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POLICYBRIEF
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Addressing Gender Disparities in Health Insurance: Pathways Towards Equitable Universal Coverage in India

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Introduction

India has made significant strides in expanding health insurance coverage over the past two decades, with public schemes like Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) enrolling over 420 million beneficiaries by 2025 and IRDAI's 2024 regulations signalling a progressive push toward inclusivity. Yet, scale of coverage does not automatically translate into equity of coverage. Despite ranking as the world's most populous democracy and the fifth-largest economy, India placed 131st out of 148 countries in the World Economic Forum's Global Gender Gap Index 2025, with persistent gaps specifically in women's health and survival, a signal that structural inequities in health access remain unresolved at the systemic level (WEF, 2025). Building upon this underexplored aspect of gender disparity and extending the analysis presented by Goyal (2026) (see Acknowledgement), this policy brief adds that the health insurance frameworks in India, across both public and private sectors, have largely failed to recognise female-specific healthcare needs as standard insurable entitlements.

To do so, it explores deep systemic gaps in coverage for female-specific healthcare needs in India, including maternity care (e.g., diagnostics, pre/post-natal services), gynaecological conditions (such as PCOS/PCOD and reproductive health issues), and mental health services (often limited to acute hospitalisations) – which, additionally, continue to be treated

Highlights

India ranked 131st out of 148 in the 2025 Global Gender Gap Index, highlighting critical structural gaps in women's health and survival.

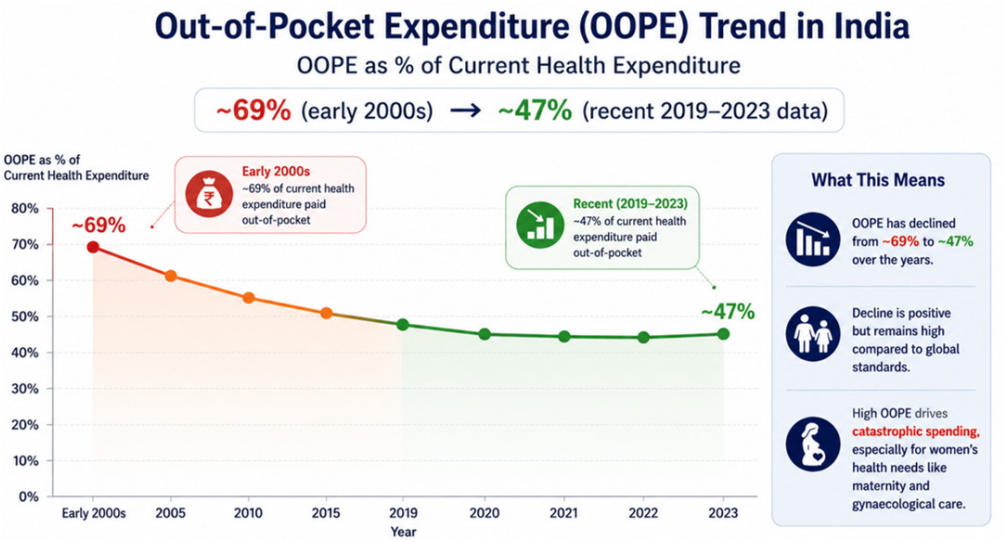
Standard public and private health insurance policies largely exclude or restrict coverage for maternity, gynaecological conditions (e.g., PCOS/PCOD), and outpatient mental health.

Where female-specific benefits exist, they are often conditional on 1–4 year waiting periods, reduced coverage caps, or high-cost premium add-ons.

Insufficient insurance coverage drives out-of-pocket health expenditure (OOPE) to nearly 45–50%, pushing low-income and marginalised women into poverty traps.

Achieving UHC (SDG 3.8) and Gender Equality (SDG 5) requires IRDAI-mandated minimum coverage for women's health, expanded public schemes (AB-PMJAY), and gender-disaggregated data.

