates)

Country	Population Coverage (%)	Public Insurance (%)	Private Insurance (%)	Uninsured (%)
India	40	38	2	60
Argentina	92	60	32	8
Australia	99	70	29	1
Finland	100	100	0	0
Kenya	25	18	7	75
South Korea	96	80	16	4
UK	100	100	0	0
USA	92	35	57	8

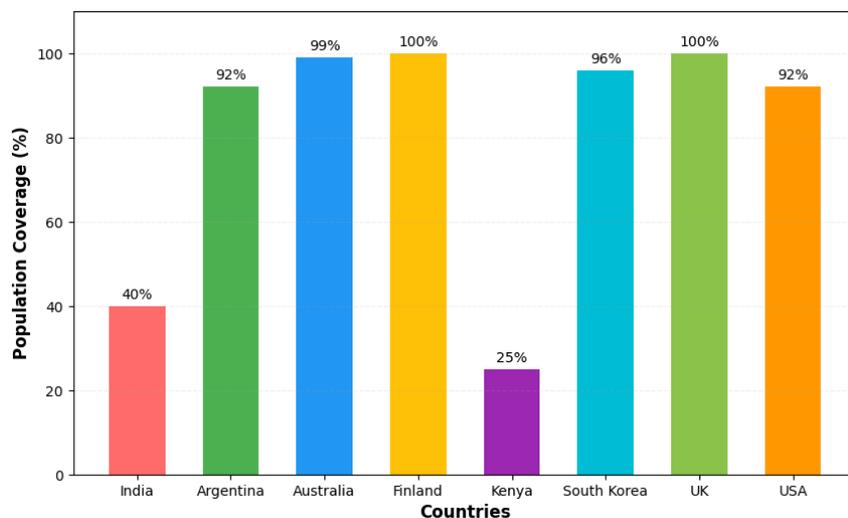


Figure 1: Health Insurance Population Coverage Across Selected Countries

Financial Protection

The more a person's health insurance protects them financially, the less money they will have to pay out of pocket. People without health insurance are financially at risk. The large out-of-pocket costs in India for left-wing protection measures, AB-PMJAY, and other programs suggest that reimbursement and benefit coverage constraints are issues. Finnish and British citizens with entirely public insurance have the lowest out-of-pocket costs. In spite of widespread health insurance, out-of-pocket medical expenses are considerable in the United States.

Table 2: Out-of-Pocket Expenditure per Capita and Total Health Expenditure (% of GDP)

Country	OOP per Capita (USD)	Total Health Expenditure (% GDP)	Government Health Expenditure (% GDP)
India	220	3.5	1.5
Argentina	500	9	6
Australia	600	9	6
Finland	200	9	7
Kenya	150	6	3
South Korea	400	8	5
UK	250	10	7
USA	1,200	17	8

