

Access, Equity, and Outcomes: A Policy Analysis of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

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Abstract

Healthcare remains as a major determinant of human development in any country. India has made significant changes since independence in 1947 still low budgetary expenditure on healthcare is reflected in quality and capacity of healthcare system. This system pushes majority of population towards costly system of treatment in private sector. Health insurance has emerged as a tool for reducing risk and catastrophic out of pocket expenditure in post liberalisation era. Union Government launched Ayushman Bharat - PM JAY, a scheme to provide health insurance to bottom 40% Indian population. This paper critically examines PM-JAY through a comparative health systems framework, contrasting India's tax-funded assurance model with the social insurance architectures of Germany and the single-payer system of South Korea.

Keywords: Health Insurance; Ayushman Bharat; PMJAY

Introduction

Health insurance policy is an assurance which provides immediate financial help in case when any medical emergency arises. It is a contract between a policyholder and the insurance company which covers medical expenses that might occur due to illness, injury or accident. Policy holder has to pay annual premium in order to receive the coverage. (Health Insurance, 2023)

Different countries have adopted different funding models in their health systems. They have either adopted publicly financed health insurance schemes ranging from coverage to all citizens or coverage to a section of citizens like elderly, low-income groups or workers. India being a Lower Middle-Income Country with population over 1.36 billion people and significant share of below poverty line families has expanded its health coverage post-independence in 1947. It has made significant efforts in public health and medical services still stagnancy in health financing remains a biggest challenge. In 2019, India's Total Health Expenditure (THE) accounted for approximately 3.01% of its GDP, with out-of-pocket expenses (OOPE) standing at 54.78% of total spending. Excessive out-of-pocket health expenditures are catastrophic, frequently pushing vulnerable households below the poverty line (World Bank, 2022). Indian

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healthcare faces lack of infrastructure for public health facilities, professionals in CHCs and rapid spread of private healthcare facilities. In such a situation it was required to have a strong policy to provide protection to poor families from high cost of healthcare (MoH&FW, Govt. of India, 2019).

Broadly Insurance system can be classified into Social Insurance and Private Insurance. Social Insurance is mandatory and run by the government or public groups. On the other hand, Private Insurance is something you choose to buy from a regular company although comes under ambit of regulatory body of respective states (Normand, 2008). In 2018, India adopted Pradhan Mantri Jan Arogya Yojana popularised as National Health Assurance Scheme. The goal of PM-JAY is to give ₹5 lakhs in yearly health cover for secondary and tertiary care hospitalization to the bottom 40% of India (National Health Authority, GoI, 2023).

The criteria for PM-JAY selection is based on the Socio-Economic Caste Census 2011 (SECC 2011) data, using specific markers of deprivation and occupation to identify rural and urban households in need. This scheme is successor to the Rashtriya Swasthya Bima Yojana (RSBY) from 2008; it ensures that families previously enrolled in RSBY remain covered, even if they aren't listed in the 2011 Census. Financially, the program is entirely tax-funded, with the Central and State governments splitting the implementation costs to avoid burden on the beneficiaries.

Design and Financing

The core architecture of a health policy gives glimpse of its equity and sustainability. PM-JAY is a completely publicly-funded scheme (cost is born by Union and State), but it operates primarily by purchasing care from empaneled private and public hospitals.

- **The Bismarck Benchmark (Germany):** Unlike PM-JAY's reliance on general taxation, Germany utilizes Statutory Health Insurance (SHI) funded by mandatory payroll contributions from employers and employees. This creates a highly sustainable, decentralized funding pool independent of annual state budget fluctuations. A critical vulnerability which is currently affecting PM-JAY is delayed state reimbursements due to which many hospitals deny care to specific states.
- **The Single-Payer Standard (South Korea):** In 2000, South Korea redesigned its healthcare system by merging hundreds of separate, fragmented insurance societies into a unified National Health Insurance (NHI) system. In India, PM-JAY operates as a massive purchaser and runs parallel to existing state schemes. We also see various schemes at state levels are performing very good in India's federal structure. Although there is constant push for implementing unified national scheme.

PM-JAY has enhanced financial ceiling significantly with aim to provide protection against health-related expenditures and enabling access to more complex and advanced medical care. This is particularly relevant for "greenfield" states, where earlier arrangements were limited to Rashtriya Swasthya Bima Yojana or where no comprehensive state-sponsored health insurance framework existed (Dong, Naib, Smith, & Chhabra, 2019, July). Pradhan Mantri Jan Arogya Yojana represents a substantive policy advancement aligned with Sustainable Development Goal 3.8, which aspires to universal health coverage through financial risk protection, equitable

access to quality essential healthcare services, and availability of safe, effective, and affordable medicines and vaccines for all.