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Source: Kamath S, Maliyekkal J, Elstin Anbu Raj S, Varshini RJ, Brand H, Sirur A, Singh V, Prabhu V, Sumit K and Kamath R (2025). Understanding out-of-pocket expenditure in India: a systematic review. Front. Public Health, 13:1594542. doi: 10.3389/fpubh.2025.1594542

as exclusions, optional riders, waiting-period-bound or premium-priced add-ons in health insurances. These gaps remain despite India's formal commitments to the Sustainable Development Goals (SDGs) and 'glocal' emphasis on SDG 5 for greater equality and the need for gender-responsive healthcare systems (Sen et al., 2020). These include SDG 5 targets on reproductive health and rights while advancing universal health coverage under SDG 3.8, social protection mechanisms (SDG 1.3.1 and 10.4), and reduced greater inequalities through SDG 10 (particularly 10.4).

Such disparities not only perpetuate out-of-pocket expenditure (OOPE) at alarmingly high levels, around 45–50% of total current health spending in recent years, but also disproportionately drive vulnerable women, especially from low-income, rural, or marginalised caste/class backgrounds, or with disabilities, into poverty traps. This undermines broader gender equity goals (SDG 5) by leaving female-specific risks underinsured, forcing reliance on costly private care or outright forgoing treatment, as evidenced by World Bank/WHO data on catastrophic health spending. As a result, insurance products that are ostensibly gender-neutral often reproduce systemic biases by embedding male-centric assumptions about health risks, care needs, and financial protection. The brief reemphasises the call for policy reforms, increased public healthcare infrastructure investment, and inclusive public-private partnerships (PPP) to ensure equitable access and progress toward Agenda 2030.

Background

India's welfare system combines social-democratic principles established after independence in 1947, including commitments to equality and constitutional rights to life and non-discrimination, with market-oriented reforms following the economic Liberalisation, Privatisation, and Globalisation of the 1990s, producing a hybrid welfare model that incorporates public-private partnerships in healthcare. Social protection via health insurance is mandated under SDG 1.3 and 10.4 to reduce vulnerabilities, and for that, the system comprises government-sponsored schemes (subsidised for poor/vulnerable) and private insurers (premium plans for middle/upper classes). It operates in a three-tier structure (primary subsidised by taxes, secondary/tertiary via strategic purchasing). The Constitution directs the state to ensure healthcare access without discrimination, but health is not a justiciable right, leaving insurers autonomy over coverage decisions.

Despite significant progress, women—nearly half of India's population—face disproportionate barriers (National Statistical Office, 2022). These barriers intersect with SDG 5 commitments on eliminating gender-based discrimination and ensuring urgent essential reproductive healthcare access. While IRDAI's 2024 regulations promote inclusive insurance, prohibiting gender identity discrimination and requiring coverage for health needs regardless of one's gender, India ranked 131st out of 148 countries in the World Economic

Forum's Global Gender Gap Index 2025, with persistent gaps in health and survival (WHO, 2025). Even if OOPE has declined to 45–50% of total health expenditure, with some estimates at 43.89% in 2023, it still remains catastrophic, especially pushing vulnerable women from low-income households below the international poverty line ($3.00/day (2021 PPP)), particularly for costly female-specific treatments, with intersectional barriers (rural/urban, caste/class) worsening this access.

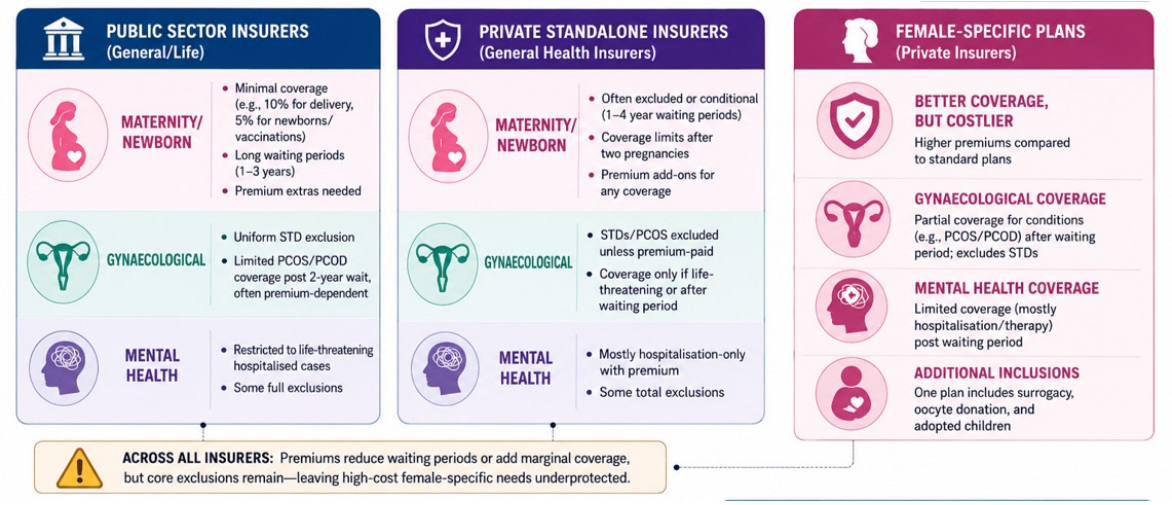
Union health budget allocation for 2025–26 stood at 10,99,78,20,900 USD, a significant increase over 2024–25, though the overall public health spending remains under 2% of GDP, which is below the 2.5% target by 2025 and is deemed inadequate for the commitment to cover universal healthcare needs of the Indian population, which is projected to reach 1.5 billion by 2030 (Bakshi, 2025).