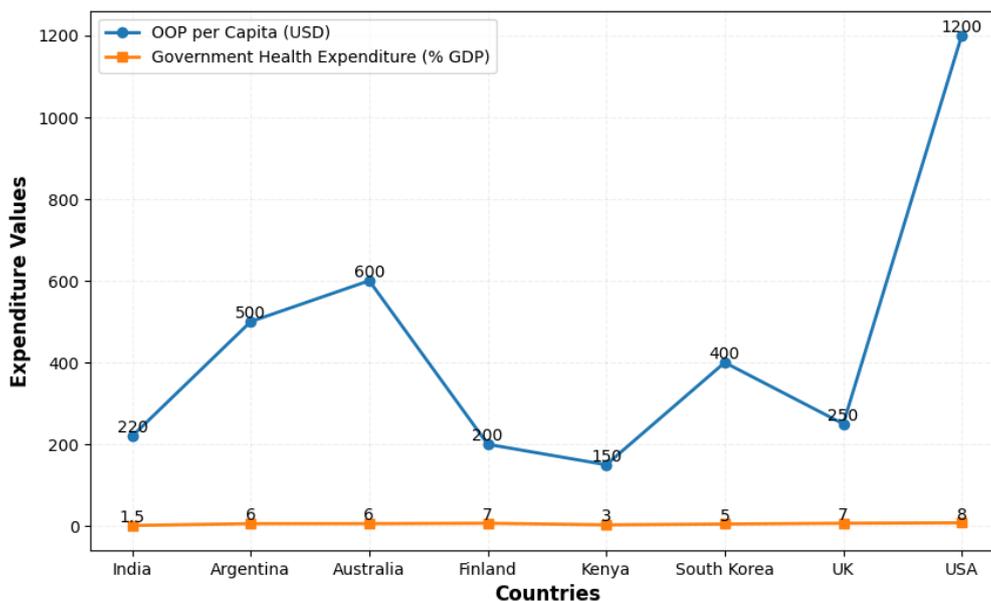


Figure 2: Comparison of Out-of-Pocket Expenditure and Government Health Spending

Governance and Administrative Efficiency

The efficiency of health insurance schemes is influenced by the government and the manner in which it manages these programs. A country's efficiency increases when its government is centralized because of the rigorous control and oversight, as well as the transparency of its procedures. Problems with monitoring, claim processing, and departmental coordination have impacted the efficient use of resources and the prompt delivery of services in India's decentralized government, which has led to AB PMJAY.

Table 3: Governance and Administrative Indicators

Country	Centralized Governance	Claim Processing Time (Days)	Administrative Cost (%)
India	Partial	30	10
Argentina	Centralized	20	8
Australia	Centralized	15	7
Finland	Centralized	10	5

Kenya	Decentralized	35	12
South Korea	Centralized	12	6
UK	Centralized	10	5
USA	Mixed	25	9

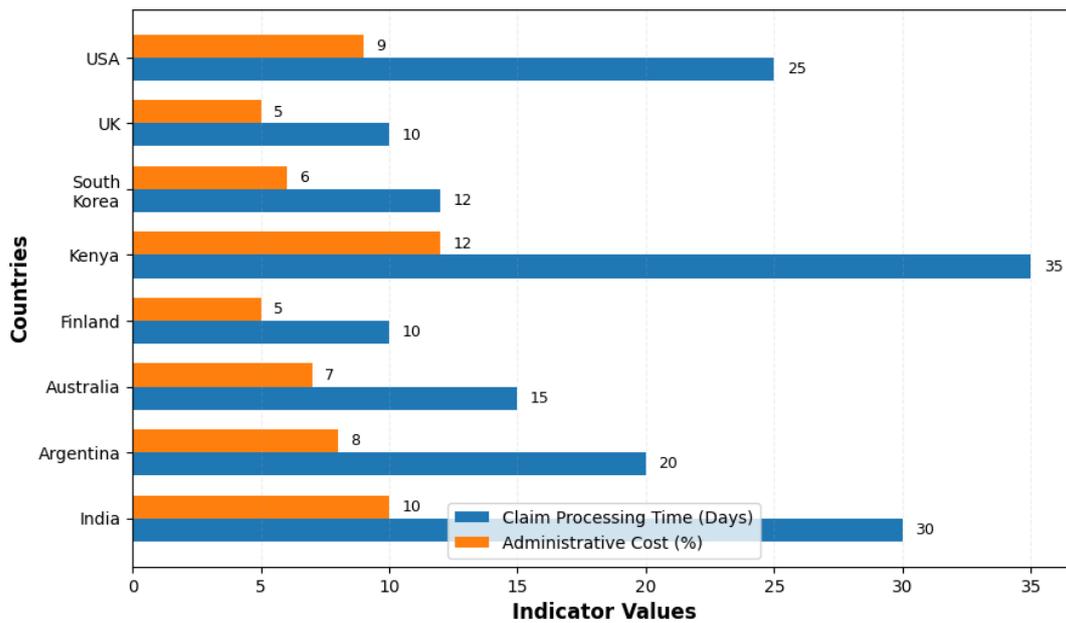


Figure 3: Claim Processing Time and Administrative Cost by Country

Equity and Social Inclusion

In order to ensure fairness, we must consider whether vulnerable and neglected groups, such as those living in rural areas, women, and the economically disadvantaged, are provided with the necessary insurance and services. The economically poor are AB-primary PMJAY's emphasis, but there are still information and geographic gaps that need to be filled. There exist income and employment-based imbalances in the United States and other mixed-system countries, in contrast to the equity-based systems developed by Finland and the United Kingdom.

