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Ayushman Bharat PM-JAY: Pathways to Social Impartiality, Legal Rights, and Health Care Access

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The Pradhan Mantri Jan Arogya Yojana (PM-JAY)[1], also known as Ayushman Bharat Yojana, denotes an important moment in India's trip towards Universal Health Coverage[2]. As the world's largest government-funded healthcare program, it signifies a massive step toward equitable access to secondary and tertiary healthcare in a country still scuffling with structural differences. This Research paper undertakes a detailed and multidimensional analysis of the scheme, beginning with its literal origins and policy aggravation. This paper undertakes a multidimensional analysis of PM-JAY, integrating indigenous, legal, policy, institutional, and socio-profitable perspectives, with Lucknow District as a focused case study. It critically examines its legal and executive frame, explores its incorporation with public and state health architectures, and uses empirical data from government and NGO sources to assess impact. In doing so, the paper evaluates both the pledges and risks of PM-JAY through legal and public health lenses. Recent perpetration challenges, exploitation issues, and digital metamorphoses similar to the Ayushman

[1] 'About Pradhan Mantri Jan Arogya Yojana (PM-JAY)' (*National Health Authority*) <https://nha-gov-in.translate.goog/PM-JAY?_x_tr_sl=en&_x_tr_tl=hi&_x_tr_hl=hi&_x_tr_pto=tc> accessed 05 August 2025
[2] 'Concept note on session "Roadmap for Universal Health Coverage in India" Arogya Manthan 2022' (*Ayushman Bharat Digital Mission*) <https://abdm.gov.in/static/media/Session%201%20Note%20-%20Universal%20Health%20Coverage.da4d39535a6227916c18.pdf> accessed 05 August 2025

Bharat Digital Mission[3] *are bandied to punctuate functional backups. Furthermore, it addresses encounters parallel to uneven primary healthcare integration, limited statutory backing, and availability gaps for marginalised groups. Eventually, this paper offers practicable, substantiation-backed policy recommendations, emphasising the need for statutory protection of health rights and stronger public health governance. The analysis reflects professional education, narrative consonance, and policy realism, safeguarding a comprehensive and original engagement with one of India's most ambitious social programs.*

Keywords: *Ayushman Bharat, Pradhan Mantri Jan Arogya Yojana, public health governance, health, wellness centres.*

INTRODUCTION

India's excursion toward *Universal Health Coverage (UHC)* has been extensive and irregular. A Nation with a massive and diverse population, India has historically faced gaps in healthcare access due to profitable inequality, Rural-urban divides, and indigenous differences in structure. Over 60% of health charges in India are paid out of pocket, frequently leading to disastrous fiscal consequences for families. Entertaining these challenges, the Indian Government launched *Ayushman Bharat in 2018* as a transformative action to produce a robust continuum of care system.

Unlike outmoded schemes fastening only on insurance or limited state-position intervention, Ayushman Bharat aimed to revise both **anticipatory** and **restorative** aspects of healthcare delivery. It was structured as a two-round Initiative:

- Health and Wellness Centre's (HWCs) for primary health care
- Pradhan Mantri Jan Arogya Yojana (PM-JAY) for minor and tertiary treatment

This duality allowed for both holistic illness anticipation and financial coverage, thereby targeting a broad spectrum of healthcare requirements. This paper delves into the birth, design, prosecution, and ongoing reform of Ayushman Bharat with a multidimensional perspective that includes legal, profitable, and social factors.

[3] 'ABDM Components Statistics' (*Ayushman Bharat Digital Mission)* <https://abdm.gov.in> accessed 05 August 2025

HISTORICAL ELABORATION

The roots of Ayushman Bharat can be traced to earlier central schemes like *Rashtriya Swasthya Bima Yojana (RSBY)*[4], introduced in *2008* and state-led models like *Tamil Nadu's Chief Minister's Comprehensive Health Insurance Scheme*[5]. While these schemes had limited fiscal cover, they demanded scalability and incorporation. Learning from their achievements and failures, Ayushman Bharat was theorised as a further extensive, sustainable model.

The advertisement came in the *2018 Union Budget* by *Finance Minister Arun Jaitley*, who declared the scheme as a step towards a "*New India 2022*[6]". The ideological foundation was heavily pinched from the *National Health Policy, 2017*[7], which supported the consolidation of primary care and threat protection. Correspondingly, the WHO[8]'s global UHC agenda handed transnational legality to India's attempt.

MILEPOSTS IN THE EXPLANATION OF AYUSHMAN BHARAT PM-JAY (2019 – 2025[9])

The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), India's leading public health assurance scheme, has witnessed a structured and transformative line since its commencement. Below is a sequential account of significant milestones that have shaped its progress

February 1, 2018: The Union Budget presented the introduction of Ayushman Bharat, marking the formal conceptualisation of the scheme.