While national level public schemes like Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) have expanded significantly, including to all senior citizens aged 70+ with Rs 5 lakh annual cover (October 2024) and over 42 crore enrolled as of October 2025 (PIB, 2024), they provide family-based cover, leaving the decision in the hands of the family head/breadwinner. Moreover, while it includes some maternity/gynaecological procedures, it excludes outpatient diagnostics, full mental health, and many female-specific risks. At the state and district level, implementation varies significantly in enrolment, awareness, supplementary coverage, and existing urban/rural healthcare infrastructural developments and specialised human resource availability in the region (which remains scarce in rural and semi-rural areas), influencing gender-based healthcare outcomes accordingly (e.g., Rajasthan's Bhamashah Swasthya Bima Yojana (BSBY) Scheme showed gender gaps in utilisation (Dupas and Jain, 2021) while Tamil Nadu's Dr. Muthulakshmi Reddy Maternity Benefit Scheme has been somewhat effective in reducing maternal mortality rates (Madonna, 2025).

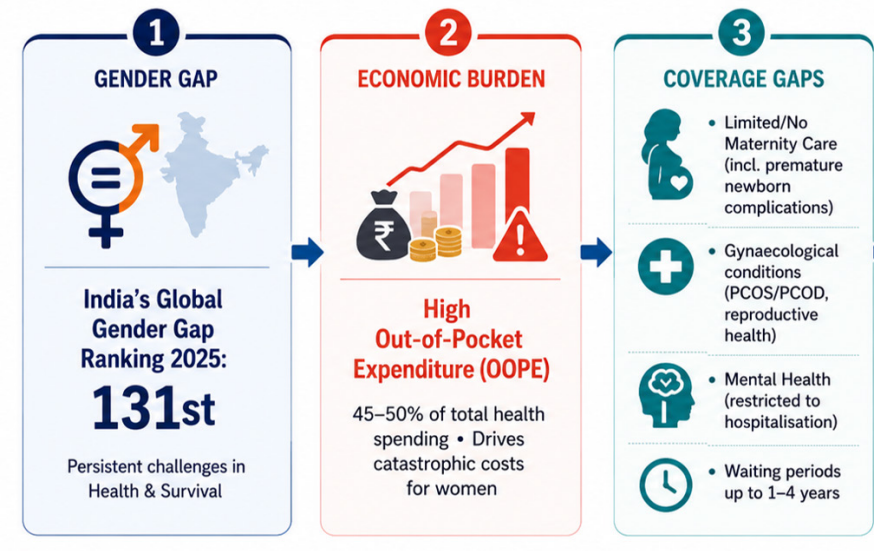
> "Maternity care is treated actuarially as a high-frequency, high-cost risk that threatens profitability, rather than as a fundamental public health necessity."

Policy Analysis and Findings

India's health insurance market is governed by the Insurance Regulatory and Development Authority of India (IRDAI) and comprises two broad segments: government-sponsored schemes (primarily the national level Ayushman Bharat Pradhan Mantri Jan Arogya Yojana, or AB-PMJAY, as well



Source: Goyal, T. (2026). Insuring injustice: Unveiling inequality in Indian health insurance policies for women. In Roman et al. (Eds.), Social inequalities within and among countries: Achieving SDG 10 through social interventions. Springer.)



