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# Ayushman Bharat PM-JAY: Evaluating Gaps Between Policy Commitments and Ground-Level Healthcare Delivery

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*This paper examines Ayushman Bharat-PMJAY from two sides that are often separated in public debate: the experience of the patient and the experience of the hospital. The aim is not to prove that the scheme is either a success or a failure, but to test where its official promise matches - or fails to match - what happens in practice.*

**Abstract:** ***Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) aims to provide eligible families with cashless access to specified secondary and tertiary hospital care. This study evaluates the extent to which this objective is reflected in beneficiary experience while remaining operationally and financially workable for empanelled hospitals. A mixed-methods approach combined secondary evidence with primary data from 500 eligible individuals and 50 empanelled hospitals. Among 340 active cardholders, 143 had used PM-JAY for hospitalization. Of these users, 38% reported completely cashless treatment, while 62% reported some out-of-pocket expenditure. Nevertheless, 76% were satisfied or very satisfied with clinical care, and 78% would definitely use PM-JAY again. Among hospitals, 90% reported at least a 10% increase in patient volume, while 56% considered package rates inadequate, 78% reported claim turnaround exceeding 30 days, and 62% considered documentation excessive. The findings indicate that PM-JAY provides meaningful access and financial protection but continues to face implementation gaps affecting both beneficiaries and providers. Improvements in claim processing, package-rate revision, beneficiary communication, monitoring of covered expenditure, and active hospital access could strengthen the scheme.***

**Keywords:** Ayushman Bharat; PM-JAY; health financing; financial protection; out-of-pocket expenditure; hospital reimbursement; Universal Health Coverage

## 1. Introduction

A serious health problem can turn into a financial problem very quickly. For families with limited savings, the cost of hospitalization, medicines, diagnostic tests, travel and lost wages can lead to borrowing, delayed treatment or the sale of assets. This is why government-backed healthcare protection matters: it is not only about paying hospital bills, but also about reducing the chance that illness pushes a family deeper into financial insecurity.

India has made progress in shifting a larger share of health spending toward public financing. The National Health Accounts Estimates 2022-23 show that out-of-pocket expenditure (OOPE) fell from 64.2% of total health expenditure in 2013-14 to 43.4% in 2022-23, while the government share rose from 28.6% to 43.7%. Social-security spending on health also increased over the period [3]. These national trends do not prove that PM-JAY alone caused the improvement, but they show the wider policy direction in which PM-JAY operates.

Ayushman Bharat was launched in 2018 as part of India's move toward Universal Health Coverage. Its hospitalization component, PM-JAY, offers publicly financed coverage for eligible families using empanelled public and private hospitals [1]. The scale is very large: as of 30 June 2026, the Government reported 12.69 crore authorized hospital admissions worth about ₹1.92 lakh crore through 37,413 public and private hospitals [2]. By 12 August 2026, more than 45.5 crore Ayushman cards had been issued and more than 38,466 hospitals were reported as empanelled [11].

Numbers of cards, admissions and hospitals are important, but they do not answer the whole question. A patient may have a valid card and still pay for medicines, travel a long distance or wait for approval. A hospital may see more patients but still struggle with package rates or reimbursement delays. This paper therefore focuses on the distance between policy entitlement and real experience.

### 1.1 Why I Chose This Topic

My interest in this topic is personal as well as academic. Through my family's connection with the medical field, I have heard and seen how government health schemes can make a major difference for families who would otherwise struggle to afford care. I have also become aware of the practical problems that can arise for hospitals, especially smaller units, when claims are delayed, package rates are tight or administrative requirements become heavy. That made me want to study both sides together instead of looking only at official scheme statistics.

### 1.2 Need for Government Healthcare Protection

- Financial protection: large medical bills can push households into debt or force them to postpone care.
- Equal access: publicly financed schemes can make expensive hospital services available to people who could not otherwise afford them.
- Protection from catastrophic spending: the purpose is not just to reimburse a bill, but to reduce the risk that illness becomes a long-term economic setback.
- Earlier treatment: when patients expect that covered care will be affordable, they may be more willing to seek treatment instead of delaying it.
- Health-system equity: public financing helps reduce the gap between households that can pay for private care directly and those that cannot.

## 2. Background and Scheme Design

### 2.1 Ayushman Bharat

Ayushman Bharat was introduced following the National Health Policy 2017 and was designed as a broader health-system reform rather than only an insurance programme. It originally had two linked components: Health and Wellness Centres for comprehensive primary care, and PM-JAY for financial protection against specified secondary and tertiary hospitalization [1]. This distinction matters because this paper mainly evaluates PM-JAY, not every service under the wider Ayushman Bharat umbrella.

The primary-care component was intended to bring preventive, maternal, child, non-communicable disease, basic diagnostic and essential medicine services closer to communities. PM-JAY, by contrast, focuses on hospital-based care. Evaluating PM-JAY as if it promised free healthcare for every outpatient visit or every medicine would therefore be inaccurate.

### 2.2 PM-JAY: Core Features

**Table 1:** Core PM-JAY design features

| Feature | Official design / entitlement |
|---|---|
| Annual family cover | Up to ₹5 lakh per eligible family per year for listed secondary and tertiary hospitalization [1]. |
| Cashless point of service | Covered treatment is intended to be cashless and paperless at empanelled hospitals [1]. |
| Public and private network | Eligible beneficiaries may use participating public and private empanelled hospitals, subject to package and specialty availability [1]. |
| Portability | Benefits can be used at empanelled facilities outside the beneficiary's home state [1]. |
| Pre-existing conditions | Pre-existing diseases are covered from day one under the scheme design [1]. |
| Family restrictions | The core scheme does not impose a cap on family size, age or gender [1]. |
| Pre/post-hospitalization | Official material includes specified expenses up to 3 days before admission and 15 days after discharge, including eligible diagnostics and medicines [1]. |
| Bundled packages | Treatment is reimbursed through predefined Health Benefit Packages that combine multiple components of care into a fixed package price [1][8]. |

### 2.3 How a PM-JAY Hospitalization Works

In practice, the PM-JAY pathway usually involves several connected steps. Each step can affect whether the experience feels smooth to the patient and financially workable to the hospital:

1) Beneficiary identification and eligibility verification at the hospital or PM-JAY help desk.
2) Selection of the relevant Health Benefit Package for the proposed treatment.
3) Pre-authorisation for procedures that require approval before treatment under the scheme.
4) Provision of the covered hospitalization and related services.
5) Discharge documentation and submission of the hospital claim through the transaction system.
6) Claim verification, possible queries or deductions, approval and final reimbursement to the hospital.

This sequence explains why PM-JAY performance cannot be judged only by card issuance. A breakdown at verification, authorisation, package selection, service availability or claim settlement can affect either the patient, the hospital, or both.

### 2.4 Scale and Use of the Scheme

The programme is not merely theoretical. Government reporting shows very high use. By 30 June 2026, 12.69 crore authorized admissions worth approximately ₹1.92 lakh crore had been recorded [2]. Private hospitals also play a major role: as of 31 January 2026, the Government reported 5.77 crore authorized admissions worth about ₹1.15 lakh crore in private hospitals [11]. These figures demonstrate demand for the programme, but utilization alone does not establish whether care was fully cashless or whether providers considered reimbursement adequate.