March 21, 2018: The Union Cabinet permitted the perpetration framework of AB PM-JAY.

March 27, 2018: Appointment of the Chief Executive Officer (CEO) offered leadership and executive direction to the scheme.

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[4] 'Rashtriya Swasthya Bima Yojana' (*National Portal of India*) <https://www.india.gov.in/spotlight/rashtriya-swasthya-bima-yojana> accessed 05 August 2025
[5] 'SALIENT FEATURES OF THE SCHEME' (*Chief Minister's Comprehensive Health Insurance Scheme*) <https://www.cmchistn.com/features.php> accessed 05 August 2025
[6] 'Budget Speech 2018-19 Speech of Arun Jaitley, Minister of Finance' (*India Budget*, 01 February 2018) <https://www.indiabudget.gov.in/budget2018-2019/ub2018-19/bs/bs.pdf> accessed 05 August 2025
[7] National Health Policy 2017
[8] 'About WHO' (*World Health Organization*) <https://www.who.int/about> accessed 05 August 2025
[9] National Health Authority, *Ayushman Bharat Digital Mission: Annual Report 2019-2020* (2021)

May 11, 2018: The National Health Authority (NHA), the sovereign body trusted with executing PM-JAY, was formally incorporated.

June 14, 2018: The Ministries' Conclave was held to substitute inter-ministerial collaboration for the scheme's execution.

August 15, 2018: The Prime Minister of India officially launched Ayushman Bharat PM-JAY from the Red Fort.

September 23, 2018: Ayushman Bharat PM-JAY was launched nationwide.

December 11, 2018: Within many months of launch, over *5 lakh beneficiaries* had received treatment under the scheme.

January 2, 2019: Completion of the first 100 days of PM-JAY and the configuration of the NHA were formally conceded.

January 24, 2019: A Memorandum of Understanding (MoU) was inked with the Ministry of Railways, bringing 91 road hospitals into the ex-panelled network.

April 11, 2019: Accretive treatment benefits extended to *20 lakh beneficiaries*.

June 24, 2019: Treatments under the scheme crossed 30 lakh beneficiaries.

September 23, 2019: On the first anniversary of the launch, *10.39 crore cards* were issued, *46.62 lakh Hospital admissions* were recorded, *and 18,236* hospitals had been empanelled under the scheme.

November 25, 2019: Further progress was apparent as *11.4 crore-cards* were issued; *62.57 lakh hospital admissions* had taken place; Total hospitalisation expenditure reached ₹*9,205 crore*; The hospital network expanded to 20,908 empanelled institutions.

May 20, 2020: The scheme reached a major milestone of 1 crore Hospital admissions, emphasising its expansive outreach during the COVID-19 epidemic.

August 10, 2020: By this date, over *12.55 crore cards* were issued; *1.09 crore* Hospital admissions had been eased; The network had grown to include 22,796 empanelled hospitals.

September 25, 2022: The deterioration in Out-of-Pocket expenditure out of Total Health Expenses from 64.2% in 2013-14 to 39.4% in 2021-22 reflects a very optimistic indicator[10]

Jan 24, 2024: 30 Crore Ayushman Cards created under PM-JAY, along with 6.2 crore free hospital admissions under this scheme.[11]

March 24, 2025: More than 36.9 Crore Ayushman Cards created under PM-JAY

This shift from fractured schemes to a centralised, intertwined model was a strategic move to protect alignment across central and state governments.

SOCIOLOGICAL LIMITS OF HEALTH AND WELLNESS AMONG PM-JAY HEIRS IN LUCKNOW DISTRICT

Health and fitness, as understood in sociological treatises, represent a compound of physical health, internal well-being, and the social conditions that enable individuals to lead productive lives. The World Health Organisation's interpretation of health *as "a state of complete physical, mental and social wellbeing and not simply the absence of disease*"[12] highlights that medical care is only one element in a wider frame of social determinants, including income security, education, occupational circumstances, gender relations, and community structure. Within this abstract frame, the Ayushman Bharat program in Lucknow District operates as a structured, state-eased medium for connecting homes, particularly those linked through the *Socio-Economic Caste Census (SECC)*[13]*,* to both preventative and restorative services.

The framework of Ayushman Bharat consists of two intertwined pillars: *the Health and Wellness Centres (HWC),* which serve as localised access points for primary level services, and *the Pradhan Mantri Jan Arogya Yojana (PM-JAY),* which delivers fiscal content for designated secondary and tertiary treatments through a network of expanded hospitals.