Source: Please refer to the bibliography section as a whole.

as state-level equivalents), and private standalone health insurers. A comprehensive document analysis of all four public sector general/life insurers and all seven private standalone health insurers (including 3 female-specific plans) with Pan-India (PAN) presence, registered with IRDAI (2021–2023), reveals systemic gaps in coverage across three critical female-specific healthcare domains: maternity/newborn care, gynaecological diseases/diagnostics, and mental distress.

In a nutshell: premiums reduce waits/add marginal coverage but still retain core exclusions. Public schemes (e.g., AB-PMJAY) provide family-based inpatient focus, sidelining outpatient/preventive needs and female-specific risks (for instance, it excludes infertility, full diagnostics, and routine mental health).

Maternity and Newborn Care

Among public sector insurers, no provider offered comprehensive coverage for maternity-related diagnostics or routine antenatal and postnatal check-ups and services essential for preventing maternal and neonatal mortality. Where pregnancy-related coverage does exist (e.g., for normal delivery, caesarean section, or ectopic pregnancies), it is capped at approximately 10% of total expenses, subject to waiting periods of one to three years, and conditional on the purchase of additional premium packages, placing it beyond the reach of the low-income women these schemes are ostensibly designed to serve (Goyal, 2026). Newborn care and vaccinations follow a similarly restrictive pattern, with coverage limited to around 5% of total costs. Critically, where empanelled hospitals lack the required specialised facilities, a common occurrence in rural and semi-urban settings, insurers routinely redirect patients to private providers at their own expense, converting a coverage gap into a catastrophic OOPE event.

Private standalone insurers offer marginally more flexibility, with five out of seven covering newborn vaccinations under a standard premium. However, two insurers exclude maternity coverage entirely unless specific premium plans are purchased, and even these are conditioned on waiting periods of one to four years and a maximum of two pregnancies, a design that penalises women who are most likely to need coverage. Female-specific plans from private insurers show modest improvement: some cover complications up to 25% of total costs, and one extends coverage to surrogate mothers and oocyte donors. But these plans are uniformly costlier, making them accessible primarily to urban, upper-middle-class women, the demographic least in need of subsidised coverage.

The structural reason for these gaps is twofold. First, because health is not a justiciable right under the Indian Constitution, insurers retain full autonomy over coverage decisions and face no legal obligation to cover female-specific risks. Second, maternity care is treated actuarially as a high-frequency, high-cost risk, one that undermines profitability rather than as a public health necessity, creating a systematic incentive to exclude or restrict it (Goyal, 2026).

Gynaecological Conditions

Coverage for gynaecological conditions across all insurer categories is minimal, inconsistent, and condition-selective in ways that bear no relation to clinical prevalence. Sexually transmitted diseases (STDs) are excluded universally and without exception across all public and private plans including female-specific ones, despite their documented role in gynaecological morbidity and fertility outcomes. Among public insurers, only three cover the most common conditions such as polycystic ovary syndrome (PCOS) and polycystic ovarian disease (PCOD), but only after a two-year waiting period; and just one covers broader gynaecological issues after a two-year wait under selective premium covers. Diagnostic tests, which are essential for early detection and management, are covered by only one public insurer, and only once every two years, with reproductive health tests explicitly excluded.

Private insurers mirror this pattern. Three exclude PCOS/PCOD entirely; others cover these conditions only if they become life-threatening or under premium plans with waiting periods of two to four years. Only three out of seven cover diagnostic tests, and only under premium plans. Female-specific policies do not substantially improve matters: PCOS/PCOD and gynaecological conditions are partially covered under premium tiers, with waiting periods of two to four years, and one insurer restricts coverage to life-threatening presentations only.

These exclusions are particularly damaging given that gynaecological conditions are among the most prevalent, chronic, and economically disruptive health risks for Indian women. Because they are rarely immediately life-threatening, they fall below the threshold of “acute hospitalisation” that most policies use as their coverage trigger, a threshold that structurally disadvantages conditions that are chronic, ambulatory, or preventive in nature, and that disproportionately affect women (WHO, 2021; Goyal, 2026).

