



RESEARCH ARTICLE

Policy to Practice: A Qualitative Study of Experiences of Ayushman Card Beneficiaries in India

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Abstract

Ayushman Bharat, Pradhan Mantri Jan Arogya Yojana (PM-JAY) is a flagship health insurance initiative of the Government of India aimed at advancing universal health coverage for economically vulnerable populations. While the scheme offers substantial financial protection, limited evidence exists on how beneficiaries experience its implementation in everyday healthcare settings. This study examines the lived experiences and challenges faced by Ayushman Card users in accessing healthcare services in urban slum communities of Vadodara, Gujarat. A qualitative exploratory approach was used. Data were collected through one-on-one interviews and case-based narratives with ten beneficiaries from the Mujhmoda and Ramnagar slum areas. The study focused on understanding barriers encountered during enrollment, verification, and service utilization. The findings indicate a significant gap between policy intent and service delivery. Beneficiaries reported low awareness of scheme features, lack of required documentation, dependence on middlemen and agents, and unofficial payments demanded by hospitals despite insurance coverage. Aadhaar based KYC and biometric verification created serious obstacles for elderly persons and individuals with disabilities. Migration and address inconsistencies further increased reliance on agents, leading to card errors and access denial. The study concludes that although Ayushman Bharat is comprehensive in design, systemic and administrative barriers undermine its effectiveness in practice. Enhancing beneficiary awareness, simplifying verification procedures, strengthening hospital accountability, and providing local facilitation support are essential for ensuring equitable and inclusive access to healthcare services.

Keywords: Ayushman Bharat, PM-JAY, healthcare access, beneficiary experiences, universal health coverage, India

Introduction

Ayushman Bharata Yojana or the Pradhan Mantri Jan Arogya Yojana (PM-JAY) is a flagship scheme of the Government of India, which was launched as a recommendation by the National Health Policy 2017, to achieve the vision of Universal Health Coverage (UHC) and was designed to meet Sustainable Development Goals (SDGs) and its underlying commitment, which is to “leave no one behind.” As the world’s largest government-funded health assurance

scheme, PMJAY provides an annual financial cover of ₹5 lakh per family for secondary and tertiary care hospitalizations, targeting over 120 million vulnerable families identified via socio-economic criteria (National Health Authority [NHA], 2025). The operational cornerstone of this initiative is the Ayushman Card, a digital identification tool that facilitates cashless and paperless service delivery across a nationwide network of empanelled public and private healthcare providers (Garg et al., 2024). Ayushman Bharat is an attempt to shift to an universal need-based healthcare system from a sectoral and segmented approach. At the primary, secondary, and tertiary levels, this program seeks to implement innovative interventions to address the healthcare system holistically including prevention, promotion, and ambulatory care. Ayushman Bharat uses an integrated system of care strategy that consists of two interlinked parts i.e. Pradhan Mantri Jan Arogya Yojana (PM-JAY) and Health and Wellness Centres (HWCs)

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana

The Hon’ble Prime Minister of India, Shri Narendra Modi, introduced this initiative in Ranchi, Jharkhand, on September

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23, 2018. The National Health Protection Scheme (NHPS) was the previous name of PM-JAY. It succeeded the Rashtriya Swasthya Bima Yojana (RSBY), which was introduced in 2008. The Socio-Economic Caste Census 2011 (SECC 2011) deprivation and occupational criteria for rural and urban areas, respectively, are used to determine which families are included. Families that were insured under RSBY but are not listed in the SECC 2011 database are also covered under PM-JAY. To make the scheme operational at the National level, and to rollout the scheme in coordination with the various State Governments, the National Health Authority (NHA) has been established (AIIMS, New Delhi, 2021)

The financing of the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY) is designed to reflect the diversity of India's states and Union Territories and to ensure that no region is left behind in providing health coverage to its people. Rather than following a single funding rule, the scheme adopts a flexible cost-sharing arrangement between the Central and State Governments. In most States and Union Territories with a legislature, the Centre and the State share expenses in a 60:40 ratio. However, recognising the greater developmental and geographic challenges faced by the North-Eastern and Himalayan regions, the Centre contributes a much larger share of 90 per cent in these areas, leaving only 10 per cent for the States. In Union Territories without a legislature, the entire cost is borne by the Central Government. This approach not only eases the financial burden on less-resourced regions but also strengthens cooperative federalism and supports the goal of providing equitable health protection to vulnerable populations across India.