## 3. Problem Statement and Research Gap

PM-JAY promises financial protection, cashless covered hospitalization and access through a nationwide empanelled network. The central problem investigated in this paper is whether those promises are experienced consistently at ground level. The study therefore looks at four connected areas: patient spending, hospital accessibility, administrative efficiency and provider sustainability. The research gap is especially important because macro statistics such as cards issued, admissions authorized and hospitals empanelled do not directly answer questions such as: Did the patient still pay? Was the right hospital nearby? Was the card accepted smoothly? Did the hospital receive payment on time? Were package rates sufficient to cover treatment costs?

The CAG performance audit strengthens the case for this type of research. It found uneven availability of empanelled providers, instances of beneficiaries being charged, delays in pre-authorisation, hospitals that did not meet prescribed standards and hospitals that were empanelled but had not provided PM-JAY treatment during the audited period [4]. This suggests that formal coverage and actual service availability are not always the same thing.

## 4. Objectives, Research Questions and Hypothesis

### 4.1 Objectives of the Study

- To understand the objectives and functioning of Ayushman Bharat-PMJAY.
- To examine the financial and healthcare benefits provided to beneficiaries.
- To examine the benefits received by empanelled hospitals.

- To determine whether patients experience significant out-of-pocket expenditure despite PM-JAY.
- To investigate hospital challenges related to reimbursement, package rates, claim processing and administration.
- To assess awareness and accessibility of PM-JAY among eligible individuals.
- To compare the official objectives of PM-JAY with reported ground-level experience.
- To suggest practical improvements that could strengthen the scheme.

### 4.2 Main Research Question

To what extent has Ayushman Bharat-PMJAY succeeded in providing accessible and financially protective healthcare while remaining financially and operationally viable for hospitals?

### 4.3 Sub-questions

- Patient side: Is PM-JAY genuinely cashless for beneficiaries using covered hospital services?
- Hospital side: Are package rates, claim processes and payment timelines adequate for empanelled hospitals?
- Implementation side: Is there a measurable gap between official policy design and ground-level experience?

### 4.4 Hypothesis

H0: There is no significant gap between the benefits promised under PM-JAY and the experience of patients and hospitals. H1: Significant implementation gaps exist between the intended benefits of PM-JAY and the experiences of patients and hospitals. The study does not assume H1 is true in advance; the conclusion is based on the evidence collected.

## 5. Review of Secondary Research

### 5.1 Healthcare Access

Official figures show that PM-JAY has created a large hospital-use pathway for eligible households [2][11]. However, the CAG audit found major differences in provider availability. During the audited period, the number of empanelled healthcare providers per lakh beneficiaries ranged from 1.8 in Bihar to 26.6 in Goa [4]. This is an important reminder that possession of a card does not automatically mean equal physical access to an appropriate hospital.

### 5.2 Financial Protection

A 2025 BMJ Open case-control study in six Haryana districts, including Ambala, Kurukshetra and Karnal, compared 386 PM-JAY beneficiaries with 386 non-beneficiaries. Mean direct medical expenditure was ₹11,131 among beneficiaries compared with ₹31,675 among non-beneficiaries, while overall expenditure was ₹14,002 compared with ₹34,093. The authors estimated direct medical expenditure to be about 65% lower among beneficiaries [5]. This is strong evidence that PM-JAY can reduce hospitalization costs, but it also shows that beneficiaries may still spend money.

**Table 2:** Expenditure reported in the 2025 Haryana case-control study [5]

| Expenditure | PM-JAY beneficiaries | Non-beneficiaries |
|---|---|---|
| Doctor fees | ₹240 | ₹5,446 |
| Medicines | ₹6,050 | ₹8,307 |
| Diagnostics | ₹3,154 | ₹6,634 |
| Bed charges | ₹404 | ₹3,673 |
| Total medical expenses | ₹11,131 | ₹31,675 |
| Overall expenses | ₹14,002 | ₹34,093 |

Not every study finds the same size of benefit. An NFHS-5 analysis of institutional deliveries found no statistically demonstrated reduction in OOPE or distress financing associated with publicly financed insurance for the delivery outcomes studied [10]. The literature is therefore mixed: PM-JAY can provide substantial financial protection in some hospitalization contexts without guaranteeing zero expenditure in every setting.

### 5.3 Patient Experience and Cashless Care

Published patient research has identified costs before hospitalization, information gaps, medicine and supply shortages and delays around authorisation [6]. The CAG audit also identified beneficiaries who were charged in empanelled hospitals in several audited states and union territories [4]. Together, these findings justify testing the difference between a formally cashless package and a completely cashless patient experience.

### 5.4 Hospital Package Rates and Provider Incentives

PM-JAY uses predetermined package prices rather than allowing hospitals to charge unlimited market rates. A national costing analysis found that about 42% of procedures under the early HBP 1.0 structure were significantly underpriced relative to estimated costs. Later revisions reduced the mismatch, showing that package pricing can be improved when it is tied more closely to hospital-cost evidence [8].

A 2025 mixed-methods study of private hospitals in Maharashtra found low reimbursement rates to be the most frequently cited reason for reluctance to participate, alongside fixed packages, delayed reimbursement, claims complexity and administrative-capacity constraints [9]. This creates an important policy balance: rates must be low enough to protect public funds, but realistic enough that hospitals remain willing to provide the service.

### 5.5 Claim Settlement and Administration

A study of early PM-JAY implementation in Gujarat and Madhya Pradesh reported that full claim payment often took substantially longer than the specified timelines [7]. NHA guidance has set defined claim-turnaround expectations, making long delays relevant not only to hospital satisfaction but also to cash flow [15]. Administrative requirements are necessary for fraud control, yet excessive or repetitive queries can make genuine treatment harder to finance.

### 5.6 CAG Audit: Key Ground-Reality Findings

- Uneven provider access: the number of empanelled providers per lakh beneficiaries varied sharply across states in the audited period [4].
- Patient charging: the audit identified cases where beneficiaries paid at empanelled facilities, increasing OOPE [4].
- Pre-authorisation delay: CAG data analysis found 39.57 lakh claims where pre-authorisation exceeded the prescribed 12-hour period in the dataset examined [4].
- Quality and empanelment gaps: some empanelled hospitals did not fulfil prescribed infrastructure/equipment standards [4].
- Inactive empanelment: some hospitals were formally empanelled but recorded no PM-JAY treatment during the period examined [4].
- Data and control weaknesses: the audit documented beneficiary-data, claim-control, anti-fraud and grievance-management weaknesses [4].

### 5.7 WHO and World Bank Perspective

WHO places PM-JAY within the wider challenge of health financing: high OOPE can cause catastrophic spending and impoverishment, so greater and more efficient public financing is central to Universal Health Coverage [12]. WHO has also examined reform of PM-JAY provider-payment mechanisms, emphasizing that how hospitals are paid affects strategic purchasing, efficiency and provider participation [13]. The World Bank has similarly emphasized that hospitalization insurance alone cannot eliminate India's overall OOPE because large amounts are spent outside inpatient episodes, especially on outpatient care, medicines and diagnostics. This is why PM-JAY should be viewed as one part of a broader health-financing system rather than as a promise that every health-related expense will be free [14].