Mental Health

Mental health coverage is the most uniformly restricted domain across the entire insurance landscape. The dominant model across both public and private insurers, is to cover mental health conditions only when they are (a) life-threatening and (b) require inpatient hospitalisation. This design effectively excludes the vast majority of mental health presentations: depression, anxiety, gynae condition-related psychological distress, perinatal mental health conditions, and trauma-related disorders — all of which are overwhelmingly managed on an outpatient basis. Among public sector general insurers, one provider excludes mental health coverage entirely; public life insurers, despite their widespread adoption among Indian households, offer no meaningful mental health differentiation at all. Private insurers are only marginally better: four cover mental health conditions post-hospitalisation and under premium plans, while three exclude the category entirely. Female-specific plans largely replicate this hospitalisation-only, life-threatening threshold, with one insurer opting out of mental health coverage altogether.

> "The persistent framing of mental healthcare as a luxury or risk category rather than a fundamental health need becomes the key issue here."

The persistent framing of mental healthcare as a luxury or risk category rather than a fundamental health need becomes the key issue here. This is compounded by India's low base of mental health infrastructure, there are fewer than 0.3 registered psychiatrists per 100,000 people in most states, meaning that even where coverage exists on paper, access is constrained by supply-side failure (Selvaraj et al., 2022). The government's tele-MANAS initiative offers a promising outpatient model, but its integration into insurance reimbursement frameworks remains absent under current policy structures.

Cross-Cutting Structural Failures

Several systemic features cut across all three coverage domains and explain why gaps persist despite regulatory attention. First, public schemes such as AB-PMJAY are structured on a family basis, delegating enrolment and claim decisions to the household head, who in India is predominantly male. With documented male-biased allocation of household healthcare resources, women in the most vulnerable income brackets are systematically sidelined from accessing even the limited benefits available (Goyal, 2026). Second, approximately 70% of insurance-affiliated hospitals are located in Tier 1 urban cities, which house less than a third of India's population, a geographic concentration that structurally disadvantages rural women, who face both the highest burden of female-specific disease and

the greatest distance to care. Third, IRDAI's 2024 inclusivity directives, while a meaningful step in prohibiting gender identity-based discrimination, do not mandate minimum coverage standards for female-specific clinical needs, leaving the exclusions documented above entirely within regulatory tolerance. Taken together, these features constitute a system that is affordable only because it excludes lower-income, higher-risk individuals, a dynamic that reinforces, rather than reduces, the social inequalities it is mandated to address (Goyal, 2026).

The Way Forward

It is widely proven that women bear unique health risks (reproductive, gynecological, mental), yet policies treat their needs as equal to that of other genders (mainly to that of males), reinforcing discrimination. High OOPE-based care services and urban-centric facilities development projects exacerbate rural/intersectional inequities. This contradicts SDG commitments, especially SDG 3 and 5 and WHO's guidelines on gender and health (mentioned in detail below), which stresses addressing intersectional inequalities (including class/caste and disability) for equitable universal health coverage (3.8) as it requires needs-based entitlement, not profit-driven exclusions. COVID-19 worsened already existing vulnerabilities with low public health spending (below 2% of GDP) limits the scope of schemes. IRDAI's 2024 push for inclusivity (e.g., transgender coverage) signals progress but must extend to gender-specific needs.

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The transformation of healthcare from a profit-driven commodity to a societally grounded, gender-responsive right demands a fundamental shift in how we define 'vulnerability.' As India navigates this transition through policies (with some needing legalisation for efficient on-ground implementation and regulation) and practices, two critical dimensions must be integrated into the final blueprint: the unique healthcare needs, intersectionality, and the rigour of global health standards.

To this end, the below-stated suggestions can serve as a reference for reforming practices and policies.

1. Aligning with WHO Gender & Health Frameworks

WHO emphasises that gender inequality produces barriers to healthcare access, intersecting with various dimensions such as gender norms, socialisation, roles, differentials in power relations and in access to and control over resources, and calls for gender-responsive services to achieve UHC (SDG 3) and in turn, gender equality (SDG 5) (WHO, 2021). India has made strides via IRDAI's inclusivity rules (e.g., transgender coverage), but adaptation requires deeper integration of female-specific needs and other intersectionalities including disabilities and local differences in class, class, region, and ethnicity. Adopting and adapting to WHO guidelines on gender and health (such as WHO recommendations on maternal and newborn care for a positive postnatal experience (2022)) can also serve as a call for national health statistical/data offices and research development institutions to include women and their intersectional health needs more effectively in all phases of health surveys—from collection through implementation, analysis, policy, and outreach—ensuring hyper-vulnerable groups are not overlooked in insurance design (WHO, 2025).