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[10] 'Union Health Ministry Releases National Health Accounts Estimates for India 2020-21 and 2021-22' (*Press Information Bureau*, 25 September 2024) <https://www.pib.gov.in/PressReleaseIframePage.aspx?PRID=2058791> accessed 05 August 2025

[11] '30 Crore Ayushman Cards Created Under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana' (*Press Information Bureau*, 14 January 2024) <https://www.pib.gov.in/PressReleaseIframePage.aspx?PRID=1996010> accessed 05 August 2025

[12] Constitution of the World Health Organization 1946

[13] Ministry of Rural Development, *Socio-Economic & Caste Census (SECC) 2011* (2014)

In Lucknow District, these HWCs and Urban Primary Health Centres (UPHCs) form the frontline of health service delivery, performing tasks such as routine wireworks, immunisation drives, non-communicable disease follow-ups, and referrals. Their integration with the PM-JAY frame enables cases diagnosed at the primary level to be referred seamlessly for hospital-based treatment at institutions such as King George's Medical University (KGMU) and Dr Ram Manohar Lohia Institute of Medical Sciences.

From a sociological viewpoint, the program's eligibility rules drawn from SECC data cross directly with the district's demographic composition. *Census 2011*[14] and *SECC*[15] *data* indicate that roughly 1/5th of Lucknow's population belongs to the Scheduled Castes, with fresh significant representation from other socioeconomically underprivileged groups. This correlation between program targeting and demographic structure has counteraccusations for patterns of access. The institutionalisation of eligibility based on deprivation pointers creates a direct pathway for historically marginalised communities to engage with formal healthcare systems.

When analysed holistically, the sociological extents of health and well-being among PM-JAY beneficiaries in Lucknow are shaped by the interplay of institutional design, demographic realities, and the integration of digital governance tools. The result is a layered system in which healthcare access is not solely a function of medical capacity, but is intermediated by eligibility fabrics, migration patterns, digital addition, and the organisational ground of service delivery.

INFLUENCE OF AYUSHMAN BHARAT ON SOCIAL IMPARTIALITY AND HEALTHCARE ACCESS IN LUCKNOW DISTRICT

The theoretical analysis of Ayushman Bharat's part in shaping healthcare access in Lucknow District must begin with its grounding in constitutional and statutory principles. *Article 21*[16] of the Constitution of India, which assures the right to life, has been judicially interpreted in cases similar to *Paschim Banga Khet Mazdoor Samity v State of West Bengal (1996)*[17] to include the

[14] 'DISTRICT CENSUS HANDBOOK LUCKNOW' (*Census of India*, 2011) <https://censusindia.gov.in/nada/index.php/catalog/1251/download/4018/DH_2011_0926_PART_B_DCHB_LUCKNOW.pdf> accessed 05 August 2025
[15] Ministry of Rural Development (n 13)
[16] Constitution of India 1950, art 21
[17] *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37

right to access timely and acceptable medical treatment. Furthermore, the *Directive Principles of State Policy — Articles 38, 41, and 47*[18] figure the State's responsibility to encourage the welfare of the individuals, secure the right to work, education, and public support, and raise the position of nutrition and public health. Ayushman Bharat operationalises these principles by creating a formal annuity to specified healthcare services, supported by a legal executive frame of guidelines, empanelment contracts, and grievance mechanisms.

In Lucknow District, the transformation of these public and state-level legal commitments into functional healthcare access is intermediated through *the Uttar Pradesh State Health Agency*, which coordinates with the National Health Authority. The state level execution data for PM-JAY indicates substantial registration and hospital empanelment, with Lucknow hosting a blend of government and private installations in its expelled network. This network includes tertiary hospitals as well as lower private and public institutions, thereby creating multiple access points for beneficiaries.

The program's executive model incorporates pre-authorisation of treatments, direct clearances of claims with hospitals, and the use of technology-grounded verification through ABHA IDs and biometric authentication. These functional factors serve binary functions; they act as procedural safeguards to ensure that services are delivered to entitled individuals, and they support the financial oversight necessary in a publicly funded healthcare scheme. Anti-fraud structures similar to *the National Anti-Fraud Unit (NAFU)* and *State Anti-Fraud Units (SAFU*) form part of the internal regulatory environment, assigned with monitoring claims and preventing misuse.

For Lucknow specifically, local adaptations include the rollout of e-prescription systems in urban primary health centres, integration of digital identity verification at the point of service, and publication of district-level empanelled facility lists for public access. These measures inclusively support translucency in service provision and align with the policy emphasis on digital governance under the Ayushman Bharat Digital Mission. From a legal and policy perspective, these mechanisms stick PM-JAY within a right grounded service delivery model that's both constitutionally predicted and administratively structured.

[18] Constitution of India 1950, arts 38, 41 & 47

In abstract terms, the impact of Ayushman Bharat on social equity and healthcare access in Lucknow is defined by the confluence of three disciplines *(1)* the constitutional mandate for indifferent access to healthcare, *(2)* the policy framework that operationalises this mandate through targeted eligibility, empanelled networks, and procedural oversight, and *(3)* the integration of digital systems that produce new modes of service commerce between the State, healthcare providers, and beneficiaries. This multi-layered structure not only allocates healthcare resources but also shapes the way healthcare is experienced, provided, and governed within the district.