A key feature of PM-JAY is its cashless and paperless access to healthcare at the point of service, which allows beneficiaries to receive treatment without making upfront payments. By covering pre-hospitalisation expenses for up to three days and post-hospitalisation care for up to fifteen days, including diagnostics and medicines, the scheme ensures continuity of care. There are no restrictions based on family size, age, gender, or pre-existing conditions, which are covered from the first day of enrollment. The portability of benefits across India further enables beneficiaries to seek treatment at any empanelled hospital nationwide. With a comprehensive package of around 1,929 procedures covering consultations, diagnostics, medicines, implants, ICU and OT charges, accommodation, and follow-up care, PM-JAY addresses the full spectrum of treatment costs. By reducing out-of-pocket expenditure and protecting households from catastrophic health spending, the scheme plays a crucial role in promoting health equity and financial risk protection.

Ayushman Card

The Ayushman Card serves as the official entitlement document for beneficiaries of the Ayushman Bharat–

Pradhan Mantri Jan Arogya Yojana (PM-JAY), enabling eligible families to access the scheme's health insurance benefits without financial barriers at the point of care. Once issued, the card contains essential beneficiary details linked to the National Health Authority's database and is recognised across all empanelled public and private hospitals nationwide, simplifying the process of receiving treatment under the scheme (GovtSchemes.in, 2025). Although not mandatory for accessing benefits, the Ayushman Card often facilitates easier verification and smooth processing of cashless treatment claims, particularly in emergency and planned care settings. Distribution of the card is continuing at a large scale, with states like Uttar Pradesh reporting significant issuance to millions of households, reflecting its role in strengthening the reach of national health protection efforts (IndiaTimes, 2025). The card's integration with digital platforms also supports online eligibility checks and downloads, contributing to increased accessibility and transparency in implementation (pmjay.gov.in; GovtSchemes.in, 2025).

The Ayushman Card issued under the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) is available only to families and individuals who meet defined eligibility criteria, primarily based on socio-economic vulnerability. Eligibility is assessed using the Socio-Economic Caste Census (SECC) and includes low-income and disadvantaged households; recent policy updates also make all Indian citizens aged 70 years and above eligible for coverage regardless of income status, allowing them to receive a separate Ayushman Vay Vandana Card (for senior citizens) with the same benefits (ayushmancard.org, 2026). Once eligibility is confirmed, application for the Ayushman Card can be completed online through the official PM-JAY web portal or mobile app by logging in, providing Aadhaar and other necessary information, and authenticating eKYC; the e-card can then be downloaded and used for cashless treatment. Alternatively, applicants may also apply offline by visiting nearby Common Service Centres (CSCs), empanelled hospital help desks, or PM-JAY kiosks, where supporting staff assist with document verification and card generation without any fee.

The eligibility framework of PM-JAY is structured as a fully subsidised scheme targeting the bottom 40 per cent of India's population, covering nearly 12 crore vulnerable households. Beneficiary identification is primarily based on the Socio-Economic Caste Census (SECC) 2011, which classifies households using clearly defined deprivation and occupational criteria across rural and urban contexts. In rural areas, inclusion is determined by indicators such as substandard housing conditions, absence of working-age members, disability within the household, landlessness, and social disadvantage. In urban settings, eligibility is linked to engagement in vulnerable occupational groups, including informal sector workers, street vendors, sanitation workers,

and other low-income service providers. By adopting SECC data as the core targeting mechanism, PM-JAY aligns with the Government of India's broader strategy of evidence-based and targeted welfare delivery. At the same time, States are provided flexibility to integrate their own beneficiary databases, provided that all SECC-eligible households are included. This dual approach ensures both national uniformity and state-level adaptability, thereby strengthening the scheme's capacity to reach populations most in need of financial protection against health-related risks.