Features of PM-JAY

- 1949 procedures covering 27 specialties
- 3 days of prehospitalisation and 15 days
- Provides health insurance coverage of up to INR 5,00,000 per family per year, including post-hospitalisation expenses.
- Ensures inclusivity by imposing no restrictions on family size, age, or gender, while covering all pre-existing conditions; registered beneficiaries and their dependents are eligible to avail services through their entitlement cards.
- Offers nationwide portability, allowing beneficiaries to access covered healthcare services across India without geographical limitations.

Funding Pattern of PM-JAY

Pradhan Mantri Jan Arogya Yojana is a fully publicly financed programme, with expenditure shared between the Union and State Governments under a defined fiscal framework. The prevailing sharing arrangement is structured as 60:40 between the Centre and States for most states and Union Territories with legislatures. For North-Eastern states and select Himalayan states, including Jammu and Kashmir, Himachal Pradesh, and Uttarakhand, the ratio is more favourable at 90:10, reflecting geographic and developmental considerations. In Union Territories without legislatures, the Union Government may assume up to 100 percent of the financial responsibility on a case-by-case basis. (PM-JAY Financing of the Scheme, n.d.).

There are two different models of implementation at state level which are Insurance and Trust. States have liberty to adopt a hybrid model too.

Mode	Meaning
Trust	Claims are settled directly by the State Health Authorities (SHAs), indicating a publicly managed risk pool without intermediary insurers.
Insurance	Claims are paid by an empanelled insurance company, with the SHA transferring a fixed premium, thereby shifting financial risk to the insurer.
Hybrid	A mixed approach in which claims up to a specified limit are covered by the insurance company, while higher-value claims beyond this limit are borne directly by the SHAs.

Finance in Different models

Financing mechanisms vary across implementation models in Pradhan Mantri Jan Arogya Yojana which reflects distinct approaches to risk pooling and fiscal management:

- **Insurance Model:** A uniform premium per eligible family is determined, irrespective of household size, Union transfers its share to the State Government, which

subsequently transfers it to the empanelled insurance provider based on the number of beneficiary families. This model facilitates budget predictability while externalising financial risk to the insurer.

- **Trust Model:** In trust model, Union contribution is determined on a reimbursement basis, linked to the actual claims incurred under the scheme, but capped by a predefined ceiling. In practice, this means that funds are released to the State Health Authority (SHA) for claim payments, with Union share limited to the lower of either the realised expenditure or the approved ceiling. This arrangement ensures that financial risk is retained within the public system while maintaining expenditure discipline through an upper limit on liability.

Household Coverage and Access to Scheme

State governments have liberty to register beneficiaries under the scheme using state database but must cover SECC Households. States are responsible to spread IEC material and awareness about PM-JAY. ASHA (Accredited Social Health Activist) is tasked to deliver letter to beneficiaries and Government has setup a toll-free helpline dedicated for PM-JAY.

Supply-Side Asymmetries and the "Greenfield" Paradox

A central critique of PM-JAY is its spatial inequity. The scheme relies heavily on the empanelment of private hospitals to supplement the overburdened public sector. However, the private healthcare market in India is deeply concentrated in wealthier, urbanized states (Brownfield states) such as Maharashtra, Tamil Nadu, and Gujarat.

Approximately 80 percent of all claims under Pradhan Mantri Jan Arogya Yojana and its aligned state schemes originate from brownfield states, with their share rising to nearly 87 percent in the case of high-value claims. Maharashtra, Tamil Nadu and Karnataka had larger share in utilization. Such high utilization is observed in brownfield states because they already had insurance schemes, beneficiary identification and hospital empanelment process in place whereas in greenfield states this process was started from pilot stage. There is also wide difference in availability of healthcare system and care-seeking behaviour in brownfield and greenfield states (Choudhury, 2020). Evidence suggests that the majority of claims under Pradhan Mantri Jan Arogya Yojana are relatively low in value. Only around 7 percent of total claims exceed INR 30,000, while approximately 1 percent are above INR 1,00,000 (Dong, Naib, Smith, & Chhabra, 2019, July).

In contrast, "Greenfield" states - those with the highest density of multidimensional poverty and the target demographic of the SECC 2011 database, suffer from a severe dearth of empanelled private facilities. The policy inadvertently subsidizes healthcare for the urban poor where private infrastructure exists, while offering merely "paper protection" to the rural and tribal poor.

Service Coverage

According to the NHA data, over 28,300 hospitals, of which 45% are private, have been empanelled so far under the PMJAY scheme. 46% patients received treatment in government facility.

States with higher poverty rates and disease burden see slightly less empanelment of hospitals (Vitsupakorn, 2021). This trend is also observed in aspirational districts, where smaller bed capacities of empanelled hospitals constrain the delivery of high-value care. On the other hand, states with better per capita income have better access and availability of private hospitals and they are availing specialised services and facilities. The result is 72% empanelled hospitals under PM-JAY are located in just seven states. These states, which had pre-existing insurance schemes prior to Pradhan Mantri Jan Arogya Yojana, now account for over 80 percent of the total claim value.