SOCIOLOGICAL PERCEPTION OF AYUSHMAN BHARAT: A SOCIAL TRANSFORMATION PROJECT

Ayushman Bharat (AB-PMJAY) is not only a health insurance action but a social metamorphosis strategy that redefines the relationship between the state, citizens, and healthcare institutions. From a sociological viewpoint, it addresses the social determinants of health education, caste, gender, poverty, migration, and rural-urban divides, which have historically structured unstable access to medical care in India.

If we talk about *Social Determinants of Health,* the scheme directly intrudes in the cycle of deprivation where poverty, deficiency of education, poor existing conditions, and social inhibiting support health exposures. *For illustration*, Scheduled Castes and Scheduled Tribes, who make up nearly *20%* of Lucknow's population, are proportionately represented among Ayushman Bharat beneficiaries, reflecting the program's effort to empower structurally marginalised groups. Correspondingly, nearly half of the beneficiaries are women, *48.5%*[19], which reflects a sensible determination to reduce *gender-based segregation in healthcare.*

Lucknow District illustrates the sociological dynamics of migration and rural-urban alteration. Rural blocks like Malihabad and Mohanlalganj witness high levels of outmigration, and the portability point of PM-JAY enables permanency of care for these mobile populations. At the same time, Rural beneficiaries depend more heavily on tertiary care (75% of cancer treatments

[19] 'Transforming Healthcare: Six Years of Ayushman Bharat PM-JAY' (*Press Information Bureau*, 23 September 2024) <https://www.pib.gov.in/PressNoteDetails.aspx?NoteId=153181&ModuleId=3> accessed 05 August 2025

under PM-JAY come from rural areas)[20], reflecting how the scheme is reforming outlines of health care mobility.

Furthermore, if observed holistically, AB-PMJAY is a community equaliser that addresses systemic disparities, reallocates healthcare access, and rebuilds the states role as a patron of quality. By merging fiscal protection with digital governance and targeted outreach to demoted groups, the scheme moves beyond policy into the realm of social metamorphosis reshaping health as a lived communal right, not just a statutory pledge.

LUCKNOW DISTRICT SOCIOLOGICAL CONFINES OF AYUSHMAN BHARAT

The perpetuation of Ayushman Bharat in Lucknow District demonstrates how a welfare scheme functions as a social intrusion scheme rather than simply a health financing apparatus. Over Secondary Data and Government Reports, the instance of Lucknow provides an exemplification of the broader sociological challenges and metamorphoses linked to PM-JAY.

From the scheme's launch in 2018 to 2025, over *41 crore Ayushman cards*[21] have been issued nationwide, with a significant share in Uttar Pradesh. Lucknow alone hosts a network of empanelled hospitals including King George's Medical University and Dr. Ram Manohar Lohia Institute, alongside private hospitals that cover secondary and tertiary care. By early 2025, *9.85 crore Hospital admissions valued at over ₹1.40 lakh crore*[22] had been authorised under PM-JAY.

Lucknow's large population of migratory manual workers determines the significance of PM-JAY's portability point, which allows beneficiaries to receive treatment across empanelled hospitals countrywide. Immigrants who move from rural perimeters to Lucknow megacity for work are suitable to pierce tertiary healthcare without the regulatory chain of reenrollment. This mobility of care underscores the scheme's part in addressing spatial inequalities in health,

[20] 'Govt: 68 lakh cancer cases treated under PM-JAY, 76 % of them in rural areas' *The Times of India* (19 March 2025) <https://timesofindia.indiatimes.com/india/govt-68-lakh-cancer-cases-treated-under-pmjay-76-of-them-in-rural-areas/articleshow/119183171.cms> accessed 05 August 2025

[21] 'About PMJAY Scheme' (*Ayushman Bharat Uttar Pradesh*) <https://ayushmanup.in/pages.aspx?pt=About-PMJAY-scheme> accessed 05 August 2025

[22] 'Over 41 Crore Ayushman Cards Created Under AB-PMJAY' (*Press Information Bureau*, 25 July 2025) <https://www.pib.gov.in/PressReleasePage.aspx?PRID=2148359> accessed 05 August 2025

strengthening the sociological principle that healthcare access must adapt to patterns of labour and migration.

OBJECTIVE OF THE PAPER

The central idea of this paper is to observe Ayushman Bharat Pradhan Mantri JanArogya Yojana (PM-JAY) as a plan that extends beyond the sphere of health assistance and enters the realm of social metamorphosis in India. Launched in 2018, PM-JAY has surfaced as the world's largest publicly sponsored healthcare scheme, with more than *41 crore Ayushman cards* issued by July 2025, nearly *20.47 crore of which belong to women beneficiaries*[23]. This scale makes the scheme not just a welfare intervention but a sociological experiment in redistributive justice, offering a unique occasion to study how state-led programs can reduce inequality and transform access to healthcare. By sticking Ayushman Bharat within a sociological frame, this Research paper highlights how the scheme addresses the social determinants of health — poverty, estate, class, gender, migration, and rural-urban divides that have historically defined who obtains medical care and who is barred.