**Table 3:** Secondary research evidence used in this paper

| Evidence area | Published/official finding | Relevance to this study |
|---|---|---|
| Official scale | 12.69 crore authorized admissions worth ~₹1.92 lakh crore by 30 Jun 2026 [2]. | PM-JAY has very large real-world utilization. |
| National OOPE trend | OOPE share fell from 64.2% (2013-14) to 43.4% (2022-23) [3]. | Public financing has grown, but this trend cannot be attributed to PM-JAY alone. |
| Access | CAG found provider availability ranging from 1.8 to 26.6 per lakh beneficiaries across states [4]. | Formal coverage does not guarantee equal geographical access. |
| Financial protection | Haryana study found ~65% lower direct medical expenditure among beneficiaries [5]. | PM-JAY can materially reduce costs. |
| Residual spending | PM-JAY beneficiaries in the Haryana study still reported average overall expenditure of ₹14,002 [5]. | Cost reduction is not the same as zero expenditure. |
| Package pricing | ~42% of procedures in early HBP 1.0 were significantly underpriced; later revisions improved this [8]. | Provider pricing is a genuine design issue, but policy can correct it. |
| Private provider participation | Low reimbursement and claims/administrative issues were major barriers in Maharashtra [9]. | Hospital incentives affect the depth of the provider network. |
| Audit controls | CAG documented pre-authorisation, empanelment, data and claim weaknesses [4]. | Implementation quality matters as much as policy design. |

## Research Methodology

The study uses a mixed-methods, descriptive, and analytical design. The quantitative part uses structured beneficiary and hospital responses. The qualitative part draws on provider/key-informant interpretation and on open-ended explanations of operational problems. Secondary evidence is used for triangulation: where the primary data show a pattern, the paper asks whether official audits and peer-reviewed research show a similar or different pattern. Study setting and recruitment: The primary survey covered mixed rural-urban clusters. [Before submission, insert the exact district(s)/state(s) and approximate data-collection period from the field records.] Eligible individuals were recruited using purposive/convenience sampling from accessible clusters. Patient-experience questions were restricted to respondents who held an active Ayushman card and had actually used PM-JAY for hospitalization. The hospital component included 50 empanelled hospitals (30 private and 20 public). [Before submission, specify which hospital representatives completed the questionnaire, for example Ayushman desk staff, administrators, billing/claims staff, or clinicians, based on the actual records.] Responses were recorded using structured questionnaires, with open-ended comments used to interpret operational problems. No identifying patient information is reported in the analysis.

**Table 4:** Primary research design

| Component | Study design |
|---|---|
| Patient sample | 500 eligible individuals from mixed rural-urban clusters. |
| Active cardholders | 340 respondents reported possessing an active Ayushman card. |
| PM-JAY users | 143 active cardholders reported using PM-JAY for hospitalization. |
| Hospital sample | 50 empanelled hospitals: 30 private and 20 public. |
| Sampling approach | Purposive/convenience sampling of eligible respondents and relevant hospital personnel; not a nationwide probability sample. |
| Patient variables | Awareness, card possession, use, distance/access, card acceptance, cashless experience, medicines, diagnostics, OOPE, approval delays, satisfaction and future use. |
| Hospital variables | PM-JAY volume, package viability, reimbursement time, claim queries/rejections, documentation, pre-authorisation, financial preference and overall benefit. |
| Analysis | Descriptive percentages and category comparisons; provider responses interpreted thematically. |
| Ethics | Anonymous, voluntary participation; avoid collecting unnecessary medical identifiers or sensitive clinical details. |

The patient-experience questions use different denominators. Awareness and enrolment use N=500; utilization uses the 340 active cardholders; detailed hospitalization experience uses n=143 PM-JAY users. Keeping these denominators separate prevents the analysis from accidentally treating people who never needed hospitalization as failed users of the scheme.

A data-quality note is also necessary. In the OOPE category table, 142 valid count-based responses were available among 143 PM-JAY users; one response is therefore recorded as missing for this item. The reported percentages sum to 100%. The raw response sheet should be checked before formal publication rather than assigning a value to the missing response.

Because the sampling is not a nationwide random sample, conventional margins of error should not be treated as proof of national representativeness. The results are best understood as evidence from the surveyed clusters and hospitals, to be compared with wider secondary research.

**Patient Survey Results**

The patient results show a pattern that is more nuanced than either "the scheme works" or "the scheme fails." Awareness and trust are relatively strong, but complete cashless protection is much weaker. The most important patient-side question is therefore not whether PM-JAY provides value, but how much financial and administrative friction remains around that value.

**Table 5:** Corrected patient survey results

| Question / metric | Distribution | Interpretation |
|---|---|---|
| Heard of PM-JAY? | Yes 84% (420); No 16% (80) | High awareness among surveyed eligible individuals. |
| Possess Ayushman card? | Active 68% (340); In process 14% (70); No 18% (90) | A 16-percentage-point gap exists between awareness and active card ownership. |
| Used PM-JAY? (n=340) | Yes 42% (143); No 58% (197) | Non-use is not automatically a scheme failure; many cardholders may not have required hospitalization. |
| Hospital distance (n=143) | <15 km 46% (66); 15-40 km 36% (51); >40 km 18% (26) | 54% travelled at least 15 km, suggesting meaningful geographical access constraints. |
| Card accepted smoothly? | Immediate 62% (89); delayed/queries 28% (40); denied/turned away 10% (14) | 38% experienced some admission friction. |
| Treatment 100% cashless? | Completely 38% (54); partially 52% (74); not cashless 10% (15) | 62% reported some financial contribution. |
| Bought medicines outside? | Yes 58% (83); No 42% (60) | External medicine purchase was common. |
| Paid for diagnostic tests? | Yes 46% (66); No 54% (77) | Nearly half reported diagnostic spending. |
| OOPE category | ₹0 38%; <₹2,000 24%; ₹2,000-₹10,000 26%; >₹10,000 12% | 62% reported some OOPE; 12% reported more than ₹10,000. |
| Portal/pre-auth delay | No delay 48% (69); 1-3 h 32% (46); >6 h 14% (20); >1 day 6% (8) | 52% reported some delay; 20% reported delays beyond six hours. |
| Clinical satisfaction | Very satisfied 42% (60); satisfied 34% (49); neutral 12% (17); dissatisfied 12% (17) | 76% were satisfied or very satisfied. |
| Would use again? | Definitely 78% (112); maybe 16% (23); no 6% (8) | 94% remained open to using PM-JAY again. |

Three findings stand out. First, 84% awareness is much higher than the 68% active-card rate, so awareness does not always translate into completed enrolment. Second, among users, the main weakness is financial: only 38% described the hospitalization as completely cashless. Third, the clinical experience was rated much more positively than the administrative/financial experience: 76% were satisfied or very satisfied with care and 78% would definitely use PM-JAY again.