2. Strengthening Regulatory Frameworks for Inclusive Coverage

Mandates should draw from state-level best practices and towards national-to-local schemes, such as enhanced maternal healthcare subsidies integration in Tamil Nadu's health schemes, and PPP examples like Rajasthan's BSBY, which used private empanelment for scale while revealing persistent gender utilization gaps addressable via targeted outreach (Dupas & Jain, 2023). It is suggested that institutions/agencies at the national level viz IRDAI and the Ministry of Health and Family Welfare need to mandate/legalise minimum standardised coverage in all base health insurance plans (public, private, PPP) for female-specific conditions, including maternity diagnostics/pre-

and post-hospitalisation, day-one newborn health coverage (including premature/complication cases), gynecological diseases (PCOS/PCOD, reproductive health tests, medically necessary STD-related care), and essential mental health outpatient services (outpatient counselling, therapy, and non-hospitalised care). Waiting periods should be capped at 6–12 months maximum, with no exclusions for pre-existing conditions including the very commonly found conditions of anemia (Jeevan et al., 2025), related to women's health in India. Premium add-ons should be regulated to prevent discriminatory pricing.

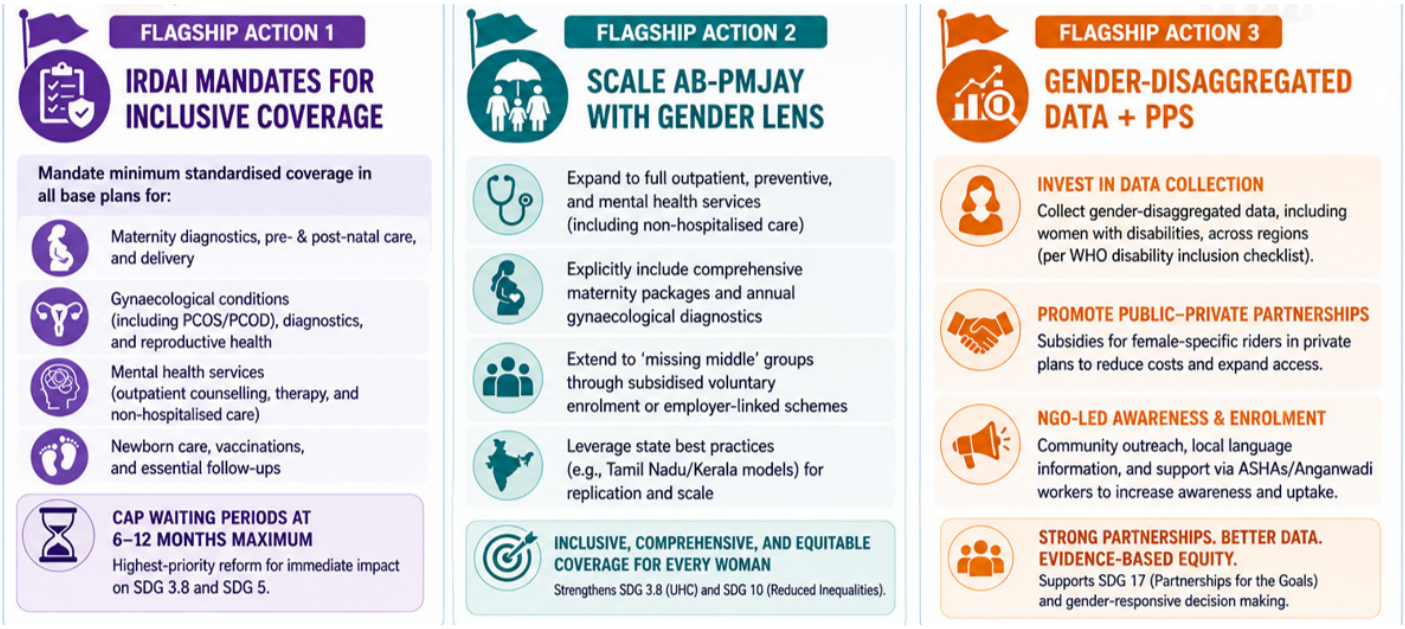
This aligns with SDG 10.3- building on elimination of discriminatory policies and draws from Organisation for Economic Co-operation and Development (OECD) models, where inclusive and comprehensive health insurance benefits are guaranteed automatically as a legal entitlement for all individuals, based on their health needs, irrespective of socio-economic status, ability to pay, or geographic location (Goyal, 2026). Building on IRDAI's inclusive regulations (prohibiting gender identity-based discrimination), mandates need to be extended to all women's health risks. Enforcement through annual IRDAI audits and penalties for non-compliance would ensure accountability..