Research Objectives

The primary aim of this qualitative study is to analyze the socio-technical and administrative hurdles that impede the seamless transition of the Ayushman Bharat policy into tangible healthcare benefits. The specific objectives are as follows:

- To explore the navigational challenges faced by potential beneficiaries during the enrollment and card-issuance phase
- To analyze the phenomenological experiences of cardholders navigating service-delivery hurdles at empanelled facilities
- To analyze the prevalence and nature of residual out-of-pocket expenditure (OOPE) among "cashless" beneficiaries

Research Methodology

This study utilizes a qualitative descriptive design to explore the phenomenological experiences and administrative challenges of Ayushman Bharat beneficiaries. This design is focused on providing a straightforward, factual account of events and experiences as reported by the participants.

Research Design and Duration

The study is a primary-data-driven inquiry conducted during December 2025. This period allowed for a real-time observation of the challenges faced by beneficiaries following the latest policy updates and eKYC requirements in Gujarat.

Study Setting and Sample

The research was conducted in two specific localities of Vadodara, Gujarat: Rampura and Mujmahuda. A purposive sample of 10 participants was selected. To ensure the study captured relevant challenges, participants were identified through a local NGO working in these neighborhoods. This NGO helped locate individuals who had specifically faced hurdles, such as pending eKYC status or difficulties during hospital admission.

Inclusion and Exclusion Criteria

Inclusion

Residents of Rampura or Mujmahuda who are eligible for the Ayushman card and have attempted to use it or apply for it recently.

Exclusion

Individuals who are not eligible for the scheme or those who did not face any difficulties in the process, as the study specifically aims to document "challenges."

Data Collection Methods

Data was collected through Face-to-Face Interviews using a simple set of open-ended questions. The researcher visited the participants in their community to understand their journey from "Policy to Practice." The interviews were conducted in Gujarati and Hindi to ensure participants could express their frustrations and experiences clearly.

Data Analysis Approach

For this concept paper, a narrative summarization approach was adopted to capture and synthesize the lived experiences of beneficiaries. Interview notes and audio recordings were carefully reviewed and analysed, after which the ten individual cases were organised into two broad thematic groups: enrollment related hurdles, such as delays in eKYC and documentation, and utilisation-related hurdles, including difficulties faced at hospitals while seeking treatment. From these narratives, the most illustrative and descriptive quotations were selected to highlight recurring problems and shared patterns of experience in the study locations of Rampura and Mujmahuda. This approach allowed the analysis to remain grounded in participants' voices while systematically presenting the key challenges encountered in accessing and using the scheme.

Scope and Limitations

The scope of this study is confined to examining the administrative and operational challenges encountered by ten selected beneficiaries in the Vadodara district. It focuses specifically on their experiences with enrolment and utilisation processes under the scheme, without extending to broader systemic or policy-level evaluation.

At the same time, the study has certain limitations. The small sample size restricts the generalisability of the findings to the wider population of beneficiaries across India. Moreover, the analysis is based on participants' recollections of their experiences, which may be influenced by recall bias and personal perceptions. These constraints should be considered while interpreting the results of the study.

Findings

The analysis of beneficiary narratives revealed significant discrepancies between the legislative intent of the Pradhan Mantri Jan Arogya Yojana (PM-JAY) and its operational reality. These findings are discussed under two primary administrative domains: enrollment barriers and point-of-care utilization.

Enrollment and Administrative Barriers

The findings indicate that the target population often lacks the foundational documentation required to initiate the enrollment process. Beneficiaries reported that medical emergencies often occurred when critical documents, such as income certificates or updated Aadhaar cards, were unavailable. One participant emphasized this vulnerability, stating,

“I had a medical emergency at that time; I didn’t have an income certificate or Aadhaar card—how will I get the benefits?”

This documentation gap is compounded by a lack of official facilitators, leading beneficiaries toward exploitative middlemen. Participants reported being manipulated by agents who demanded “service fees” for a card that is legally free, with one beneficiary noting that an agent took ₹2,000 but failed to provide a functioning card.

Furthermore, technical and biological hurdles significantly impeded enrollment for elderly and disabled participants. The reliance on biometric eKYC created systemic exclusion for geriatric beneficiaries with age-related physical changes, such as loose skin affecting fingerprints or cataracts hindering iris scans. Additionally, a unique migration-ration link was observed in residents of Rampura and Mujmahuda as they often refused to update their Aadhaar addresses for fear of losing localized Public Distribution System (PDS) benefits, forcing them to rely on unauthorized agents for card issuance.

