Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY): In Quest of Providing Accessible, Affordable & Quality Solutions to Achieve Universal Healthcare

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ABSTRACT

Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana is a flagship scheme of the Government of India, with a vision of Universal Health Coverage (UHC) as its underlying commitment of "leaving no one behind." Launched in 2018, AB-PMJAY is the world's largest health assurance scheme, aiming at providing a health cover for secondary and tertiary care hospitalization to over 12 crores poor and vulnerable families. With more than 42.7 crore Ayushman cards created across the country, and 32,500 empanelled hospitals, the AB-PMJAY scheme is currently providing cashless healthcare services for 1,961 procedures across 27 medical specialities. AB-PMJAY scheme has been evolving since its inception and is constantly adding new features in its portfolio, such as coverage of 70+ population; shift from volume-based to value-based care system, strengthening of district implementation units, to name a few. The scheme has many achievements, however, there are gaps and irregularities in the current disposition. The article outlines these gaps and gives pragmatic solutions to fill those loopholes. Filling these critical gaps is critical before the programme goes on to the next level, in terms of coverage without compromising on the quality of care.

Keywords: Ayushman Bharat- Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), Out-of-Pocket expenditure (OOPE), Accessibility of healthcare services, health insurance

Current Policy Scenario

Launched in 2018, Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) aimed to reduce Out-of-Pocket expenditure (OOPE), and improve affordability of healthcare services, especially secondary and tertiary care to the poor and vulnerable sections of the population. The schemes encouraged the inclusion and utilization of the Private Sector to improve accessibility and quality of healthcare for the vulnerable population. The policy aspired to solve multiple systemic issues in India's healthcare system, such as fragmented insurance coverage across states, weak financial protection for acute & chronic illnesses and reduce catastrophic expenditure on healthcare services.

A health insurance cover of 5 lakhs per family per year for secondary and tertiary care hospitalization to over 10.741 crore families from the poor and vulnerable section of the population (based on SECC, 2011) was offered. The eligible families are given cashless and paperless access to healthcare services at the empanelled hospitals, be it public or private. More recently, in 2024, senior citizens aged above 70 years, irrespective of their socioeconomic status, have also been made eligible to avail the benefits of AB-PMJAY.

AB-PMJAY provides seamless and portable health insurance across the country with no age bar and capping on family size. All the preexisting conditions are covered along with additional benefits such as coverage of the cost of diagnostics and medicines for up to 3 days pre-hospitalization and 15 days post-hospitalization[i]. The scheme dared to include various health insurance schemes such as Rashtriya Swasthya Bima Yojana (RSBY), Central Government Health Scheme (CGHS), Employees' State Insurance Scheme (ESIS) and state-funded extension schemes – with different coverage and varying benefits. Since the launch, the scheme has been constantly revising the Health Benefit Packages (HBPs) and setting appropriate reimbursement rates on an annual basis[ii].

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Another critical element of AB-PMJAY has been the availability of huge health data on which extensive research, analysis and documentation can be done, thus making evidence-based analysis and course correction more feasible. Health data included NHA annual reports and dashboard analytics, on which CAG Audits, evaluations and impact analysis by independent agencies such as WHO, PHFI, and NITI Aayog were based. Apart from these, studies on utilisation and financial protection; investigations on fraud, exclusion, and behavioural issues by human resource and private hospitals have been developed. Though well-designed and constantly evolving, AB-PMJAY still suffers from various problems such as operational issues, quality of care provided, regional disparities in utilization and financial protection, and low awareness among common people. This review policy paper discusses these issues and attempts to offer pragmatic solutions for fulfilling those gaps.