3. Scaling Up Public Investment and Existing Scheme Expansion

The union health budget must expand AB-PMJAY and similar schemes to cover outpatient, preventive, and mental health services. AB-PMJAY should explicitly include full maternity packages (diagnostics, complications, newborn vaccinations without limits), gynaecological diagnostics annually, and mental health (for e.g., tele-MANAS (a 24/7 mental health support initiative launched by the Government of India) integration for non-hospitalised care), leveraging its existing improvements. Extension of coverage to the 'missing middle' (middle-income groups including lower middle class) via subsidised voluntary enrolment or employer-linked schemes is needed to reduce OOPE and prevent impoverishment.

4. Building Evidence and Capacity for Gender-Responsive Policies

Investment in gender-disaggregated data collection needs to be prioritised through partnerships with local governments, data collection government verticals, NGOs, and think-tanks with inclusion of female participants and researchers, and social workers to map region-specific and intersectional women's health needs (e.g., rural vs urban, caste/class/disabilities intersections), aligning with WHO



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recommendations. Using this data will help refine risk pooling in insurance schemes and design tailored plans (e.g., higher coverage for high-prevalence conditions such as anemia or PCOS in specific states). Capacity-building workshops for insurers, policymakers, and healthcare providers on gender-sensitive insurance design should be institutionalised. Such enhanced data would enable evidence-based reforms, reducing blind spots in current policies and advancing gender equality..

5. Fostering Multi-Stakeholder Partnerships and Awareness

Promotion and subsidisation of PPP models are needed where the partnership subsidises premiums for female-specific riders in private plans, minimising administrative costs while widespreading the scheme and pooling risks locally. NGOs and community health workers (especially, Accredited Social Health Activists/Anganwadi (ASHA)) should lead awareness campaigns and enrolment drives targeted at women to address male-biased/patriarchal household decision-making. Dissemination of simplified policy information in local languages via helplines and apps, and monitoring of scheme implementation through independent audits involving civil society would be needed. This will build trust, increase uptake among vulnerable women, aligning with SDG 17 (partnerships for the SDGs). For e.g., drawing from successful international gender-responsive PPP toolkits (World Bank, 2023) and Chiranjeevi Yojana in Gujarat (PPP for skilled birth attendance and Emergency Obstetric Care (EmOC) with private providers for poor/tribal women) that improved access (Nundy et al., 2021).

6. Advancing Legal and Global Alignment

There is a need to pursue judicial activism and legislative reform to recognise health as a justiciable fundamental right (strengthening Constitutional Article 21 interpretations), making discriminatory exclusions enforceable violations, aligning domestic policies with global best practices (e.g., OECD entitlement-based models, SDG 3.8 benchmarks) through regular reviews and international benchmarking.

This could also include LGBTQIA+ and intersectional needs in future frameworks. The path forward is clear: health equity cannot be achieved through a "one size fits all" model. By strengthening regulatory frameworks, scaling public investment, and institutionalizing gender-disaggregated data, India can move toward a system where health is a justiciable right. Addressing the specific needs of women is a prerequisite for sustainable development. If we fail to bridge these intersectional gaps, we risk the 2030 Agenda becoming, as UN Secretary-General António Guterres warned, a reminder of a missed opportunity. Instead, by adopting these reforms, India can become one of the examples for the Global South in creating a healthcare system that is not only robust and resilient but, above all, profoundly human.

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EDITORIAL INFORMATION

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Drawing from the chapter's evidence base and extending it with recent official data and policy developments (2024–2025), the brief presents findings from a comprehensive document analysis of health insurance policies offered by India's public sector general/life insurers and private standalone health insurers (primarily 2021–2023 policy data). It incorporates recent updates from the Insurance Regulatory and Development Authority of India (IRDAI), Ministry of Health and Family Welfare (MoHFW), and related international authoritative reports from bodies like the World Bank and WHO.

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