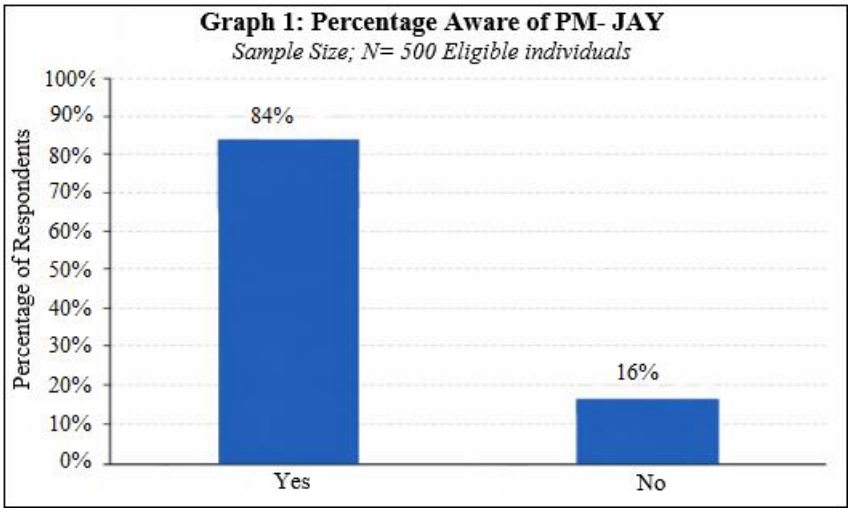


**Figure 1:** Awareness of PM-JAY. Source: Primary survey (N=500).

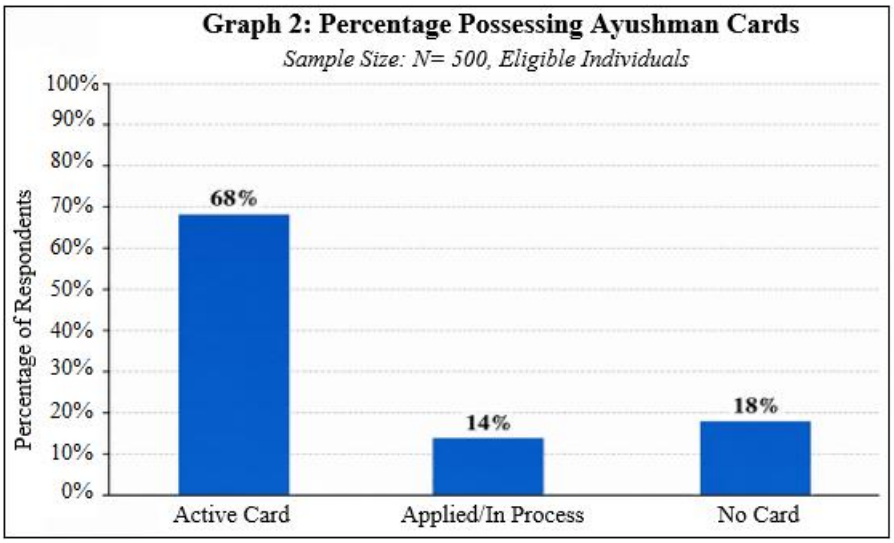


**Figure 2:** Ayushman card possession. Source: Primary survey (N=500)

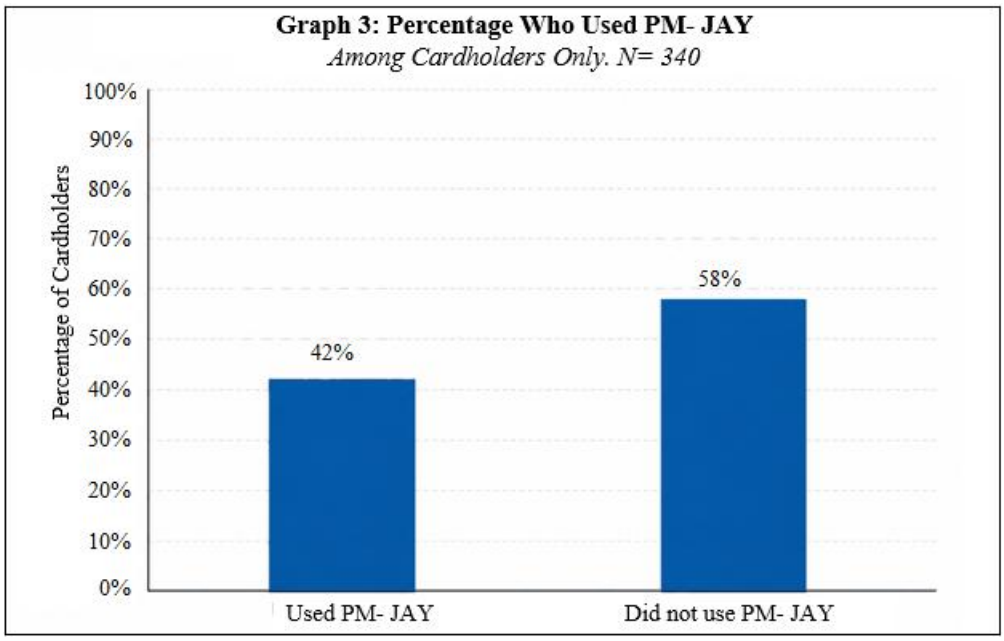


**Figure 3:** PM-JAY utilization among active cardholders. Source: Primary survey (n=340).

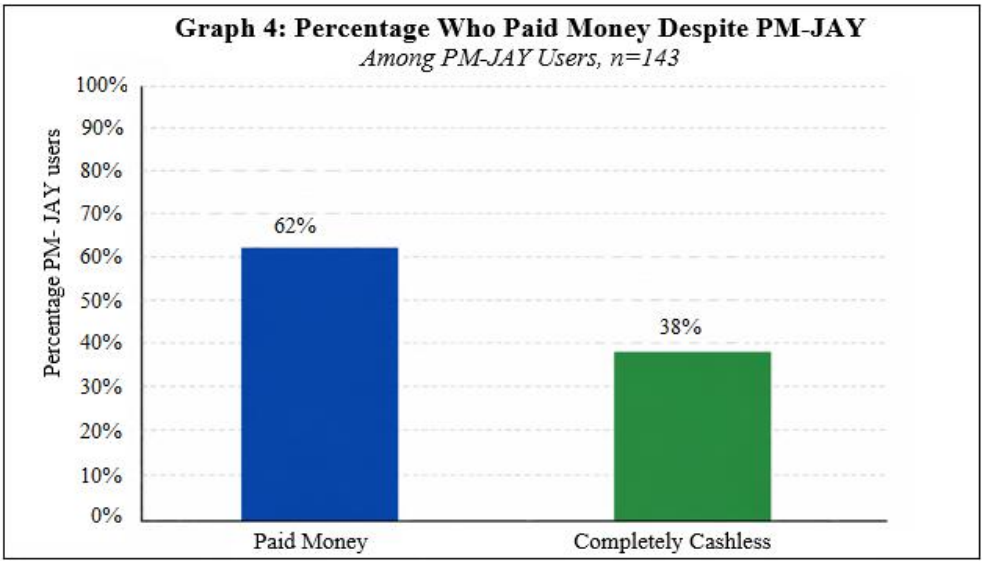


**Figure 4:** Share of PM-JAY users who paid money despite using the scheme. Source: Primary survey (n=143)

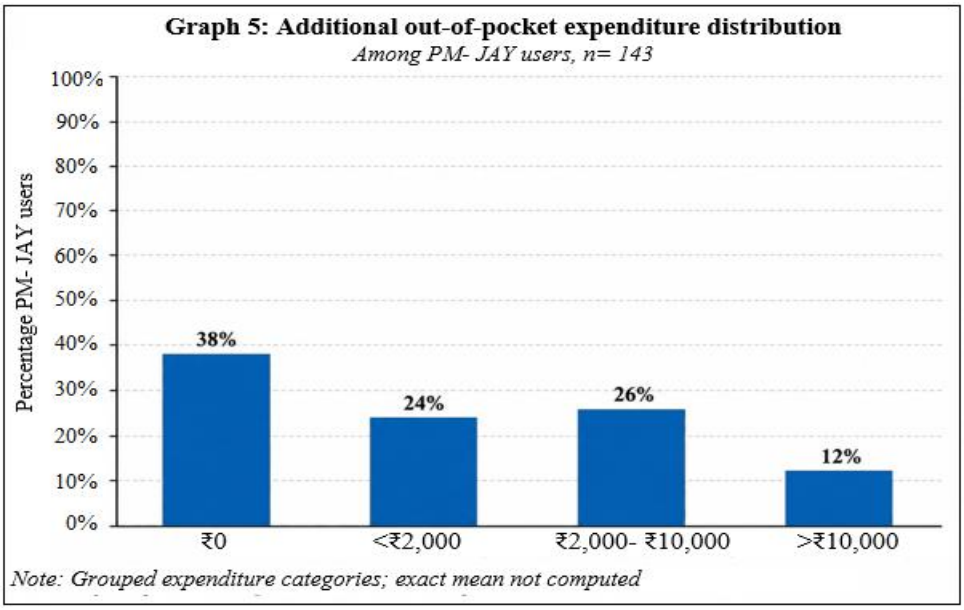


**Figure 5:** Additional out-of-pocket expenditure distribution. Source: Primary survey (n=143). Exact mean is not calculated from grouped categories

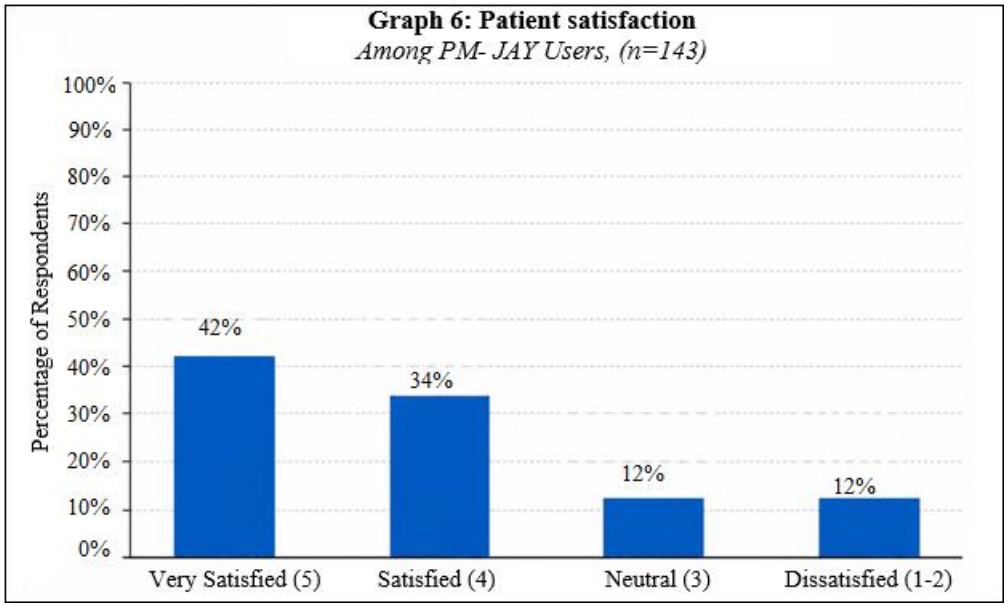


**Figure 6:** Patient satisfaction with clinical care. Source: Primary survey (n=143)

**Hospital Survey and Key-Informant Results**

The hospital data show the other side of the same policy. PM-JAY appears to bring substantial patient volume into participating hospitals, but the surveyed providers expressed greater concerns about the financial and administrative aspects of implementation.

**Table 6:** Corrected hospital survey results

| Question / metric | Distribution | Interpretation |
|---|---|---|
| Monthly PM-JAY admissions | Small <50 beds: 15-35/month; medium 50-150 beds: 60-140/month; large/tertiary >150 beds: 250+/month | Volume rises sharply with hospital size. |
| Increased patient volume? | >25% increase 64% (32); 10-25% 26% (13); <10% 10% (5) | 90% reported at least a 10% increase. |
| Package rates viable? | Inadequate/below cost 56% (28); break-even 34% (17); viable/profitable 10% (5) | Most hospitals did not consider package rates comfortably viable. |
| Claim turnaround | <30 days 22% (11); 31-60 38% (19); 61-120 28% (14); >120 12% (6) | 78% reported turnaround beyond 30 days; 40% beyond 60 days. |