Table 4: Population Coverage for Vulnerable Groups (%)

Country	Rural Coverage (%)	Women Coverage (%)	Low-Income Coverage (%)
India	35	42	40
Argentina	90	92	91
Australia	97	99	96
Finland	100	100	100
Kenya	20	25	18
South Korea	95	96	94
UK	100	100	100
USA	85	87	82

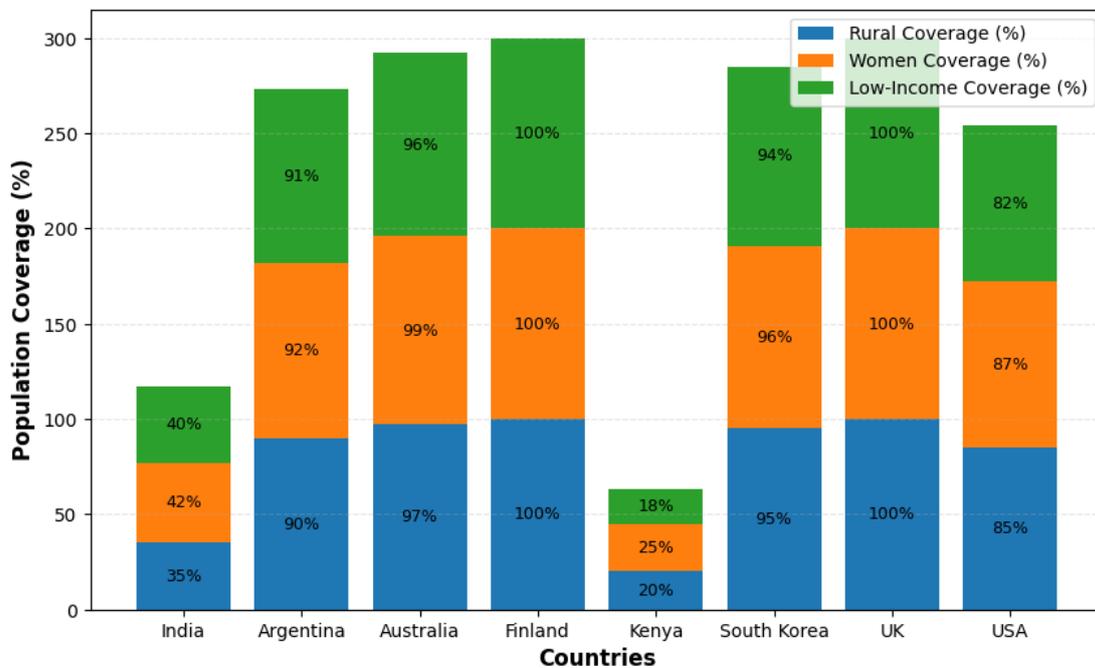


Figure 4: Health Insurance Coverage for Vulnerable Groups Across Countries

Sustainability and Adaptability

A long-term financial and operational view is taken into account when discussing health insurance systems in terms of sustainability. To be adaptive, one must be able to incorporate new ideas, scale up or down programs, and react to shifts in population size or illness trends. Public funding and inadequate private insurance integration threaten AB-PMJAY's long-term viability. South Korean and Australian systems exhibit robust adaptive performance as a result of meticulous budgeting and consistent policy tweaks.