There is marked geographic variation in the availability of hospitals providing highly specialised services, which contributes to differences in high-value claims. States with higher poverty headcount ratios tend to report lower claim volumes. Notably, ten states recorded no private hospital admissions in their aspirational districts, indicating significant disparities in access to empanelled private healthcare facilities (Vitsupakorn, 2021). This shows there is uneven system of empanelled facilities in some areas and also hesitancy to avail services. 874 hospitals in Tamil Nadu submitted high value claims whereas in NE states, less than 10 hospitals had high value claims. The highly unequal distribution points to substantial capacity gaps across regions. PM-JAY allows portability feature to avail treatment in other states but the reality is that patients don't have knowledge and finance to avail treatment at a distant hospital.

Number of Beds in Empaneled Hospitals per 1000 population

Top States	Top NE/ Hilly States	Top UTs
Goa	Himachal Pradesh	Puducherry
Kerala	Arunachal Pradesh	Chandigarh
Haryana	Sikkim	A & N Islands
Tamil Nadu	Manipur	Lakshadweep
Maharashtra	Mizoram	Ladakh

Hospitalization per Lakh Beneficiary Population

Top States	Top NE/ Hilly States	Top UTs
Kerala	Meghalaya	Chandigarh
Tamil Nadu	Mizoram	DNH and DD
Chhattisgarh	Himachal Pradesh	Puducherry
Gujarat	Tripura	Jammu & Kashmir
Goa	Uttarakhand	A & N Islands

Source : NHA Annual Report 2021 - 22

Financial Protection

Pradhan Mantri Jan Arogya Yojana has delivered mixed outcomes in terms of financial risk protection, as it excludes outpatient services, which constitute nearly 60 percent of out-of-pocket expenditure in India. As India needs preventive care hence coverage of outpatient care is one of the significant requirements. 32% claims are high-value, exceeding INR 30,000, indicating that the scheme has facilitated access to cost-intensive services that would otherwise require out-of-pocket expenditure and potentially lead to financial burden for households. An in-depth study in Chhattisgarh found that PM-JAY has failed to reduce OOPE expenditure although 100% population is covered by PM-JAY or state scheme (Garg, 2020). This raises concern that practitioners are delivering expensive services to collect more fees and hospitals are double billing and prescribing patients to purchase medicines from outside.

Coverage Architecture and "The Missing Middle"

PM-JAY utilizes a targeted approach, originally using the 2011 Socio-Economic Caste Census (SECC) to identify the poorest 40% of the population.

- **Targeted vs. Universal Risk Pooling:** PM-JAY's targeted design closely resembles the United States' Medicaid program, which provides state-administered, federally-backed coverage for low-income individuals. Both systems face the challenge of a "Missing Middle" - those who earn too much to qualify for the scheme but too little to afford private insurance coverage.
- **The Path to Universality:** In contrast, both Germany and South Korea mandate universal coverage. South Korea achieved this rapidly (within 12 years) by sequentially expanding mandatory coverage from large corporations down to the self-employed and rural populations. PM-JAY's recent expansion to all citizens aged 70 and above marks a philosophical shift from strict US-style targeting toward South Korean-style demographic universality.

Suggestions

- **PM-JAY** should increase its coverage by expanding eligibility criteria and accommodating more families.
- State wise disparities in presence of health infrastructure needs to be addressed.
- Expansion of coverage to Outpatient care should be considered.
- Strengthening of HWCs and proper operationalization to reduce burden of OOPE.

Conclusion

In conclusion, health insurance policies provide financial support during medical emergencies and are important in safeguarding families from the high costs of healthcare. India, a lower middle-income country with a substantial population living below the poverty line, has adopted various state-funded insurance schemes to expand publicly financed health coverage for its population. Still, resources and availability of hospitals remains a major concern for India. OOPE pushes millions of Indian families towards poverty every year, OOPE rate has not dropped down to an extent even when these insurance schemes have been implemented.

PM-JAY is performing better in brownfield states due to the presence of existing state schemes and stronger hospital networks. Healthcare-seeking behaviour and the perception of PM-JAY as an entitlement also play a significant role. However, even in these states, awareness about the conditions under which the scheme can be utilised remains limited.

Government and policy experts need to focus how healthcare services can be improved in green field states as larger population suffers poverty in these states and state governments suffers shortfall of funds to provide health services. Data from various sources quoted in the paper including government reports suggest that people are not using Ayushman Bharat Card to avail healthcare in greenfield states as they seek in brownfield states. Availability of Healthcare system and healthcare seeking behaviour both remain a major challenge.

Some states are struggling to implement PM-JAY as they lack proper infrastructure and mechanism to cater. PM-JAY also misses OOPE expenditure on its priority list. Union Government must understand the needs of the states and customize implementation plan for more efficient results and reducing challenges in PM-JAY on a time bound manner.

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