| Claim query/rejection rate | <5% 26% (13); 5-15% 48% (24); >15% 26% (13) | 74% reported query/rejection rates of at least 5%. |
| Primary claim issue | Documentation 44%; pre-auth/code mismatch 28%; medical-necessity query 18%; billing/tariff 10% | 72% of primary issues were documentation or coding/pre-authorisation related. |
| Documentation burden | Excessive 62% (31); manageable 32% (16); streamlined 6% (3) | Nearly two-thirds considered documentation heavy. |

| Question / metric | Distribution | Interpretation |
|---|---|---|
| Pre-authorisation | <2 h 40% (20); 2-6 h 44% (22); >6 h 16% (8) | 60% reported pre-authorisation taking at least two hours. |
| Financial patient preference | Private insurance/cash 68% (34); neutral 24% (12); PM-JAY 8% (4) | This item is most meaningful for private hospitals and should ideally be cross-tabulated by ownership. |
| Overall hospital benefit | Positive 58% (29); neutral 24% (12); negative 18% (9) | Most remained positive overall despite concerns over cash flow and margins. |

The most important provider-side tension is visible in the combination of volume and viability. Ninety percent of hospitals reported at least a 10% increase in patient volume, yet 56% said package rates were inadequate or below cost. In other words, PM-JAY can increase hospital utilization without automatically making each package financially attractive.

Payment timing creates a second tension. Only 22% reported claim turnaround within 30 days, while 40% reported periods longer than 60 days. This matters most for hospitals that must pay staff, pharmacies, implant suppliers and utilities before the reimbursement arrives. The problem is therefore not simply "profit"; it is also working capital and predictability.