In sociological terms, this represents a medium of empowerment and social inclusion, challenging deep-rooted hierarchies by giving demoted groups access to services preliminarily exploited by the middle and upper classes. Similarly, women who traditionally encounter walls such as fiscal dependence, artistic restrictions, and gender bias in healthcare delivery now constitute nearly half of all PM-JAY beneficiaries. Their access to dedicated packages similar as maternal healthcare, breast and cervical cancer screenings, and reproductive surgeries exemplifies how welfare strategy can also act as a gender justice intervention.

Another core objective is to understand the schemes' influence on rural-urban divides and migration-grounded inequalities. Lucknow, like numerous urban sections in India, is characterised by heavy invasions of migratory workers from neighbouring peri-urban and rural blocks such as Malihabad and Mohanlalganj. PM-JAY compactness point, which allows beneficiaries to avail treatment at any empanelled hospital in the states, is particularly transformative for similar populations.

[23] *Ibid*

These numbers highlight not only the scheme's redistributive part in expanding tertiary care to depressed rural households, but also the sociological implications of healthcare mobility in an economy marked by labour migration. For immigrants, mobility prevents the interruption of healthcare privileges across geographical boundaries, thereby reducing the vulnerability associated with insecure employment and unstable hearthstone.

RELEVANCE OF THE STUDY

Healthcare in India has not once been simply a specialised or executive concern; it has always been a sociological question of justice, equity, and quality. The significance of examining Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY) lies in its measures to address structural differences in Indian society through the medium of health. This study is particularly applicable in 2025 because Ayushman Bharat has grown into the major publicly sponsored healthcare program in the world, with over *41 crore Ayushman cards issued by July 2025,* nearly *20.47 crore of them to women beneficiaries, and more than 8.99 crore sanitarium admissions worth about ₹1.26 lakh crore authorised by March 2025*[24]. These record still, are not significant in insolation. Their true significance lies in what they reveal about India's attempt to alter healthcare access into a social right, one that links longstanding divides of caste, class, gender, and geography.

This is thus applicable not only for its descriptive analysis of Ayushman Bharat but also for its influence on broader sociological debates on equity, enablement, and structural inequality. It shows how welfare programs can concurrently strike certain hierarchies while emphasising new ones, similar to the digital divide.

LEGAL AND INSTITUTIONAL OUTLINE

PM-JAY is administered by the *National Health Authority (NHA),* recognised as an attached office under the Ministry of Health and Family Welfare. NHA was latterly designated as an independent body in 2019 to bring quickness and effectiveness into direction.

[24] 'Over 8.9 Crore Hospital Admissions Authorised under Ayushman Bharat: Health Minister J.P. Nadda' *News on Air* (28 March 2025) <https://www.newsonair.gov.in/over-8-9-crore-hospital-admissions-authorized-under-ayushman-bharat-health-minister-jp-nadda/> accessed 05 August 2025

Despite its ambitious extent, PM-JAY lacks a statutory frame. Unlike employment guarantee schemes or food security programs assisted by devoted legislation, PM-JAY remains a superintendent motivated mission. This limits enforceability and creates nebulosity in intergovernmental liabilities.

The NHA coordinates with **State Health Agencies (SHA**) that act as perpetration arms at the state level. States have the flexibility to choose one of the following functional models.

Trust Model: Where the government directly pays providers.

Insurance Model: Where insurance companies manage beneficiary claims.

Hybrid Model: Combination of both, depending on state structure.

Legal responsibilities, rights of beneficiaries, and grievance redressal mechanisms are governed by functional guidelines issued by NHA. Nevertheless, the absence of judicial oversight has led some scholars to advocate for a statutory health rights frame, especially in light of India's indigenous commitment under *Article 21,*[25] to the right to life.

PM-JAY functions under the aegis of the *National Health Authority (NHA),* which was established in *2019* as a sovereign entity by a Cabinet decision under the *Ministry of Health and Family Welfare*. Though not supported by a separate legislation *like the Mahatma Gandhi National Rural Employment Guarantee Act (MGNREGA)*[26], PM-JAY has surfaced as a vigorous health assurance action erected upon a dynamic combination of superintendent orders, state-position Memoranda of Understanding (MoUs), and public-private contractual fabrics with empanelled hospitals.

The absence of a statutory foundation has not deterred the government from constituting strong mechanisms for oversight and responsibility. The NHA plays a vital supervisory part through its structured framework, which includes

- A *three-tiered grievance redressal system* accessible to all stakeholders.