Point-of-Care Utilization and Information Asymmetry

Even for those with valid cards, the “cashless” promise of the scheme was frequently undermined by information gaps and illegal hospital charges. Beneficiaries exhibited a profound lack of knowledge regarding hospital empanelment, specifically which facilities provided certain specialized services versus general care. This information asymmetry left families unable to identify appropriate providers during emergencies.

The most significant utilization barrier involved the demand for informal payments at empanelled private hospitals. Participants described instances where hospitals charged supplementary fees despite the presentation of a valid Ayushman card. One beneficiary recounted their experience during a relative’s surgery:

“Our relative recently had an operation with an Ayushman card in a private hospital. The hospital took ₹10,500 over it, gave no receipt, and said you should not tell about this to anyone.”

These supplementary charges, often framed as administrative costs, directly increase out-of-pocket expenditure (OOPE) and erode public trust in the scheme. Another participant summarized this disillusionment by stating,

“They say it is free, it is free... but nothing is free.”

Such findings are consistent with secondary research indicating that private provider moral hazard is a persistent obstacle to achieving universal health coverage.

Suggestions

The identified implementation gaps necessitate a multi-stakeholder approach to ensure the Ayushman Bharat scheme achieves its intended impact. A primary recommendation is the formalization of a Public-Private Partnership (PPP) model. By incentivizing private healthcare consultants and technology firms to collaborate with state health agencies, the government can streamline the e-KYC process and hospital pre-authorizations. This model would allow for the integration of private-sector efficiency into the public delivery system, ensuring that technical glitches and administrative delays are resolved through professionalized service-level agreements.

Furthermore, the integration of Corporate Social Responsibility (CSR) and Non-Governmental Organizations (NGOs) is critical for community-level facilitation. Large corporations, particularly those operating in the Vadodara industrial corridor, should be encouraged to direct CSR funding toward the establishment of permanent Ayushman Help Desks in vulnerable clusters like Rampura and Mujmahuda. These desks, managed by trained NGO personnel, would serve as accountable intermediaries to assist beneficiaries with documentation, bypass exploitative agents, and provide direct advocacy when hospitals demand illegal payments. Such localized support centers would bridge the trust deficit and ensure that the “cashless” mandate is strictly enforced at the provider level.

To address the profound information asymmetry observed among cardholders, the government must launch a comprehensive communication and advertisement campaign. This strategic propaganda should move beyond simple awareness and focus on functional literacy. By utilizing celebrity endorsements, local folk media, and high-frequency digital advertisements, the campaign can clarify the complexities of hospital empanelment and package limitations. Clear, attractive messaging that educates the public on their right to a cash free experience and provides a visible helpline number would empower beneficiaries to resist manipulation by both agents and providers.

Finally, the technical exclusion of the elderly and disabled must be addressed through a “reach-out” rather than “call-in” strategy. This involves the deployment of mobile biometric units that can perform iris scans and face-authentication at the beneficiary’s doorstep. By combining this mobile infrastructure with the existing NGO network, the government can achieve “saturation” in enrollment without placing a physical or financial burden on the most fragile demographics. These collective measures ranging from CSR-NGO collaboration to strategic advertising, would

ensure that the Ayushman card functions not just as a piece of plastic, but as a guaranteed portal to equitable healthcare.

Conclusion

The transition of the Ayushman Bharat PM-JAY from a landmark healthcare policy to an effective reality remains a complex challenge, particularly for vulnerable populations in urban clusters like Rampura and Mujmahuda. This study has demonstrated that while the Ayushman Card holds the potential for transformative financial protection, its efficacy is currently hampered by a grassroot implementation gap characterized by biometric exclusion of the elderly, exploitative intermediary practices, and illegal out-of-pocket demands by providers. To move forward, the scheme must evolve beyond a digital identification framework toward a more integrated, human-centric delivery model. By leveraging Public-Private Partnerships (PPP), utilizing CSR-funded NGO help desks for localized facilitation, and launching high-impact, transparent communication campaigns, the government can dismantle the information asymmetry and administrative friction that currently exclude the very citizens the policy was designed to protect. Ultimately, the success of India's journey toward Universal Health Coverage will be measured not by the number of cards issued, but by the dignity and financial security afforded to beneficiaries at the point of care.

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