Achievements of AB-PMJAY

- More than 42.7 crore Ayushman cards have been created across the country. AB-PMJAY have authorized more than 9.8 crore hospitals till November 2025[iii].
- Around 32,500 hospitals have been empanelled, out of which around 15,500 are private[iv].
- AB-PMJAY scheme provides cashless healthcare services for 1,961 procedures across 27 medical specialities in its latest national master of Health Benefit Package (HBP) [v].
- PMJAY guidelines stipulate that final approval or rejection must be done within 30 minutes after online submission of patient data. According to the CAG 2023 report[vi], more than 3.8 lakh cases were under process for approval or rejection. The number of days of delay in these cases ranged from one to 940 days. Delays in processing rejection cases ranged from one to 404 days.
- Information, Education and Communication (IEC) cell was formed in just seven States/UTs, according to CAG 2023. The IEC plan was prepared only in four States, Chhattisgarh, Madhya Pradesh, Manipur and Rajasthan. Less than 25% spending of the IEC Budget has been spent[vii].
- In six States/UTs, ineligible beneficiaries availed the benefits of the Scheme. The expenditure on these ineligible beneficiaries ranged from ₹0.12 lakh in Chandigarh to ₹22.44 crore in Tamil Nadu[viii].

Unique Features and Achievements of AB-PMJAY

The AB-PMJAY scheme has seen a continuous evolution since its inception through constantly adding new features and frequent course-correction measures. Some of them are coverage of 70+ population; shift from volume-based to value-based care system; efforts to encourage hospital empanelment; undertaking virtual and physical capacity-building of hospital HR; setting up of District Implementation Units (DIUs) to check on empanelled hospitals and beneficiaries. More importantly, a revised Health Benefit Package (HBP) has been released by NHA with 1961 procedures, and rates have been increased for 350 packages, along with the addition of new packages[ix].

All public hospitals with in-patient services form an indispensable part of the AB-PMJAY, and they are also reimbursed for health services provided under AB-PMJAY at par with private hospitals. These funds act as an additional supplementary financing source for public hospitals (over and above the supply-side financing). The supplementary funds can be used for various inputs at the facility level, and an indicative list and allocation shares have been defined by NHA. The funds can be used to improve the quality of care, infrastructure upgradation; adding new HR; providing incentives to existing HR; purchasing new equipment, medicines and consumables; and for administrative expenses.

Implementation Gaps

In an effort to provide quality healthcare accessible to the vulnerable population, AB-PMJAY has incorporated many components with role differentiation at the State and District level. However, there are ample issues in the implementation of these initiatives at every level. While the coverage of population is being expanded and

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worked upon, it is time to focus on patient safety and the quality of care being offered at the empanelled hospitals. Some of the critical issues that the scheme has encountered are:

- **Regional disparities:** In a diverse country like India, different states with varied populations have different sets of health problems. These disparities among States have translated into disparate implementation of the AB-PMJAY scheme across the country. For instance, UP has more than 5.4 crore Ayushman Cards made, while states like Punjab, Kerala, Tamil Nadu, Telangana, Uttarakhand, Mizoram, Meghalaya, and Tripura have less than a crore Ayushman Cards.

  Tamil Nadu leads in the number of authorized hospitalizations (>1.1 crore) while Himachal Pradesh has the lowest (around 0.04 crores). The number of hospitals empanelled is highest in Uttar Pradesh (6139) and lowest in Jammu & Kashmir (270).[x]

- **Operational challenges** like fraud, low empanelment, issues with claim settlements, issues of ineligible beneficiaries, misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, unnecessary procedures, false/ misdiagnosis, referral misuse, etc.

- **Lack of awareness among beneficiaries:** Many studies have pointed out low awareness levels as reasons for low utilization of the AB-PMJAY scheme. [xi, xii]

- **Limited impact on improving utilisation and financial protection**[xiii] , which the scheme aspired to achieve.

- **Discrepancies in payment utilization by Public Hospitals:** The CAG 2023 report has highlighted several incongruities in the spending of the claim amount received by the public healthcare facilities – they were either used for inadmissible purposes or kept idle. Hospitals in many states did not give any money as staff incentives, nor did not spend any amount on hospital up-gradation and quality improvement.