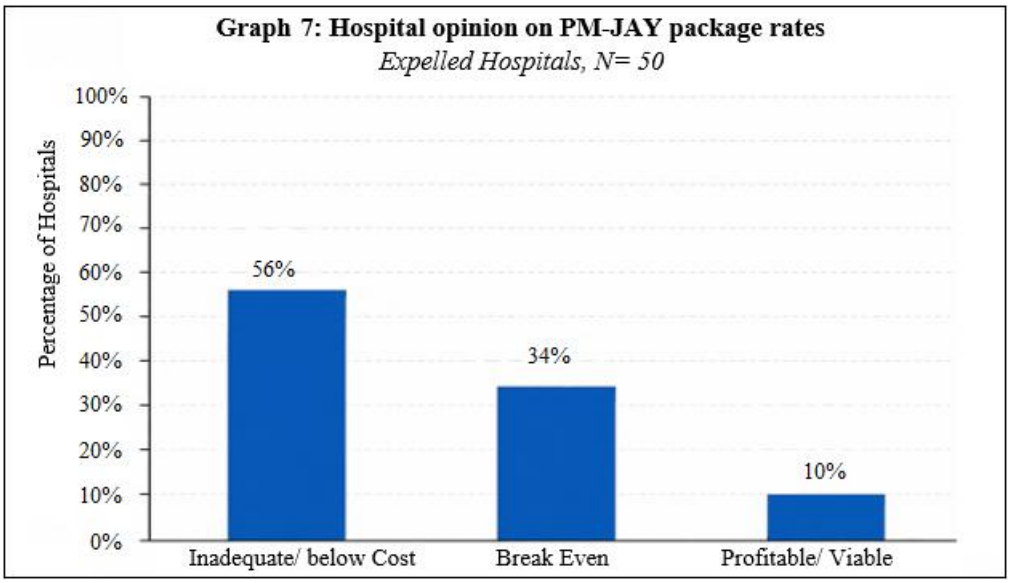


**Figure 7:** Hospital opinion on PM-JAY package rates. Source: Hospital survey (N=50)

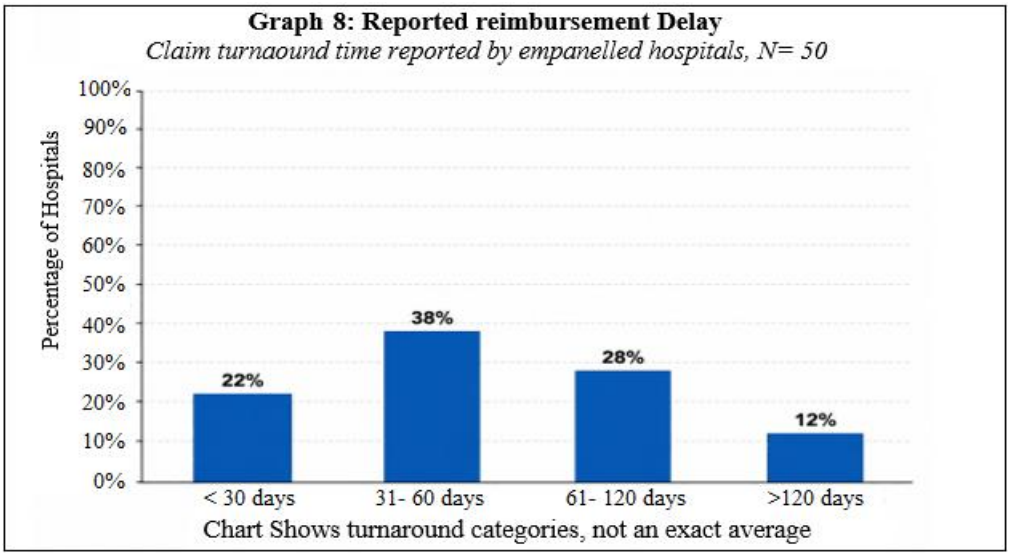


**Figure 8:** Reported reimbursement / claim-turnaround categories. Source: Hospital survey (N=50)

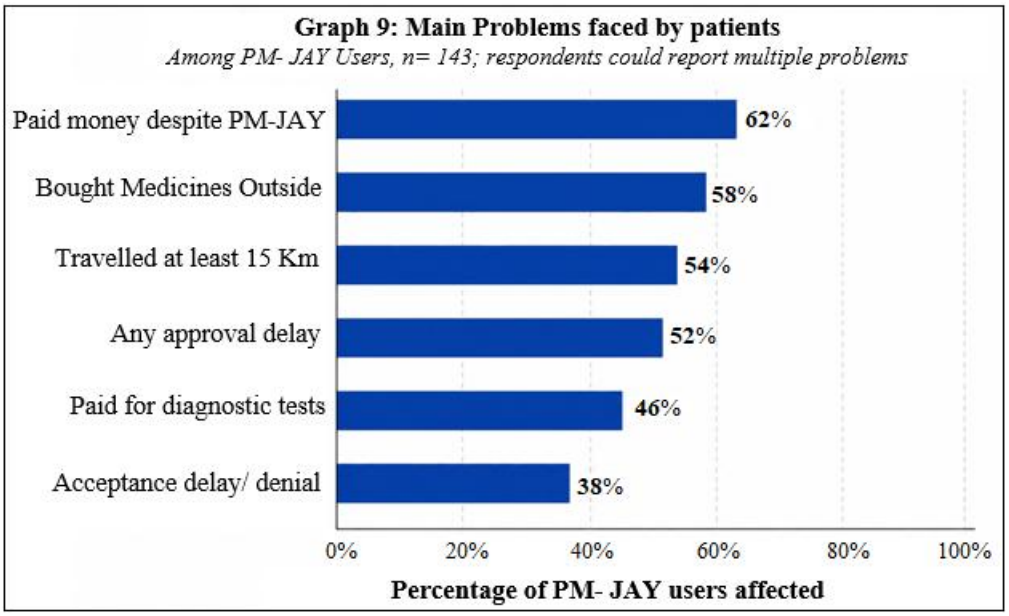


**Figure 9:** Main problems reported by PM-JAY patients. Source: Primary survey (n=143). Indicators come from separate questions and should not be added together.

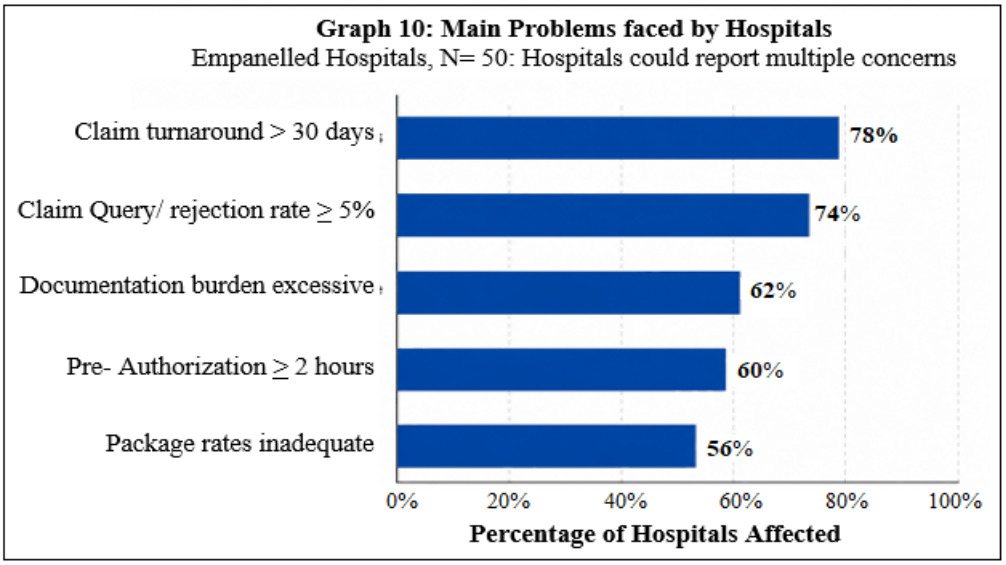


**Figure 10:** Main problems reported by empanelled hospitals. Source: Hospital survey (N=50). Indicators come from separate questions and should not be added together. PM-JAY: Promise vs Ground Reality