[25] Constitution of India 1950, art 21
[26] Mahatma Gandhi National Rural Employment Guarantee Act 2005

- Obligatory *audit trails and translucency protocols*, including e-cards, pre-authorisation processes, and real-time dashboards.
- *Standard Treatment Guidelines (STGs)* to help gratuitous procedures and ensure medical quality.

This administrative model allows the government to remain quick in policy response, modify benefit packages as per changing epidemiological necessities, and integrate Real-time data analytics into the governance mechanism.

ADMISSIBILITY, COVERAGE, AND ENACTMENT MODEL FROM PROMISE TO PRACTICE

In the framework of worldwide health care, the ground between strategy intent and people's welfare lies in effective delivery mechanisms. *Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY)* not only promises equity and access but also strives to operationalise them through its finely calibrated eligibility criteria, extensive content, and a flexible yet robust perpetuation model. What sets this scheme separately is its dynamic interplay of data, design, devolution, and digitisation making it one of the most structurally sound and socially responsive health enterprises in the Global South.

Targeting the Right Beneficiaries Equity through Substantiation: Rather than counting on income instruments or private parameters, PM-JAY identifies beneficiaries through **the *Socio-Economic Caste Census (SECC) 2011***[27], making the eligibility frame both empirical and unprejudiced. This data-driven method ensures that the most socio-economically marginalised are prioritised, without the procedural hurdles that have customarily barred them from recognised welfare structures.

In **Rural Areas,** eligibility is determined through *automatic addition criteria* (similar to homes without Shelters or landless families dependent on homemade labour) and *seven deprivation indicators (D1 – D7).* This parameter scheme of poverty multidimensionally goes beyond just income to embrace structural disadvantages like casing, education, and occupation.

[27] Ministry of Rural Development (n 13)

In **Urban Areas**, the scheme covers families based on *11 predefined occupational categories,* similar to road merchandisers, gharry scullers, sanitation workers, and domestic help, numerous of whom belong to the informal sector and are outside traditional state protection. This not only distinguishes the unseen workforce of rural India but also extends quality by connecting their work to social security entitlements. Correspondingly, the segregation of income duty payers and those retaining certain earnings ensures resources are not diverted to non-needy populations. In this way, PM-JAY delicately blends inclusivity with financial prudence.

Widespread Coverage Beyond the Traditional Miscellanies of Health Insurance: Ayushman Bharat moves beyond conventional "insurance" standards by offering comprehensive health assurance rather than simply cost-payment. Each eligible family is entitled to *₹5 lakh per time*, covering over *1,500 treatment* packages that span *25 specialities,* from coronary bypasses and cancer care to newborn and protective health services.

Importantly, the scheme includes

- Pre and post-hospitalisation charges for 3 and 15 days, independently,
- Day care procedures like cataract and dialysis,
- Follow-up sessions and diagnostics,
- Coverage for comorbidities and difficulties, which are frequently excluded in private insurance contracts.

This makes PM-JAY clinically inclusive and patient-centric, especially for the unprivileged people who suffer most from out-of-pocket expenses due to secondary and tertiary health requirements.

In certain cases, the transferability point allowing beneficiaries to access services at any empanelled Hospital across India ensures healthcare mobility, a corner invention in a country with vast regional migration.

Rigidity in enactment and Cooperative Federalism at Work: Honouring India's diversity in executive capacities, health structure, and governance preferences, PM-JAY offers **three functional models**, empowering the country to customise delivery while clinging to a public framework —

Insurance Model: The state signs agreements with insurance companies to handle beneficiary claims and threat pooling. This is the Insurance Model of PM-JAY. Through a competitive bidding process, insurers promise to carry the fiscal weight for every devisee family, at a fixed rate per time. Once the contract is signed, they become the scheme's risk managers, processing claims, settling hospital bills, authenticating eligibility, and keeping fraud in check. However, the insurer swallows the loss if they stay below, the insurer keeps the redundant, if claims shoot above expected levels. The State Health Agency plays the watchful adjudicator, administering strict Service Level Agreements that set the clock ticking on pre-authorisations, hospital empanelments, and grievance redressals. It's a neat handover of fiscal liability, freeing the government to concentrate on oversight while the insurer brings in its fast, tech-heavy claims systems. But then the balancing act if the premium is too low, the insurer might still strain payouts; too high, and taxpayers foot the redundant bill. Maharashtra and Chhattisgarh have used this model to roll out PM-JAY snappily, riding on the insurers' readymade networks and claims ministry.

Trust Model: The state forms a health trust or society to directly repay hospitals and oversee claims. In the Trust Model, the government keeps every rupee of control and responsibility in-house. The SHA becomes both the treasurer and the director, channelising finances received from the Centre and State budgets directly to hospitals for treating PM-JAY beneficiaries. The SHA, frequently structured as an independent society, either runs the claim agreement process itself or hires third-party directors as redundant hands. This model gives the government unmatched flexibility. Prices for treatment packages can be adjusted overnight, new hospitals can be brought in without insurer accommodations, and services can be fine-tuned to match state health pretensions. But with this control comes weighty responsibility; every claim, every fraud threat, every audit falls back on the State's office. Tamil Nadu and Kerala, known for their strong public health systems, favour this model, using their established networks and governance muscle to keep the machine running easily.