- **Prioritizing patient safety and quality of care:** The system of grievance redressal; financial incentives and quality certifications for empanelled hospitals (PM-JAY Bronze, Silver, and Gold Quality certifications, NABH Accreditation Incentives) are not proving enough to assure patient safety and quality of care at the empanelled hospitals. CAG 2023 discusses the lack of knowledge of Nodal officers regarding various protocols and guidelines of AB-PMJAY.

RECOMMENDATIONS

The implementing agency of AB-PMJAY, National Health Authority (NHA), has been extremely proactive in reviewing and revising the implementation protocols and solving operational issues. Further suggestions to tackle the policy gaps are as follows:

- **Encouraging a more proactive role of the State Health Authorities (SHAs) and DIUs**: SHAs and DIUs need to take ownership of the implementation of AB-PMJAY in their respective regions. This is imperative to solve operational issues such as fraud, delay in claim settlements, ineligible beneficiaries, wrongful beneficiary identification, overcharging, unnecessary procedures, false/ misdiagnosis, referral misuse, etc.

- **While balancing access and quality, SHAs and DIUs** should actively take up increasing the empanelment of private hospitals, utilization of claim amounts by the public hospitals as per the national and state protocols.

- **Prioritizing patient safety and improving vigilance on the quality of services** being provided at the empanelled hospitals. Consideration of the quality of healthcare services is critical to improving the utilization of the AB-PMJAY scheme. While independent audits, surprise checks can be done, following standards like NQAS, NABH, and JCI can be mandated for all the empanelled facilities.

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- Implementation of **strict monitoring and regulation of empanelled hospitals** to prevent frauds and unethical practices, while encouraging patient safety and quality of care. The process of de-empanelment needs to be strengthened to discourage fraudulent practices.

- **Awareness activities**: On-field activation and awareness efforts are important to enhance the uptake of the scheme. The utilization of the IEC budget must be increased through encouraging an active role of the IEC cells.

- **Increasing investment in expanding healthcare facilities in rural interior areas** to reduce the distance beneficiaries need to travel to access the required medical treatment. At the same time, the expansion of services to patients requiring long-term and rehabilitative care should also be planned simultaneously.

- **Firming up the shift towards Value-Based Care (VBC):** It aims to deliver patient-centric healthcare services through incentivising and encouraging healthcare providers. The performance of PMJAY empanelled hospitals is being measured on 5 key performance indicators, including beneficiary satisfaction, hospital readmission rate, extent of OOPE, confirmed grievance-handling system and improvement in patients ' health-related quality of life.

- AB-PMJAY is already exploring and utilizing data from multiple impact evaluations, large-scale costing studies done by various government and non-government agencies. HBPs have been revised four times since the inception of the scheme, along with the reimbursement rates. **Utilization of existing data and streamlining research efforts** can be done by NHA. Impact evaluation & Cost-effectiveness studies can be done in a phased manner, in a way that the findings can be utilized more efficiently. Research studies on Health Benefit Packages can be planned to review the opportunity costs, and the relationship between tariff revision and outcomes (in terms of quality, financial risk protection, mortality, QoL) can be studied.

CONCLUSION

Providing health insurance to the most vulnerable section of society, almost 40% of the Indian population, is an exemplary task which is being fulfilled immaculately by the NHA and related agencies. The implementation of this ambitious scheme is already being quoted and set as an example for other low-and-middle-income countries to follow. Addressing the ever-neglected elderly care, **inclusion of the 70+ population in AB-PMJAY** is a big step being undertaken smoothly, though it would require further expansion of HBPs.

AB-PMJAY is expected to provide accessible and quality healthcare services to people across the country. **AB-PMJAY also aspires to initiate and roll out the coverage of the middle-income population, and various co-payment systems** are being talked about for this unique population segment. However, before taking on this major step towards access, the quality of care being provided to the currently covered population should reach the planned and pre-thought level. The programme has to plug in many underlying gaps before it expands its coverage to diseases requiring long-term care, including palliative care and rehabilitative care services.

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