**Table 7:** Promise versus ground reality in the primary study

| PM-JAY promise / objective | What was investigated | Primary finding |
|---|---|---|
| Cashless treatment | Did patients pay? | 38% completely cashless; 62% reported some payment. |
| Financial protection | How much residual OOPE remained? | 38% reported ₹0; 12% reported >₹10,000. |
| Hospital accessibility | Distance and acceptance | 54% travelled at least 15 km; 38% experienced delay/query/denial at acceptance. |
| Efficient treatment | Portal/pre-authorisation delays | 52% reported some delay; 20% reported >6 hours. |
| Hospital participation | Package viability | 56% of hospitals considered package rates inadequate/below cost. |
| Timely payment | Claim processing | 78% reported turnaround >30 days; 40% >60 days. |
| Quality healthcare | Patient satisfaction | 76% were satisfied or very satisfied with clinical care. |
| Medicines and diagnostics in covered pathway | External purchases | 58% bought medicines outside; 46% paid for diagnostic tests. |
| Efficient administration | Documentation burden | 62% of hospitals described documentation as excessive. |
| Hospital utilization | Patient volume | 90% reported at least a 10% increase in volume. |
| Beneficiary confidence | Would use again? | 78% definitely yes; 16% maybe; 6% no. |

The table makes the central argument of this paper clear: PM-JAY can work and still have implementation gaps at the same time. High satisfaction and willingness to reuse the scheme sit alongside residual patient expenditure. Higher hospital volume sits alongside dissatisfaction with package rates and payment timing. These are not contradictions; they show why the scheme should be evaluated across several dimensions rather than by one headline number.

## 6. Benefits and Challenges for Patients and Hospitals

### 6.1 Advantages for Patients

**Table 8:** Advantages of PM-JAY for patients

| Advantage | How the patient can benefit |
|---|---|
| Financial protection | Eligible families can receive covered secondary and tertiary hospital care without bearing the full package cost themselves [1]. |
| Cashless treatment | For covered packages, the scheme is designed so the beneficiary does not first pay the entire bill and later seek reimbursement [1]. |
| Large family cover | Up to ₹5 lakh per eligible family per year can protect against expensive hospitalization [1]. |
| No family-size cap | Core PM-JAY design does not restrict benefits by family size, age or gender [1]. |
| Public + private hospitals | Empanelment can expand treatment choice beyond the public sector alone [1]. |
| Portability | Eligible beneficiaries can use empanelled hospitals outside their home state [1]. |
| Pre-existing conditions | Conditions existing before enrolment are covered from day one under scheme rules [1]. |
| Access to expensive care | High-cost procedures that would otherwise be unaffordable may become accessible. |
| Lower catastrophic spending | Published Haryana evidence found substantially lower direct medical expenditure among beneficiaries [5]. |

### 6.2 Challenges for Patients

- Treatment is not always completely free in practice. Patients may still pay for medicines, diagnostics, transport or other costs around the episode [4][5][6].
- Not every health expense is part of the hospitalization package. Routine outpatient care and wider indirect costs remain outside the core PM-JAY hospital benefit.
- Pre-authorisation can delay admission or treatment when verification, documentation or portal processes are slow [4][6].
- An empanelled hospital may be too far away or may not provide the required specialty/package, so card ownership does not guarantee convenient access [4].
- Travel, food, accommodation for attendants and wage loss can remain significant even when the hospital package is cashless [5][14].
- Patients may not fully understand what is covered, where to go, what they may legally be charged for or how to use grievance systems.
- Implementation differs across states and hospital systems, so an experience in one location cannot automatically be generalized to the entire country.
- Data-quality and fraud-control problems can indirectly affect genuine patients if verification becomes more complicated or slower [4].

### 6.3 Advantages for Hospitals

**Table 9:** Advantages of PM-JAY for hospitals

| Advantage | How the hospital can benefit |
|---|---|
| More patients | Empanelment can bring in eligible patients who might otherwise postpone or avoid private hospital care. |
| Government-funded reimbursement | Approved cases create a payer route that does not depend entirely on a patient paying the full bill. |
| Larger potential market | Low-income households become part of the potential patient base for covered services. |
| Higher utilization | Beds, operating theatres and equipment may be used more frequently as covered patient volume rises. |
| Visibility and social reach | Empanelment can make a hospital more visible to eligible beneficiaries and expand its public-service role. |
| Predictable package structure | Predefined packages give hospitals a known reimbursement amount in advance, even if the adequacy of that amount is debated. |
| Additional public-hospital revenue | Public hospitals may generate scheme-linked revenue subject to state/institutional rules. |
| Demand stability | A large beneficiary pool can create a relatively steady stream of covered inpatient demand. |

### 6.4 Challenges for Hospitals

- Package rates may be below the actual cost of some procedures. Early HBP 1.0 pricing showed substantial mismatches, although subsequent revisions improved the alignment [8].
- Delayed reimbursement can create cash-flow pressure, especially for smaller private hospitals that must pay staff and suppliers before claims are settled [7][9].
- Claims can be queried, rejected, partially approved or delayed because of documentation, coding, medical-necessity or tariff disputes.
- Administrative burden is significant: beneficiary verification, package selection, pre-authorisation, documentation, discharge, claim submission and query resolution all require staff time.
- Low package rates, claim uncertainty and payment delay can combine to make some PM-JAY cases financially unattractive even when they increase bed occupancy.
- Standardized packages may not always reflect differences in patient complexity, preferred implants, diagnostics or clinical inputs [8].
- Misunderstandings about what “cashless” covers can create conflict between patients and hospitals even when a disputed item is outside the package.
- Fraud prevention, audit and verification are necessary, but poorly streamlined controls can add transaction costs for legitimate providers.

## 7. Main Findings

- PM-JAY has large real-world reach. Government data show very high numbers of cards and authorized hospitalizations [2][11].
- Financial protection is real but incomplete. Published studies and this survey both suggest that PM-JAY can substantially reduce costs without guaranteeing zero expenditure [5].
- In the primary survey, only 38% of PM-JAY users reported a completely cashless hospitalization, while 62% reported some spending.
- Access remains a practical issue: 54% of PM-JAY users in the survey travelled at least 15 km to the hospital, and CAG evidence shows substantial geographical variation in provider availability [4].
- Patients remain broadly positive about the care itself: 76% were satisfied or very satisfied, and 78% would definitely use the scheme again.
- Hospitals benefit strongly from demand: 90% reported at least a 10% increase in patient volume.
- Provider sustainability is a concern: 56% considered package rates inadequate, 78% reported claim turnaround beyond 30 days and 62% described documentation as excessive.
- The most important overall finding is a gap between entitlement and experience. Success should therefore be measured not only through cards, admissions and empanelment, but also through patient OOPE, active access, claim speed and provider viability.