Hybrid Model: A combination, where some sections are managed by the insurance model while others are managed by the trust model. Think of it as the State saying, *"Some corridor I'll handle myself, some I'll outsource."* In practice, this might mean urban districts with a dense private hospital network are managed by insurance companies for speed and scale, while rural or high-cost specialised treatments stay under the government trust's vigilant eye. The State

Health Agency becomes the captain of a two-part symphony, one section playing to the meter of insurer contracts and decorations, the other performing under direct government backing and control. Andhra Pradesh has used this approach, assigning high-viscosity urban care to insurers while keeping rural areas within the hybrid setup, which offers flexibility and rigidity, but it also demands sharp collaboration to help avoid confusion and to keep the beneficiary experience uniform, no matter which side of the system they fall into.

This multicultural approach represents collaborative federalism in action. States like *Tamil Nadu and Kerala* have effectively run trust models using their strong public systems, while others like *Maharashtra and Chhattisgarh* have acclimated insurance models to swiftly measure coverage. This decentralisation has enhanced responsibility, rigidity, and innovation at the state level.

Hospital Empanelment Private Participation Meets Public Oversight: With over *28,000 empanelled hospitals, including 12,000 private institutions*, PM-JAY is fostering a new ecosystem of public-private accumulations in health. Empanelment is grounded on demanding quality marks, NABH delegation (or state equivalents), and continuous monitoring.

This has multiple positive goods.

- Expanding access in underserved regions,
- Improving quality through competition and benchmarking,
- Encouraging private investment in tier-2 and tier-3 metropolises,
- Reducing pressure on overloaded government hospitals.

States like Gujarat and Andhra Pradesh have established that strategic Hospital empanelment, coupled with Real-time checkups, can ensure both reach and trustworthiness.

PM-JAY AS A PATHWAY TO HEALTH IMPARTIALITY: COVERAGE, PROTECTION, AND SOCIAL ENCLOSURE

While perpetuation challenges persist, particularly in civic informal sectors and remote ethnical areas, the scheme's data-backed progress and evolving digital integration tools like ABHA ID signal a positive line toward Universal Health Coverage (UHC) by 2030.

Coverage and Application: As of 2025, PM-JAY has alleviated over *31,466 Hospital admissions*[28], with a wide range of treatments being retrieved by economically weaker sections. The network of *28,000 empanelled hospitals* includes *14,194 private providers*, indicating strong public-private cooperation.

PM-JAY has particularly served rural populations, women, and lower-income households, who initially demanded access to high-quality tertiary care. According to the *NHA report,* a majority of claims under PM-JAY seem to come from rural beneficiaries, particularly in high-cost treatments such as cancer, where rural recipients accounted for over 75%[29].

Financial Protection: A crucial success of PM-JAY lies in reducing *out-of-pocket expenditure* (OOPE), a primary cause of poverty in India. According to the *National Health Accounts 2021–22*[30], the share of OOPE in total health spending in India declined from *64.2% in 2013–14 to 39.4% in 2021–22,* a trend that PM-JAY has helped accelerate. Likewise, a PM-JAY policy detail indicates prominent reductions in inpatient OOPE, particularly among the most financially disadvantaged homes. Independent evaluations, similar to those by *Oxfam India*, affirm that PM-JAY has reduced the prevalence of disastrous health expenditure in devisee homes. These earnings reflect the pro-poor exposure of the scheme.

Gender and Equity Lens: PM-JAY has also surfaced as a *gender-sensitive intervention*, with women comprising *48.5% of the enrolled beneficiaries*[31]. The addition of *female-specific treatment packages*, similar to maternal healthcare, breast and cervical cancer screenings, and reproductive surgeries, has further assured gender equity in health care access.

Distinct attention has been given to socially marginalised groups, including Scheduled Castes and Scheduled Tribes, with targeted outreach and basic registration procedures. Yet, certain parts like the urban poor and homeless populations still face segregation due to lack of

[28] Over 41 Crore Ayushman Cards Created Under AB-PMJAY (n 22)
[29] 'Over 75% Cancer Treatments Under PM-JAY Availed by Rural Areas: Health Minister' *DD News* (19 March 2025) <https://ddnews.gov.in/en/over-75-cancer-treatments-under-pmjay-availed-by-rural-areas-health-minister/> accessed 05 August 2025
[30] Union Health Ministry Releases National Health Accounts Estimates for India 2020-21 and 2021-22 (n 10)
[31] 'LOK SABHA UNSTARRED QUESTION NO. 1585 TO BE ANSWERED ON 28TH JULY, 2023' (*Digital Sansad*) <https://sansad.in/getFile/loksabhaquestions/annex/1712/AU1585.pdf?source=pqals> accessed 05 August 2025

documentation or address proof. Feting this, the government is exploring the use of *One Nation One Health Card (ABHA ID)* to ground similar gaps.