Table 5: Indicators of Sustainability and Adaptability

Country	Public-Private Integration	Policy Revision Frequency (Years)	Fiscal Sustainability Score*
India	Partial	5	65
Argentina	Moderate	3	75
Australia	High	2	85
Finland	High	3	90
Kenya	Low	5	55
South Korea	High	2	88
UK	High	3	90
USA	Moderate	3	80

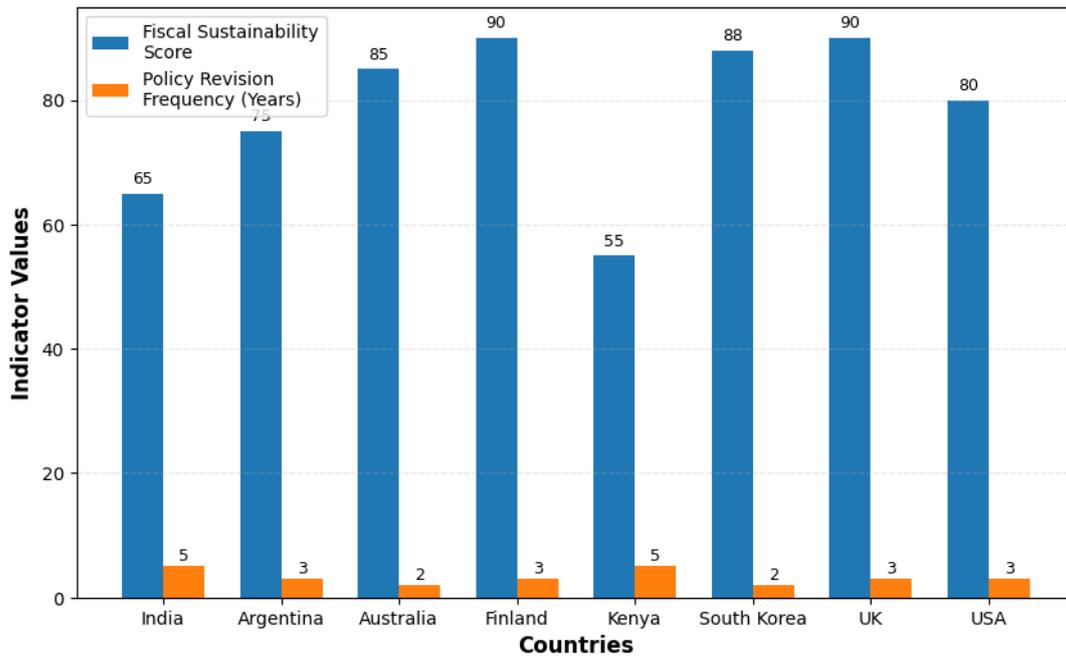


Figure 5: Comparison of Fiscal Sustainability and Policy Revision Frequency

CONCLUSION

Comparing the health insurance systems of India, Argentina, Australia, Finland, Kenya, South Korea, the UK, and the US can help determine the most effective, egalitarian, and sustainable health care finance systems. The analysis found governance, coverage, equity, and financial gaps in India's Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), which provides universal health coverage. International comparisons show excellent administrative efficiency in Finland, Australia, the UK, and the US social insurance and tax-funded programs. They also have strong centralised government, rigorous rules, and integrated service delivery systems. These nations' health care systems have low or no out-of-pocket fees for services. India can emulate the US' mixed-system health care system, which uses private health insurance and provides unaligned coverage. Indian health insurance systems may learn from others. India must restock its underserved response systems and diversify its health care finance to make its systems more financially viable and enhance fairness. The analysis shows that equity-focused strategies may fill gaps easily. This study shows that India may improve its health insurance system by embracing global best practices and evidence-based policies. These metrics might include quantitative performance measures, subjective explanations, and institutional frameworks. AB-PMJAY's comprehensive, efficient, and long-term policy

framework would allow all Indians to afford high-quality medical care. This is how AB-PMJAY would help India achieve universal health insurance.

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