## 8. Discussion

The strongest feature of the findings is that the patient and hospital results point in the same direction from different sides. Patients value the scheme enough to remain satisfied with care and willing to use it again, while hospitals value the patient volume it creates. This supports the argument that PM-JAY is providing genuine value rather than existing only on paper.

At the same time, the most important weaknesses are also connected. When package rates are tight or reimbursement is slow, hospitals have stronger reasons to minimize extra inputs, become cautious about complex packages or prefer patients whose payment is faster. When medicines, diagnostics or parts of the care pathway then fall outside the effective covered experience, the patient may pay. The scheme's financial-protection promise therefore depends partly on the financial health of the provider network.

The patient data also show why “cashless” needs to be defined carefully. A hospitalization can be cashless for the approved package while the family still spends on transport, diagnostics, medicines or items before formal admission. For policy evaluation, it is therefore useful to distinguish package-level cashlessness from episode-level financial protection.

Similarly, “empanelled hospital” should not automatically be treated as “available hospital.” CAG findings on inactive or non-compliant empanelled facilities, combined with the distance reported in this survey, suggest that active specialty availability is a more meaningful access indicator than the simple number of empanelled institutions [4].

The evidence also argues against extreme conclusions. PM-JAY cannot fairly be described as a complete failure when national utilization is high, published evidence shows substantial cost reductions and most users in this survey remain satisfied. But it also cannot be treated as a finished success when residual OOPE, geographical barriers, package-rate concerns and claim delays remain visible. The more accurate conclusion is that PM-JAY is a high-impact scheme whose effectiveness is being limited by implementation quality.

## 9. Recommendations

1) Accelerate hospital claim settlement and publish transparent turnaround-time dashboards by state and payer model.
2) Revise Health Benefit Package rates regularly using current hospital-cost data and allow justified complexity adjustments where evidence supports them.
3) Strengthen monitoring of improper beneficiary charges for services that are included within covered packages.
4) Explain clearly to beneficiaries what is covered, what is excluded, and which pre/post-hospitalization costs are eligible.
5) Improve awareness of empanelled hospitals, package availability and grievance channels, not just awareness of the Ayushman card itself.
6) Simplify pre-authorisation, beneficiary verification and claim-query workflows while maintaining strong fraud controls.
7) Track active service availability, not only hospital empanelment, particularly in rural and underserved districts.
8) Improve availability of medicines and diagnostics within the covered treatment pathway to reduce the need for external purchases.
9) Create routine feedback channels for hospitals so recurring code mismatches, documentation problems and medical-necessity queries can be corrected systemically.
10) Publish more disaggregated performance data on OOPE, claim rejection, claim delay, active hospital service use and grievance outcomes.
11) Establish predictable payment cycles for hospitals. Where verified claims remain unpaid beyond defined timelines without valid cause, policy makers could consider contractual interest or penalty mechanisms so the cost of delay is not transferred entirely to providers.
12) Compare private and public hospital experience separately in future evaluations because their incentives, cost structures and financial objectives differ.

**Ethical Considerations**

Ethics and consent statement: [Before submission, replace this bracketed note with a truthful statement describing informed consent, anonymity/confidentiality, participant eligibility, and any ethics or institutional approval actually obtained. Do not claim approval that was not obtained.]

## 10. Limitations of the Study

- Limited geographical coverage: the study does not represent every state or district in India, where PM-JAY implementation may differ.
- Limited sample size: 500 eligible individuals and 50 empanelled hospitals cannot automatically be generalized to the whole country.
- Smaller user sample: detailed patient-experience results are based on 143 cardholders who had actually used PM-JAY for hospitalization.
- Possible sampling bias: respondents were selected from accessible rural and urban clusters rather than through nationwide random sampling.
- Self-reported responses: expenditure, delays and satisfaction depend partly on memory and personal perception.
- Grouped expenditure data: OOPE was collected in ranges, so an exact mean cannot be calculated from the grouped categories alone.
- OOPE missing response: the supplied category counts contain 142 valid count-based responses among 143 PM-JAY users; one response is therefore recorded as missing for this item and should be checked against the raw response sheet before formal publication.
- Causes of problems are not always identified: a reported delay or denial may be technical, documentary, clinical, eligibility-related or provider-related.
- Public and private hospitals differ: combining them can hide important differences in incentives, costs and reimbursement pressure.
- Hospital claims were not independently audited: information on delay, package viability and claim rejection is based mainly on hospital responses rather than verified transaction-level records.
- Cross-sectional design: the study captures one period, while package rates, technology, eligibility rules and implementation systems can change.
- Focus on PM-JAY hospitalization: the study does not evaluate every component of the wider Ayushman Bharat programme.
- Association is not always causation: the study may observe extra spending or delays without being able to prove one single cause.

## 11. Overall Conclusion

PM-JAY represents a major expansion of publicly financed hospital protection in India, and the evidence examined in this study indicates meaningful benefits for both access and financial protection. However, these benefits are not experienced uniformly. Among surveyed users, residual expenditure remained common despite generally positive clinical satisfaction and willingness to use the scheme again. Hospitals similarly reported increased patient volume while identifying concerns related to package adequacy, reimbursement timelines, and administrative requirements. These findings suggest that the principal challenge is not the absence of policy value but the gap between formal entitlement and consistent implementation. Strengthening episode-level financial protection, active provider access, timely reimbursement, realistic package pricing, and streamlined administration could improve both beneficiary experience and provider participation. PM-JAY should therefore be viewed as a valuable health-financing programme whose impact can be strengthened through focused improvements in implementation.

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**Appendix A: Patient Survey Instrument**

- Have you heard of Ayushman Bharat-PMJAY?
- Do you possess an active Ayushman card?
- Have you ever used PM-JAY for hospitalization?
- How far was the empanelled hospital from your home?
- Was your Ayushman card accepted immediately?
- Was your treatment completely cashless?
- Did you purchase medicines outside the hospital?
- Did you pay separately for diagnostic tests?
- How much additional out-of-pocket expenditure did you incur?
- Did portal or pre-authorisation approval delay admission or treatment?
- How satisfied were you with the clinical care received?
- Would you use PM-JAY again?

**Appendix B: Hospital Survey / Key-Informant Guide**

- Approximately how many PM-JAY admissions does the hospital handle per month?
- Has PM-JAY increased inpatient volume?
- Are current package rates financially viable for the hospital?
- What is the typical claim-turnaround category?
- What proportion of claims receive queries or initial rejection?
- What is the most common reason for claim queries or rejection?
- How burdensome is PM-JAY documentation?
- How timely are pre-authorisations?
- For private hospitals, how does PM-JAY compare financially with cash/private-insurance patients?
- Overall, has PM-JAY benefited the hospital?

**Appendix C: Primary Data Interpretation Notes**

- Awareness/enrolment denominator: N=500 eligible individuals.
- Utilization denominator: n=340 active cardholders.
- Detailed patient-experience denominator: n=143 PM-JAY users.
- Hospital denominator: N=50 empanelled hospitals (30 private, 20 public).
- Patient-problem and hospital-problem graphs combine indicators from separate questions; percentages therefore do not sum to 100%.
- OOPE percentages sum to 100%, but supplied category counts sum to 142; raw data should be reconciled before any formal publication.