These achievements inclusively position PM-JAY not just as a health assurance scheme, but as a transformational instrument in India's pursuit toward universal health coverage (UHC) and social justice.

LEGAL AND INDIGENOUS FRAMEWORK OF AYUSHMAN BHARAT

Ayushman Bharat is not simply a welfare scheme it is embedded in the constitutional vision of social justice and health equity, reflecting the fundamental duties of the state and the rights of the citizen. *Article 21*[32] *of the Constitution of India,* which guarantees the *Right to Life*, has been generously understood by the Supreme Court in cases similar to *Paschim Banga Khet Mazdoor Samity v State of West Bengal*[33]*,* where the Court of law held that the state is naturally obliged to give acceptable medical facilities. This jurisprudential foundation establishes healthcare as a justiciable right, indeed, though it is not expressly mentioned in the Fundamental Rights chapter.

Further, *Directive Principles of State Policy (DPSPs)* under *Articles 38, 39 (e), 41, 42,* and *47*[34] lay down the state's duty to encourage the welfare of the individuals by safeguarding a social order conducive to justice. Specifically, *Article 47* casts a primary responsibility on the state to raise the level of nourishment and the standard of living and to ameliorate public health.

Furthermore, Ayushman Bharat operates within the supervisory context of the *Clinical Establishments (Registration and Regulation) Act, 2010*[35], *the National Health Authority (NHA) guidelines*[36]*,* and numerous state-specific health insurance regulations. The legal backing for data confidentiality in the PM-JAY frame also ties into the awaiting *Digital Personal Data Protection Act, 2023*[37], which is anticipated to play a vital part in securing sensitive medical and demographic data of beneficiaries. Hence, Ayushman Bharat is a fine illustration of

[32] Constitution of India 1950, art 21
[33] *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37
[34] Constitution of India 1950, arts 38, 39(e), 41, 42, 47
[35] Clinical Establishments (Registration and Regulation) Act 2010
[36] 'Policy & Guidelines' (*Ayushman Bharat, Haryana*) <https://ayushmanbharat.haryana.gov.in/policy-guidelines/> accessed 05 August 2025
[37] Digital Personal Data Protection Act 2023

collaborative federalism invested with constitutional morality, wherein the Centre and States unite to uphold citizens' right to quality and well-being.

CHALLENGES AND REVIEWS A FORMATIVE LENS

Despite its remarkable progress, Ayushman Bharat is not without its structural and functional challenges. Critics have correctly refocused out that the scheme emphasises tertiary care and hospitalisation, potentially neglecting primary healthcare and preventative health in the long term. While Health and Wellness Centers (HWCs) aim to ground this gap, their rollout and capacity remain uneven across State.

Additionally, private hospitals in metropolitan cities occasionally avoid treating complex or precious cases under PM-JAY due to limited package rates, creating a quality-access imbalance. Urban homeless, nomadic tribes, transgender individuals, and persons without formal ID evidence face lesser difficulty in getting enrolled or receiving benefits, despite being among the most vulnerable. There are also cases of fraudulent billing, indistinguishable e-cards, and "phantom" treatments, which have been reported in states like Uttar Pradesh and Rajasthan. Still, the National Anti-Fraud Unit (NAFU), backed by digital forensics and state alert brigades, has made significant strides in addressing similar issues. Constructively, these reviews should not be viewed as failures but as course corrections that give openings to strengthen the system. The policy community increasingly sees Ayushman Bharat as a "living scheme" able to adapt, conform, and evolve to serve the people more.

CONCLUSION

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) marks a watershed moment in India's trip toward universal health coverage. Its sheer scale, ambitious pretensions, and decentralised, state-sensitive perpetration model position it as one of the largest administration-patronised healthcare enterprises encyclopedically. The scheme’s superintendent framework, while lacking legislative backing, has nevertheless laid the foundation for a rights-grounded approach to healthcare by making hospitalisation accessible and cashless for the poorest strata of society.

Despite certain legal inscrutability and functional challenges ranging from rejection crimes to urban-pastoral difference, the PM-JAY has introduced a robust digital backbone, performance-

linked empanelment mechanisms, and AI-driven fraud discovery systems that gesture a move toward responsible and technology-enabled public health governance. The success stories arising from states like Gujarat, Kerala, and Chhattisgarh, as well as individual beneficiaries, emphasise the transformative eventuality of the scheme when well-executed.

With continued legal refinement, inter-sectoral collaboration, and inclusive expansion, Ayushman Bharat has the potential to become the foundation of a truly indifferent and flexible public health armature in India.